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

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

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

INSTRUCTIONS

FOR UPDATING THE

IOWA ADMINISTRATIVE CODE

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

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

Human Services Department[441]

- Replace Chapter 7
- Replace Chapter 36
- Replace Chapter 75
- Replace Chapters 77 and 78
- Replace Chapter 83

Inspections and Appeals Department[481]

- Replace Analysis
- Replace Chapter 74 with Reserved Chapter 74

Homeland Security and Emergency Management Department[605]

- Replace Analysis
- Replace Chapter 10

Professional Licensure Division[645]

- Replace Analysis
- Replace Chapter 200
- Replace Chapter 203
- Replace Chapter 206

Regents Board[681]

- Replace Chapter 4

Transportation Department[761]

- Replace Analysis
- Replace Chapters 161 and 162
- Replace Chapter 174
- Replace Chapter 700
- Replace Chapter 710
- Replace Chapters 715 to 717
- Replace Chapter 800
- Replace Chapter 802
- Replace Chapter 810
- Replace Chapter 813
- Replace Chapter 822

Workers' Compensation Division[876]
Replace Chapter 8

CHAPTER 7
APPEALS AND HEARINGS

[Ch 7, July 1973 IDR Supplement, renumbered as Ch 81]

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

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

PREAMBLE

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.

“*Administrative hearing*” means a type of hearing that an appellant may elect in which the presiding officer reviews the written record only and makes a decision based on the facts available within the appeal file. An administrative hearing does not require an in-person or teleconference hearing. The final determination to establish whether an administrative hearing may be held will be made by the appeals section or the presiding officer.

“*Administrative law judge*” means an employee of the department of inspections and appeals who conducts appeal hearings.

“*Agency*” means the Iowa department of human services, including any of its local, institutional, or central administrative offices.

“*Aggrieved person*” means a person against whom the department has taken an adverse action. This includes a person who meets any of the conditions in rule 441—7.2(17A).

“*Appeal*” denotes a review and hearing request made by a person who is affected by a decision made by the agency or its designee. An appeal shall be considered a contested case within the meaning of Iowa Code chapter 17A.

“*Appeals advisory committee*” means a committee consisting of central office staff who represent the department in the screening of proposed decisions for the director.

“*Appeals section*” means the unit within the department of human services that receives appeal requests, certifies requests for hearing, and issues final appeal decisions.

“*Appellant*” denotes the person who claims or asserts a right or demand or the party who takes an appeal from a hearing to an Iowa district court.

“*Attribution appeal*” means an appeal to determine if additional resources can be allocated for the community spouse when the other spouse has entered a medical institution or is applying for home-and community-based waiver services. The result of the attribution appeal may affect Medicaid eligibility. An appellant may elect to have an attribution appeal held by administrative hearing.

“*Authorized representative*” means a person or organization designated by an appellant to act on the appellant’s behalf or who has legal authority to act on behalf of the appellant, such as a guardian or power of attorney.

“*Bidder*” means an individual or entity that submits a proposal in response to a competitive procurement issued by the department of human services.

“*Contested case*” means a proceeding defined by Iowa Code section 17A.2(5) and includes any matter defined as a “no factual dispute” contested case under Iowa Code section 17A.10A.

“*Department*” means the Iowa department of human services.

“*Department of inspections and appeals*” means the state agency that contracts with the department to conduct appeal hearings.

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

“*Due process*” denotes the right of a person affected by an agency decision to receive a notice of decision or notice of action and an opportunity to be heard at an appeal hearing and to present an effective defense.

“*Electronic account*” means a web-based account established by the department for an applicant or member for communication between the department and the applicant or member.

“Electronic case record” means an electronic file that includes all information collected and generated by the department regarding each individual’s Medicaid or healthy and well kids in Iowa eligibility and enrollment, including all documentation required for eligibility and any information collected or generated as part of a fair hearing process conducted by the department or through the exchange appeals process.

“Ex parte communication” means written, oral, or other forms of communication between a party to the appeal and the presiding officer while an appeal is pending when all parties were not given the opportunity to participate.

“Exchange” means an American health benefit exchange established pursuant to Section 1311 of the Patient Protection and Affordable Care Act of 2010 (Pub. L. 111-148). This entity makes qualified health plans available to qualified individuals and qualified employers.

“First-level review” means a review process that must be exhausted through a managed care organization before an appeal hearing is granted. Once the first-level review process is complete, a notice of decision will be issued by the managed care organization and will identify further appeal rights, if applicable.

“FMAP-related” describes coverage groups whose eligibility criteria are derived in relation to the family medical assistance program, directed toward children and their parents or caretakers.

“Food assistance administrative disqualification hearing” means a type of hearing used to determine if an individual fraudulently received benefits for which the individual was not eligible. A presiding officer shall determine if the individual will be banned from participating in the food assistance program for a period of time.

“Group hearings” denotes an opportunity for two or more persons to present their case jointly when all have the same complaint against agency policy.

“Informal conference” means a type of meeting between the appellant and the appellant’s representative, unless precluded by federal law or state statute, and a representative of the department. The purpose of the 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, to provide an opportunity for the appellant to explain the appellant’s action or position, and to provide an opportunity for the appellant to examine the contents of the case record, including any electronic case record, plus all documents and records to be used by the department at the hearing in accordance with 441—Chapter 9.

“In person or face-to-face hearing” means an appeal hearing conducted by an administrative law judge who is physically present in the same location as the appellant.

“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 Food and Nutrition Act of 2008, food assistance program regulations, or any state law relating to the use, presentation, transfer, acquisition, receipt, possession, or trafficking of an electronic benefit transfer (EBT) card. An intentional program violation is determined through a food assistance administrative disqualification hearing. The hearing may result in a period of ineligibility for the program, a claim for overpayment of benefits, or both.

“Local office” means the county, institution or district office of the department of human services.

“Managed care organization” or *“MCO”* 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” in Iowa Code section 514B.1.

“Party” means a party as defined in Iowa Code subsection 17A.2(8).

“Prehearing conference” means a type of meeting between the appellant and the appellant’s representative, unless precluded by federal law or state statute, a representative of the department and a presiding officer. The purpose of the prehearing conference is to discuss the appealed issue, to inquire as to the potential for voluntary settlement, to establish the hearing date, to establish the location of the hearing including whether the hearing will be by telephone or in person, and to discuss procedural matters relevant to the case.

“*Presiding officer*” means an administrative law judge employed by the department of inspections and appeals. The presiding officer may also be the department’s director or the director’s designee. The presiding officer has the authority to conduct appeal hearings and render proposed and final decisions.

“*Presumption*” denotes an inference as to the existence of a fact not known or drawn from facts that are known.

“*PROMISE JOBS discrimination complaint*” means any written complaint filed in accordance with the provisions of rule 441—7.8(17A) by a PROMISE JOBS participant or the participant’s representative which alleges that an adverse action was taken against the participant on the basis of race, creed, color, sex, national origin, religion, age, physical or mental disability, or political belief.

“*PROMISE JOBS displacement grievance*” means any written complaint filed with a PROMISE JOBS contractee by regular employees or their representatives that alleges that the work assignment of an individual under the PROMISE JOBS program violates any of the prohibitions against displacement of regular workers described in rule 441—93.17(239B).

“*Proposed decision*” means the presiding officer’s recommended findings of fact, conclusions of law, and decision and order in contested cases where the department did not preside.

“*Reconsideration*” means a review process that must be exhausted before an appeal hearing is granted. Such review processes include, but are not limited to, a reconsideration request through:

1. The Iowa Medicaid enterprise (IME),
2. A division or bureau within the department,
3. The mental health and disability services commission,
4. A licensed health care professional as specified in 441—paragraph 9.9(1)“i,” or
5. Any division or bureau within the department, from a bidder in a competitive procurement bid process.

Once the reconsideration process is complete, a notice of decision or notice of action will be issued with appeal rights.

“*Sent*” means deposited in the mail with first-class postage or posted to an individual’s electronic account.

“*SSI-related*” describes medical assistance coverage groups whose eligibility criteria, except for income and resource limits, are derived from the supplemental security income (SSI) program for people who are aged, blind, or disabled.

“*Teleconference hearing*” means an appeal hearing conducted by an administrative law judge over the telephone.

“*Timely notice period*” is the time from the date a notice is sent to the effective date of action. That period of time shall be at least ten calendar days, except in the case of probable fraud of a beneficiary. When probable fraud exists, “timely notice period” shall be at least five calendar days from the date a notice is sent.

“*Vendor*” means a provider of health care under the medical assistance program or a provider of services under a service program.

[ARC 8003B, IAB 7/29/09, effective 9/2/09; ARC 8994B, IAB 8/11/10, effective 10/1/10; ARC 9254B, IAB 12/1/10, effective 1/1/11; ARC 0304C, IAB 9/5/12, effective 11/1/12; ARC 0487C, IAB 12/12/12, effective 2/1/13; ARC 0583C, IAB 2/6/13, effective 4/1/13; ARC 0819C, IAB 7/10/13, effective 9/1/13; ARC 1206C, IAB 12/11/13, effective 1/15/14; ARC 1261C, IAB 1/8/14, effective 3/1/14; ARC 1611C, IAB 9/3/14, effective 11/1/14; ARC 3093C, IAB 6/7/17, effective 7/12/17]

441—7.2(17A) Conditions of an aggrieved person. To be eligible for an appeal hearing, a person must meet the definition of “aggrieved person” in rule 441—7.1(17A) and qualify on a program-specific basis.

7.2(1) Financial assistance. Financial assistance includes, but is not limited to, the family investment program; refugee cash assistance; child care assistance; emergency or disaster assistance; family or community self-sufficiency grants; family investment program hardship exemptions; and state supplementary assistance dependent person, in-home health-related care, and residential care facility benefits. Issues may include:

- a. A request to be given an application was denied.
- b. An application for assistance has been denied or has not been acted on in a timely manner.
- c. The effective date of assistance is contested.

- d. The amount of benefits granted is contested.
- e. The assistance will be reduced or canceled.
- f. An overpayment of benefits has been established, and repayment is requested.

7.2(2) Food assistance. Issues may include:

- a. A request to be given an application was denied.
- b. An application for assistance has been denied or has not been acted on in a timely manner.
- c. The effective date of assistance is contested.
- d. The amount of benefits granted is contested.
- e. The assistance will be reduced or canceled.
- f. A request to receive a credit for benefits from an electronic benefit transfer (EBT) account has been denied.
- g. An overpayment of benefits has been established, and repayment is requested.

7.2(3) Medical assistance eligibility. Medical assistance eligibility includes, but is not limited to, FMAP-related coverage groups, SSI-related coverage groups, the breast and cervical cancer treatment program, the health insurance premium payment program, healthy and well kids in Iowa (HAWK-I), the Iowa Health and Wellness Plan, and waiver services. Issues may include:

- a. A request to be given an application was denied.
- b. An application has been denied or has not been acted on in a timely manner.
- c. The person's eligibility has been terminated, suspended or reduced.
- d. The level of benefits the person is eligible to receive has been reduced.
- e. A determination of the amount of medical expenses that must be incurred to establish income eligibility for the medically needy program or a determination of income for the purposes of imposing any premiums, enrollment fees or cost sharing is contested.
- f. The level of care requirements have not been met.
- g. The failure to take into account the appellant's choice in assignment to a coverage group.
- h. The effective date of assistance is contested.
- i. The amount or effective date of one of the following is contested:
 - (1) Health insurance premiums,
 - (2) Healthy and well kids in Iowa premiums,
 - (3) Medicaid for employed people with disabilities premiums,
 - (4) Iowa Health and Wellness Plan contributions,
 - (5) Client participation, or
 - (6) Medically needy program spenddown.
- j. An overpayment of benefits has been established, and repayment is requested.

7.2(4) Fee-for-service medical coverage. Issues may include:

- a. The level of services that the person is eligible to receive has been reduced.
- b. The level of services provided by a nursing facility is not needed based on a preadmission screening and resident review (PASRR) evaluation.
- c. The effective date of services is contested.
- d. A claim for payment or prior authorization has been denied.
- e. The medical assistance hotline has issued notification that services not received or services for which an individual is billed are not payable by medical assistance.
- f. Nonemergency medical transportation services by the broker designated by the department pursuant to rule 441—78.13(249A) have been denied.

7.2(5) Managed care organization medical coverage.

- a. A Medicaid member, an authorized representative or a provider who is acting on behalf of a member has been notified that the first-level review process through a managed care organization has been exhausted and remains dissatisfied with the outcome.
- b. If a provider or authorized representative is acting on behalf of a member by filing this type of appeal, the member's written consent to appeal must be submitted on Form 470-5526, Authorized Representative for Managed Care Appeals, with the appeal request. If the appeal is filed verbally, the

managed care organization or agency is responsible for obtaining the member's written consent for the provider or authorized representative.

c. If the managed care organization fails to adhere to the notice and timing requirements in 42 CFR 438.408, the Medicaid member, authorized representative or provider who is acting on behalf of the member is deemed to have exhausted the managed care organization's appeals process. The Medicaid member, authorized representative or provider who is acting on behalf of the member may initiate a state fair hearing.

7.2(6) Providers. Providers can be an individual or an entity. Issues may include:

a. A license, certification, registration, approval or accreditation has been denied or revoked or has not been acted on in a timely manner.

b. A fee-for-service claim for payment or request for prior authorization of payment has been denied in whole or in part and the provider states that the denial was not made according to department policy.

c. A medical assistance patient manager contract has been terminated.

d. A payment has been withheld to recover a prior overpayment, or an order to repay an overpayment pursuant to 441—subrule 79.4(7) has been received.

e. An application for child care quality rating has not been acted upon in a timely fashion.

f. A child care quality rating decision is contested.

g. A certificate of child care quality rating has been revoked.

h. An adverse action has been taken relating to the Iowa electronic health record incentive program pursuant to rule 441—79.16(249A), including:

(1) Provider eligibility determination,

(2) Incentive payments, or

(3) Demonstration of adopting, implementing, upgrading and meaningful use of technology.

i. An application or reapplication for licensure was issued as a provisional license.

j. A license has been issued for a limited time.

7.2(7) Social services. Social services include, but are not limited to, adoption, foster care, and family-centered services. Issues may include:

a. A request to be given an application was denied.

b. An application for services or payment for adoption subsidy or foster care has been denied or has not been acted on in a timely manner.

c. An application or license has been denied based on a record check evaluation.

d. A determination that a person must participate in a service program is contested.

e. A claim for payment of services has been denied.

f. A protective or vendor payment has been established.

g. The services have been reduced or canceled.

h. An overpayment of services has been established, and repayment is requested.

i. An adoptive placement of a child has been denied or delayed when an adoptive family is available outside the jurisdiction with responsibility for handling the child's case.

j. A referral to community care was not made as provided in rule 441—186.2(234).

k. A referral to community care as provided in rule 441—186.2(234) was made and the community care provider's dispute resolution process has been exhausted.

7.2(8) Child support recovery. Issues may include:

a. A person is not entitled to a support payment in full or in part because of the date of collection, as provided under rule 441—95.13(17A), or a dispute based on the date of collection has not been acted on in a timely manner.

b. A claim or offset is contested as provided in 441—subrule 95.6(3), 95.7(8), or 98.81(3) by a person's alleging a mistake of fact. "Mistake of fact" means a mistake in the identity of the obligor or in whether the delinquency meets the criteria for referral or submission. The issue on appeal shall be limited to a mistake of fact. Any other issue may be determined only by a court of competent jurisdiction.

c. A name has been certified for passport sanction as provided in Iowa Code section 252B.5.

d. A termination in services has occurred as provided in rule 441—95.14(252B).

7.2(9) PROMISE JOBS. Issues may include:

- a. A claim for participation allowances has been denied, reduced, or canceled.
- b. The contents of the family investment agreement are not sufficient or necessary for the family to reach self-sufficiency.
- c. The results of informal grievance resolution procedures are contested, an opportunity for an informal grievance resolution has been declined, or a decision was not made within the 14-day period.
- d. PROMISE JOBS services will be canceled due to imposition of a limited benefit plan.
- e. An overpayment of benefits has been established, and repayment is requested.
- f. Acts of discrimination are alleged on the basis of race, creed, color, sex, age, physical or mental disability, religion, national origin, or political belief.

7.2(10) Child abuse registry, dependent adult abuse registry, or record check evaluation. Issues may include:

- a. A person is alleged responsible for child abuse.
- b. A correction of dependent adult abuse information has been requested.
- c. A record check evaluation restricted or denied employment in a health care facility, state institution, or other facility. "Employment" includes, but is not limited to, service as an employee, a volunteer, a provider, or a contractor. "Facility" includes, but is not limited to, county or multicounty juvenile detention homes and juvenile shelter care homes, child-placing agencies, substance abuse treatment programs, group living foster care facilities, child development homes, child care centers, state resource centers, mental health institutes, and state training schools.
- d. A record check evaluation results in the restriction of participation in an educational training program.

7.2(11) Mental health and disability services. Issues may include:

- a. An application for state payment under 441—Chapter 153, Division IV, has been denied or has not been acted upon in a timely manner.
- b. Services under the state payment program have been reduced or canceled.
- c. A request to be given an application was denied.
- d. The person's eligibility has been terminated, suspended or reduced.
- e. The level of benefits or services the person is eligible to receive has been reduced.
- f. The effective date of assistance or services is contested.
- g. The reconsideration process has been exhausted, and a person remains dissatisfied with the outcome.
- h. The amount or effective date of cost-sharing requirements for the autism support program is contested.
- i. A service authorization request for applied behavioral analysis services has been denied or reduced.

7.2(12) HIPAA (Health Insurance Portability and Accountability Act). A current or former applicant for or recipient of Medicaid or HAWK-I, or a person currently or previously in a department facility whose request:

- a. To restrict use or disclosure of protected health information was denied.
- b. To change how protected health information is provided was denied.
- c. For access to protected health information was denied. When the denial is subject to reconsideration under 441—paragraph 9.9(1) "i," persons denied access due to a licensed health care professional's opinion that the information would constitute a danger to that person or another person must first exhaust the reconsideration process.
- d. To amend protected health information was denied.
- e. For an accounting of disclosures was denied.

7.2(13) Drug manufacturers. A manufacturer that has received a notice of decision regarding disputed drug rebates pursuant to the dispute resolution procedures of a national drug rebate agreement or an Iowa Medicaid supplemental drug rebate agreement disagrees with the decision.

7.2(14) Bidders that have participated in a competitive procurement bid process. Appeals resulting from a competitive procurement bid process will be handled pursuant to Chapter 7, Division II.

7.2(15) Family planning program. Issues may include:

- a. A request to be given an application was denied.
- b. An application has been denied or has not been acted on in a timely manner.
- c. The person's eligibility has been terminated or reduced.
- d. Who contests the effective date of assistance or services.
- e. Whose claim for payment or prior authorization has been denied.
- f. Who has received notice from the medical assistance hotline that services not received or services for which an individual is being billed are not payable by the family planning program.
- g. Who has been notified that an overpayment of benefits has been established and repayment is requested.

7.2(16) Other individuals or providers. Individuals or providers that are not listed in rule 441—7.2(17A) may meet the definition of an aggrieved person if the department has taken an adverse action against that individual or provider.

[ARC 3093C, IAB 6/7/17, effective 7/12/17; ARC 3199C, IAB 7/19/17, effective 7/1/17; ARC 3389C, IAB 10/11/17, effective 11/15/17; ARC 3871C, IAB 7/4/18, effective 8/8/18]

DIVISION I

441—7.3(17A) Presiding officer. Appeal hearings shall be conducted by a presiding officer appointed by the department of inspections and appeals pursuant to Iowa Code section 10A.801. The presiding officer shall not be connected in any way with the previous actions or decisions on which the appeal is made. Nor shall the presiding officer be subject to the authority, direction, or discretion of any person who has prosecuted or advocated in connection with that case, the specific controversy underlying that case, or any pending factually related contested case or controversy involving the same parties.

441—7.4(17A) Notification of hearing procedures. Hearing procedures shall be published in the form of rules and shall be made available to all applicants, recipients, appellants, and other interested groups and individuals. Procedures for hearings shall be identified in the notice of hearing issued to all parties as provided in subrule 7.10(7).

7.4(1) Hearing procedures must be furnished in electronic and paper format and orally as appropriate. The procedures must be written in plain language and in a manner that is accessible:

- a. To individuals who are limited English proficient through oral interpretation, written translations, and taglines in non-English languages indicating the availability of language services. The services shall be at no cost to the individual.
- b. To individuals living with disabilities through the provision of auxiliary aids in accordance with the Americans with Disabilities Act and Section 504 of the Rehabilitation Act. The services shall be at no cost to the individual.

7.4(2) The department shall inform individuals of the availability of the services and how to access such services.

[ARC 1261C, IAB 1/8/14, effective 3/1/14]

441—7.5(17A) The right to appeal. An aggrieved person who qualifies for an appeal as stated in rule 441—7.2(17A) may file an appeal. The appeals section shall determine whether a hearing shall be granted.

7.5(1) When a hearing is granted. A hearing shall be granted to any appellant when the right to a hearing is granted by state or federal law, except as limited in subrules 7.5(2) and 7.5(4).

7.5(2) When a hearing is not granted. A hearing shall not be granted when:

- a. One of the following issues is appealed:
 - (1) The service is no longer available through the department.
 - (2) Repayment of food assistance benefits as a result of trafficking has been requested on Form 470-4179, Notice of Food Assistance Trafficking Debt.
 - (3) Payment for a medical claim has been made in accordance with the Medicaid payment schedule for the service billed.

- (4) Children have been removed from or placed in a specific foster care setting.
- (5) Children have not been placed with or have been removed from a preadoptive family.
- (6) A qualified provider or qualified entity has denied a person presumptive eligibility for Medicaid under 441—subrule 75.1(30), 75.1(40), or 75.1(44).
- (7) A qualified provider or qualified entity has determined a person to be presumptively eligible for Medicaid under 441—subrule 75.1(30), 75.1(40), or 75.1(44), but presumptive eligibility ends due to the person's failure to file an application.
- (8) Notice has been issued from the treasury offset program for a food assistance overpayment.
- (9) A rate determination for foster group care services has been reviewed under rule 441—152.3(234).
- (10) The maximum provider rate ceiling has been contested for child care assistance under 441—subrule 170.4(7).
- (11) The risk pool board has accepted or rejected an application for assistance from the risk pool fund or the tobacco settlement fund risk pool fund in whole or in part under rules 441—25.66(426B) and 441—25.77(78GA,ch1221).
- (12) The appellant has a complaint about child support recovery matters other than those described in numbered paragraph “5” of the definition of an aggrieved person in rule 441—7.1(17A). This includes collection of an annual fee for child support services as specified in Iowa Code chapter 252B.
- (13) The appellant has a complaint about a local office employee (when this is the only issue of the appeal).
- (14) A request for an exception to policy under 441—subrule 1.8(1) has been denied.
- (15) A final decision from a previous hearing with a presiding officer has been implemented.
- (16) The issue appealed is not eligible for further hearing based on the doctrine of issue preclusion.
- (17) The appeal involves patient treatment interventions outlined in the patient handbook of the civil commitment unit for sexual offenders.
- (18) A provider or an authorized representative, for a managed care appeal, fails to submit Form 470-5526, Authorized Representative for Managed Care Appeals, providing the member's approval of the request for appeal.
- (19) Notice was issued by the exchange regarding determination of eligibility for enrollment in a qualified health plan or for advance payment of the premium tax credit or cost-sharing reductions.
- (20) Notice has been issued regarding the completion of a family assessment that indicates no determination of child abuse or neglect has been made and no information has been reported to the child abuse registry.
- (21) Notice has been issued regarding an MCO grievance request.
- (22) Notice has been issued by an MCO to a provider regarding a claims dispute issue.
 - b.* Either state or federal law requires automatic grant adjustment for classes of recipients. The director of the department shall decide whether to grant a hearing in these cases. When the reason for an individual appeal is incorrect grant computation in the application of these automatic adjustments, a hearing may be granted.
 - c.* State or federal law or regulation provides for a different forum for appeals.
 - d.* The appeal is filed prematurely as:
 - (1) There is no adverse action by the department,
 - (2) The appellant has not exhausted the reconsideration process, or
 - (3) The appellant has not exhausted the first-level review process with a managed care organization except as provided at paragraph 7.2(5)“c.”
 - e.* Upon review, it is determined that the appellant does not meet the criteria of an aggrieved person as defined in rule 441—7.1(17A).
 - f.* The sole basis for denying, terminating or limiting assistance under 441—Chapter 47, 441—Chapter 58 or 441—Chapter 87 is that funds for the respective programs have been reduced, exhausted, eliminated or otherwise encumbered.
 - g.* Rescinded IAB 6/7/17, effective 7/12/17.
 - h.* The issue appealed is moot.

i. The issue appealed has previously been determined in another appeal by the same appellant.

7.5(3) Group hearings. The appeals section may respond to a series of individual requests for hearings by requesting the department of inspections and appeals to conduct a single group hearing in cases in which the sole issue involved is one of state or federal law or policy or change in state or federal law or policy. An appellant scheduled for a group hearing may withdraw and request an individual hearing.

7.5(4) Time limit for granting hearing to an appeal. Subject to the provisions of subrule 7.5(1), when an appeal is made, the granting of a hearing to that appeal shall be governed by the following timeliness standards:

a. General standards. In general, a hearing shall be held if the appeal is made within 30 days after official notification of an action or before the effective date of action. When the appeal is made more than 30 days but less than 90 days after notification, the director shall determine whether a hearing shall be granted.

(1) The director may grant a hearing if one or more of the following conditions existed:

1. There was a serious illness or death of the appellant or a member of the appellant's family.
2. There was a family emergency or household disaster, such as a fire, flood, or tornado.
3. The appellant offers a good cause beyond the appellant's control, which can be substantiated.
4. There was a failure to receive the department's notification for a reason not attributable to the appellant. Lack of a forwarding address is attributable to the appellant. A hearing may be granted if an appellant provides proof that a forwarding address was not supplied due to fear of domestic violence, homelessness, or other good cause.

(2) The time in which to appeal an agency action shall not exceed 90 days. Appeals made more than 90 days after notification shall not be heard.

(3) The day after the official notice is sent is the first day of the period within which an appeal must be filed. When the time limit for filing falls on a holiday or a weekend, the time will be extended to the next workday.

b. Food assistance, medical assistance eligibility, fee-for-service medical coverage, family planning program or autism support program standard. For appeals regarding food assistance, medical assistance eligibility, fee-for-service medical coverage, the family planning program or the autism support program, a hearing shall be held if the appeal is made within 90 days after official notification of an action.

c. Managed care organization medical coverage. For appeals regarding a health care decision made by a managed care organization, a hearing shall be held if the appeal is made within 120 days after written notification that the first-level review process through the managed care organization has been exhausted. A hearing shall be held if the appeal is made within 120 days after the appeal is deemed to have exhausted the managed care organization's appeals process, as provided in paragraph 7.2(5) "c."

d. Offset standards. For appeals regarding state or federal tax or debtor offsets, a hearing shall be held if the appeal is made within 15 days after official notification of the action. Counties have 30 days to appeal offsets, as provided in 441— subrule 14.4(3). When the appeal is made more than 15 days but less than 90 days after notification, the director shall determine whether a hearing shall be granted.

(1) The director may grant a hearing if one or more of the following conditions existed:

1. There was a serious illness or death of the appellant or a member of the appellant's family.
2. There was a family emergency or household disaster, such as a fire, flood, or tornado.
3. The appellant offers a good cause beyond the appellant's control, which can be substantiated.
4. There was a failure to receive the department's notification for a reason not attributable to the appellant. Lack of a forwarding address is attributable to the appellant. A hearing may be granted if an appellant provides proof that a forwarding address was not supplied due to fear of domestic violence, homelessness, or other good cause.

(2) The time in which to appeal an offset action shall not exceed 90 days. Appeals made more than 90 days after notification shall not be heard.

(3) The day after the official notice is sent is the first day of the period within which an appeal must be filed. When the time limit for filing falls on a holiday or a weekend, the time will be extended to the next workday.

e. Abuse standard.

(1) For appeals regarding dependent adult abuse, a hearing shall be held if the appeal is made within six months after official notification of the action as provided in Iowa Code section 235B.10.

(2) For appeals regarding child abuse, a hearing shall be held if the appeal is made by a person alleged responsible for the abuse within 90 days after official notification 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 hearing within 10 calendar days after the appeal notification.

(3) The day after the official notice is sent is the first day of the period within which an appeal must be filed. When the time limit for filing falls on a holiday or a weekend, the time will be extended to the next workday.

f. Displacement and discrimination standard. PROMISE JOBS displacement and discrimination appeals shall be granted hearing on the following basis:

(1) An appeal of an informal grievance resolution on a PROMISE JOBS displacement grievance shall be made in writing within 10 days of issuance (i.e., mailing) of the resolution decision or within 24 days of the filing of the displacement grievance, whichever is the shorter time period, unless good cause for late filing as described in subparagraph 7.5(4)“a”(1) is found.

(2) An appeal of a PROMISE JOBS discrimination complaint shall be made within the time frames provided in paragraph 7.5(4)“a” in relation to the action alleged to have involved discrimination.

g. Risk assessment standard. An appeal of a sex offender risk assessment shall be made in writing within 14 calendar days of issuance of the notice.

7.5(5) Informal settlements. The time limit for submitting an appeal is not extended while attempts at informal settlement are in progress.

7.5(6) Appeals of family investment program (FIP), refugee cash assistance (RCA), and PROMISE JOBS overpayments.

a. Subject to the time limits described in subrule 7.5(4), a person’s right to appeal the existence, computation, and amount of a FIP, RCA, or PROMISE JOBS overpayment begins when the department sends the first notice informing the person of the overpayment. The notice shall be sent on:

- (1) Form 470-4683, Notice of FIP or RCA Overpayment; or
- (2) Form 470-4688, Notice of PROMISE JOBS Overpayment.

b. A hearing shall not be held if an appeal is filed in response to a second or subsequent notice as identified in paragraph “a.”

c. Subject to the time limits described in subrule 7.5(4), a person’s right to appeal the recovery of an overpayment through benefit reduction, as described at rule 441—46.25(239B), but not the existence, computation, or amount of an overpayment, begins when the person receives Notice of Decision or Notice of Action, Form 470-0485, 470-0485(S), 470-0486, or 470-0486(S), informing the person that benefits will be reduced to recover a FIP or RCA overpayment.

7.5(7) Appeals of medical assistance, state supplementary assistance (SSA), and HAWK-I program overpayments.

a. Subject to the time limits described in subrule 7.5(4), a person’s right to appeal the existence and amount of a medical assistance, state supplementary assistance, or healthy and well kids in Iowa (HAWK-I) program overpayment begins when the department sends the first notice informing the person of the overpayment. The notice shall be sent on:

- (1) Form 470-2891, Notice of Medical Assistance Overpayment; or
- (2) Form 470-3984, Notice of Healthy and Well Kids in Iowa (HAWK-I) Premium Overpayment.

b. A hearing shall not be held if an appeal is filed in response to a second or subsequent notice as identified in paragraph “a.”

c. A program overpayment means medical assistance, state supplementary assistance, or healthy and well kids in Iowa (HAWK-I) assistance was received by or on behalf of a person in excess of that

allowed by law, rules or regulations for any given month or in excess of the dollar amount of assistance. Subrule 7.5(7) relates to overpayments received by recipients, not by providers of the medical assistance program.

7.5(8) *Appeal rights under the family investment program limited benefit plan.* A participant only has the right to appeal the establishment of the limited benefit plan once at the time the department issues the timely and adequate notice that establishes the limited benefit plan. However, when the reason for the appeal is based on an incorrect grant computation, an error in determining the eligible group, or another worker error, a hearing shall be granted when the appeal otherwise meets the criteria for hearing.

7.5(9) *Appeals of child care assistance benefit overpayments.*

a. Subject to the time limits described in subrule 7.5(4), a person's right to appeal the existence, computation, and amount of a child care assistance benefit overissuance or overpayment begins when the department sends the first notice informing the person of the child care assistance overpayment. The notice shall be sent on Form 470-4530, Notice of Child Care Assistance Overpayment.

b. A hearing shall not be held if an appeal is filed in response to a second or subsequent notice about the same overpayment.

c. A program overpayment means child care assistance was received by or on behalf of a person in excess of that allowed by law, rules or regulations for any given month or in excess of the dollar amount of assistance. Subrule 7.5(9) relates to overpayments received by recipients and child care providers. Either entity may be responsible for repayment.

7.5(10) *Appeals of food assistance overpayments.*

a. Subject to the time limits described in subrule 7.5(4), a person's right to appeal the existence, computation, and amount of a food assistance overpayment begins when the department sends the first notice informing the person of the food assistance overpayment. The notice shall be sent on Form 470-4668, Notice of Food Assistance Overpayment.

b. Subject to the time limits described in subrule 7.5(4), a person's right to appeal the recovery of an overpayment through benefit reduction, but not the existence, computation, or amount of an overpayment, begins when the person receives Notice of Decision or Notice of Action, Form 470-0485, 470-0485(S), 470-0486, or 470-0486(S), informing the person that benefits will be reduced to recover a food assistance overpayment.

7.5(11) *Appeals of family planning program overpayments.*

a. Subject to the time limits described in subrule 7.5(4), a person's right to appeal the existence and amount of a family planning program overpayment begins when the department sends the first notice informing the person of the overpayment. The notice shall be sent on Form 470-5483, Notice of Family Planning Program Assistance Overpayment.

b. A hearing shall not be held if an appeal is filed in response to a second or subsequent notice as identified in paragraph 7.5(11) "a."

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441—7.6(17A) Informing persons of their rights.

7.6(1) *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.
- (4) Provisions, if any, for payment of legal fees by the department.

b. Written notification shall be given on the application form and on all notices of decisions. Oral explanation shall also be given regarding the policy on appeals during the application process and at the time of any contemplated action by the agency when the need for an explanation is indicated.

c. Persons not familiar with English shall be provided a translation into the language understood by them in written form or orally. Appellants are entitled to have an interpreter present during appeal hearings. In all cases when a person is illiterate or semiliterate, the person shall be advised of each right to the satisfaction of the person's understanding.

d. 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.

7.6(2) *Authorized representation or responsible party.* Persons may be represented for purposes of this chapter by an authorized representative or an individual, organization, or provider recognized by the department as acting responsibly for an applicant or beneficiary pursuant to policy governing a particular program (hereinafter referred to as a "responsible party"), unless otherwise specified by statute or federal regulations.

a. The designation of an authorized representative must be in writing and include the signature of the person designating the authorized representative. Medicaid members may appoint an authorized representative or provider to act on their behalf during the appeals process regarding an adverse benefit determination made by a managed care organization by signing Form 470-5526, Authorized Representative for Managed Care Appeals. Legal documentation of authority to act on behalf of a person, such as a court order establishing legal guardianship or a power of attorney, shall serve in place of a signed designation by the person.

b. An authorized representative or responsible party must agree to maintain, or be legally bound to maintain, the confidentiality of any information regarding an applicant or beneficiary provided by the department.

c. A provider or staff member or volunteer of an organization serving as an authorized representative or responsible party must affirm that such provider, staff member or volunteer will adhere to the regulations in Part 431, Subpart F, of 42 CFR Chapter IV and in 45 CFR 155.260(f) (relating to confidentiality of information), § 447.10 of 42 CFR Chapter IV (relating to the prohibition against reassignment of provider claims as appropriate for a health facility or an organization acting on the facility's behalf), as well as other relevant state and federal laws concerning conflict of interest and confidentiality of information.

d. An authorized representative or responsible party may file an appeal on the appellant's behalf, receive copies of appeal correspondence, and act on behalf of the appellant in all other matters regarding the appeal.

e. The authorized representative or responsible party is responsible for fulfilling all responsibilities encompassed within the scope of the authorized representation to the same extent as the individual the authorized representative or responsible party represents.

f. The power to act as an authorized representative is valid until the appellant modifies the authorization or notifies the department that the representative is no longer authorized to act on the appellant's behalf, or the authorized representative informs the agency that the authorized representative is no longer acting in such capacity, or there is a change in the legal authority upon which the individual's or organization's authority was based. Such notice must be in writing and include the appellant's, authorized representative's or responsible party's signature as appropriate.

g. Designations of authorized representatives, legal documentation of authority to act on behalf of a person, and modifications or terminations of designations or legal authority may be submitted by mail, by electronic mail, by facsimile transmission or in person.

h. Designations of authorized representatives, legal documentation of authority to act on behalf of a person, and modifications or terminations of designations or legal authority previously submitted to the department that comply with the requirements of this rule will continue to apply for purposes of appeals, consistent with their terms.

[ARC 8003B, IAB 7/29/09, effective 9/2/09; ARC 1261C, IAB 1/8/14, effective 3/1/14; ARC 3871C, IAB 7/4/18, effective 8/8/18]

441—7.7(17A) Notice of intent to approve, deny, terminate, reduce, or suspend assistance or deny reinstatement of assistance.**7.7(1) Notification.**

a. Whenever the department proposes to cancel or reduce assistance or services or to revoke a license, certification, approval, registration, or accreditation, it shall give timely and adequate notice of the pending action, except:

(1) When a service is deleted from the state's comprehensive annual service plan in the social services block grant program at the onset of a new program year, or

(2) As provided in subrule 7.7(2).

b. For the purpose of this subrule, "assistance" includes food assistance, medical assistance, the family investment program, refugee cash assistance, child care assistance, emergency assistance, the family planning program, family or community self-sufficiency grant, PROMISE JOBS, state supplementary assistance, healthy and well kids in Iowa (HAWK-I) program, foster care, adoption, aftercare services, or other programs or services provided by the department.

c. The department shall give adequate notice of the approval or denial of assistance or services; the approval or denial of a license, certification, approval, registration, or accreditation; and pending action for a state or federal tax or debtor offset.

d. "Timely" means that the notice is sent at least ten calendar days before the date the action would become effective. The timely notice period shall begin on the day after the notice is sent.

e. "Adequate" means a written notice that includes:

- (1) A statement of what action is being taken,
- (2) The effective date of such action,
- (3) A clear statement of the specific reasons supporting the intended action,
- (4) The corresponding rule reference,
- (5) An explanation of the appellant's right to appeal, and
- (6) The circumstances under which assistance is continued when an appeal is filed.

7.7(2) Dispensing with timely notice. Timely notice may be dispensed with, but adequate notice shall be sent no later than the date benefits would have been issued when:

a. There is factual information confirming the death of a recipient or of the family investment program payee when there is no relative available to serve as a new payee.

b. The recipient provides a clear written, signed statement that the recipient no longer wishes assistance, or gives information which requires termination or reduction of assistance, and the recipient has indicated, in writing, that the recipient understands this must be the consequence of supplying the information.

c. The recipient has been admitted or committed to an institution that does not qualify for payment under an assistance program.

d. The recipient has been placed in skilled nursing care, intermediate care, or long-term hospitalization.

e. The recipient's whereabouts are unknown and mail directed to the recipient has been returned by the post office indicating no known forwarding address. When the recipient's whereabouts become known during the payment period covered by the returned warrant, the warrant shall be made available to the recipient.

f. The agency establishes that the recipient has been accepted for assistance in another state.

g. Cash assistance or food assistance is changed because a child is removed from the home as a result of a judicial determination or is voluntarily placed in foster care.

h. A change in the level of medical care is prescribed by the recipient's physician.

i. A special allowance or service granted for a specific period is terminated and the recipient has been informed in writing at the time of initiation that the allowance or service shall terminate at the end of the specified period.

j. The notice involves an adverse determination made with regard to the preadmission screening requirements.

k. The department terminates or reduces benefits or makes changes based on a completed Form 470-2881, 470-2881(S), 470-2881(M), or 470-2881(MS), Review/Recertification Eligibility Document, as described at 441—subrule 40.27(3) or rule 441—75.52(249A).

l. The agency terminates benefits for failure to return a completed report form, as described in paragraph “*k.*”

m. The agency approves or denies an application for assistance.

n. The agency implements a mass change based on law or rule changes that affect a group of recipients.

7.7(3) Action due to probable fraud. When the agency obtains facts indicating that assistance should be canceled, suspended, or reduced because of the probable fraud of the recipient, and, where possible, the facts have been verified through collateral sources, notice of the action shall be timely when sent at least five calendar days before the action would become effective. The notice shall be sent by certified mail, return receipt requested.

7.7(4) Conference during the timely notice period. Rescinded IAB 7/10/13, effective 9/1/13.

7.7(5) Notification not required. Notification is not required in the following instances:

a. When services in the social service block grant preexpenditure report are changed from one plan year to the next, or when the plan is amended because funds are no longer available.

b. When service has been time-limited in the social service block grant preexpenditure report, and as a result the service is no longer available.

c. When the placement of a person(s) in foster care is changed.

d. When payment has been in accordance with the Medicaid payment schedule for the service billed because there is no adverse action.

7.7(6) Reinstatement.

a. Whenever the department determines that a previously canceled case must remain canceled for a reason other than that covered by the original notice, timely and adequate notice shall be sent except as specified in subrule 7.7(2).

b. Whenever the department determines that a previously canceled case is eligible for reinstatement at a lower level of benefits, for a reason other than that covered by the original notice, timely and adequate notice shall be sent except as specified in subrule 7.7(2).

c. Food assistance cases are eligible for reinstatement only in circumstances found in rule 441—65.44(234). FIP cases are eligible for reinstatement only in circumstances found in 441—subrule 40.22(5).

[**ARC 8003B**, IAB 7/29/09, effective 9/2/09; **ARC 0819C**, IAB 7/10/13, effective 9/1/13; **ARC 1261C**, IAB 1/8/14, effective 3/1/14; **ARC 3093C**, IAB 6/7/17, effective 7/12/17; **ARC 3199C**, IAB 7/19/17, effective 7/1/17; **ARC 3389C**, IAB 10/11/17, effective 11/15/17]

441—7.8(17A) Opportunity for hearing.

7.8(1) Initiating an appeal. To initiate an appeal, a person, the person’s authorized representative or an individual or organization recognized by the department as acting responsibly for the person pursuant to policy governing a particular program must state in writing that the person disagrees with a decision, action, or failure to act on the person’s case.

a. Food assistance, medical assistance, child care assistance, family planning program and family investment program appeals may be made in person, by telephone or in writing as specified in subrule 7.8(2).

b. All other appeals, subject to paragraph 7.8(1)“*a.*,” shall be made in writing.

c. A written request may be submitted via the appeals section’s website or may be delivered by mail, electronic mail, facsimile transmission or personal delivery to the appeals section, to the local office, or to the department office that took the adverse action.

d. A request by telephone or in person may be made to the appeals section or to the department office that took the adverse action.

e. A Medicaid provider or an authorized representative requesting a hearing on behalf of the member regarding an adverse benefit determination made by a managed care organization must have the prior express written consent of the member or the member’s lawfully appointed guardian on Form

470-5526, Authorized Representative for Managed Care Appeals. Legal documentation of authority to act on behalf of a person, such as a court order establishing legal guardianship or a power of attorney, shall serve in place of a signed designation by the person. No hearing will be granted unless the provider submits a document providing the member's consent to the request for a hearing.

7.8(2) *Filing the appeal.* The appellant shall be encouraged, but not required, to make written appeal on Form 470-0487 or 470-0487(S), Appeal and Request for Hearing, and the worker shall provide any instructions or assistance required in completing the form. When the appellant is unwilling to complete or sign this form, nothing in this rule shall be construed to preclude the right to perfect the appeal, as long as the appeal is in writing (except for food assistance, medical assistance, child care assistance, family planning program and family investment program appeals) and has been communicated to the department by the appellant or appellant's representative.

A written appeal submitted by mail is filed on the date postmarked on the envelope sent to the department or, when the postmarked envelope is not available, on the date the appeal is stamped received by the agency. When an appeal is submitted through an electronic delivery method, such as electronic mail, submission of an online form, 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, 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.

7.8(3) *Informal conference.* 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.

An informal conference need not be requested for the appellant to examine the contents of the case record, including any electronic case record, as provided in subrule 7.13(1) and 441—Chapter 9.

7.8(4) *Prehearing conference.* When requested, a prehearing conference may be held with the appellant, a representative of the department and a presiding officer as soon as possible after the appeal has been filed. An appellant's representative shall be allowed to attend and participate in the prehearing conference, unless precluded by federal rule or state statute.

7.8(5) *Interference.* Neither an informal conference nor a prehearing conference shall be used to discourage appellants from proceeding with their appeals. The right of appeal shall not be limited or interfered with in any way, even though the person's complaint may be without basis in fact, or because of the person's own misinterpretation of law, agency policy, or methods of implementing policy.

7.8(6) *Right to deny or dismiss an appeal.* The appeals section or the department of inspections and appeals has the right to deny or dismiss the appeal when:

- a. It has been withdrawn by the appellant pursuant to subrule 7.8(8).
- b. The sole issue is one of state or federal law requiring automatic grant adjustments for classes of recipients.
- c. It has been abandoned.
- d. The agency, by written notice, withdraws the action appealed and restores the appellant's status that existed before the action appealed was taken.
- e. The agency implements action and issues a notice of decision or notice of action to correct an error made by the agency which resulted in the appeal.

Abandonment may be deemed to have occurred when the appellant, the appellant's authorized representative, or the department fails, without good cause, to appear at the prehearing or hearing.

7.8(7) *Denial of due process.* Facts of harassing, threats of prosecution, denial of pertinent information needed by the appellant in preparing the appeal, as a result of the appellant's communicated desire to proceed with the appeal shall be taken into consideration by the administrative law judge in reaching a proposed decision.

7.8(8) *Withdrawal.* When the appellant desires to voluntarily withdraw an appeal, the worker, the presiding officer, or the appeals section shall accept a request from the appellant to withdraw the appeal

by telephone, in writing or in person. A written request may be submitted in person, by mail or through an electronic delivery method, such as electronic mail, submission of an online form, or facsimile. The appellant may use Form 470-0492 or 470-0492(S), Request for Withdrawal of Appeal, for this purpose. For child abuse and dependent adult abuse appeals, the request to withdraw an appeal must be made on the record before an administrative law judge or in writing and signed by the appellant or the appellant's legal counsel.

7.8(9) 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. Forward a summary and supporting documentation of the worker's or agent's factual basis for the proposed action to the appeals section within ten days of the receipt of the appeal.

c. Provide the appellant and the appellant's representative copies of all materials sent to the appeals section or the presiding officer to be considered in reaching a decision on the appeal at the same time as the materials are sent to the appeals section or the presiding officer.

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441—7.9(17A) Continuation of assistance pending a final decision on appeal.

7.9(1) General standards for when assistance continues.

a. Assistance, subject to paragraph 7.9(1)"*b*," shall not be suspended, reduced, restricted, or canceled, nor shall a license, registration, certification, approval, or accreditation be revoked or other proposed adverse action be taken pending a final decision on an appeal when:

(1) An appeal is filed before the effective date of the intended action; or

(2) The appellant requests a hearing within ten days from receipt of a notice suspending, reducing, restricting, or canceling 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 beneficiary shows that the beneficiary did not receive the notice within the five-day period.

b. If it is determined at a hearing that the issue involves only federal or state law or policy, assistance will be immediately discontinued.

c. Assistance shall be continued on the basis authorized immediately prior to the notice of adverse action, subject to paragraph 7.9(2)"*c*."

d. The appellant may ask to have the appellant's benefits continue on Form 470-0487 or 470-0487(S), Appeal and Request for Hearing. If the form does not positively indicate that the appellant has waived continuation of benefits, the department shall assume that continuation of benefits is desired.

e. Once benefits are continued or reinstated, the department will not reduce or terminate benefits while the appeal is pending, subject to subrule 7.9(2).

7.9(2) General standards for when assistance does not continue. Assistance shall be suspended, reduced, restricted, or canceled; a license, registration, certification, approval, or accreditation shall be revoked; and other proposed action shall be taken pending a final decision on appeal when:

a. An appeal is not filed before the effective date of the intended action or within ten days from the date notice is received. The date on which notice is received is considered to be five days after the date on the notice, unless the beneficiary shows that the beneficiary did not receive the notice within the five-day period.

b. Benefits or services were time-limited through a certification period or prior authorization for which notice was given when established or for which adequate notice was provided.

c. The appellant directs the worker in writing to proceed with the intended action.

d. Adverse action was taken because the appellant failed to return a complete review form.

7.9(3) When assistance continues for food assistance.

a. Assistance, subject to paragraph 7.9(3)"*b*," shall not be suspended, reduced, restricted, or canceled or other proposed adverse action taken pending a final decision on an appeal when the

appellant requests a hearing within ten days from receipt of a notice suspending, reducing, restricting, or canceling benefits.

The date on which the notice is received is considered to be five days after the date on the notice, unless the beneficiary shows that the beneficiary did not receive the notice within the five-day period.

b. If it is determined at a hearing that the issue involves only federal or state law or policy, assistance will be immediately discontinued.

c. Assistance shall be continued on the basis authorized immediately prior to the notice of adverse action, subject to paragraph 7.9(4) “*c.*”

d. The appellant may ask to have the appellant’s benefits continue on Form 470-0487 or 470-0487(S), Appeal and Request for Hearing. If the form does not positively indicate that the appellant has waived continuation of benefits, the department shall assume that continuation of benefits is desired.

e. Once benefits are continued or reinstated, the department must not reduce or terminate benefits while the appeal is pending, subject to subrule 7.9(4).

7.9(4) *When assistance does not continue for food assistance.* Assistance shall be suspended, reduced, restricted, or canceled or other proposed action shall be taken pending a final decision on appeal when:

a. An appeal is not filed within ten days from the date notice is received. The date on which notice is received is considered to be five days after the date on the notice, unless the beneficiary shows that the beneficiary did not receive the notice within the five-day period.

b. Benefits or services were time-limited through a certification period or for which adequate notice was provided.

c. The appellant directs the worker in writing to proceed with the intended action.

d. Adverse action was taken because the appellant failed to return a complete review form.

7.9(5) *When assistance continues for managed care organization health care services.*

a. Health care services may not be reduced, limited, suspended, canceled or other proposed adverse action taken pending a final decision on an appeal when:

(1) An appeal is filed timely. “Timely” means the appeal is filed on or before the effective date of the adverse benefit determination or within ten calendar days of the date the managed care organization sent the notice of adverse benefit determination. The date on which the notice is received is considered to be five days after the date on the notice, unless the beneficiary shows that the beneficiary did not receive the notice within the five-day period;

(2) The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment;

(3) The services were ordered by an authorized provider;

(4) The period covered by the original authorization has not expired; and

(5) The appellant requests that health care services be continued.

b. If, at the appellant’s request, the managed care organization continues or reinstates the member’s health care services while the appeal is pending, the benefits must continue until one of the following occurs:

(1) The appellant withdraws the appeal.

(2) The appellant fails to request an appeal within ten calendar days from the date the managed care organization mails the notice of action.

(3) A hearing decision is issued that is adverse to the appellant.

7.9(6) *When assistance does not continue for health care services managed by a managed care organization.* Health care services may be reduced, limited, suspended, canceled or other proposed adverse action taken pending a final decision on an appeal when:

a. An appeal is not filed timely. “Timely” means the appeal is filed on or before the effective date of the adverse benefit determination or within ten calendar days of the date the managed care organization sent the notice of adverse benefit determination. The date on which the notice is received is considered to be five days after the date on the notice, unless the beneficiary shows that the beneficiary did not receive the notice within the five-day period;

b. The appeal does not involve the termination, suspension, or reduction of a previously authorized course of treatment;

c. The services were not ordered by an authorized provider;

d. The period covered by the original authorization has expired; or

e. The appellant fails to request that health care services be continued.

7.9(7) *Recovery of excess assistance paid pending a final decision on appeal.* Continued assistance is subject to recovery by the department if the department's action is affirmed, except as specified at subrule 7.9(9).

When the department's action is sustained, excess assistance paid pending a final decision shall be recovered to the date of the decision. This recovery is not an appealable issue. However, appeals may be heard on the computation of excess assistance paid pending a final decision.

7.9(8) *Recovery of excess assistance paid when the appellant's benefits are changed prior to a final decision.* Recovery of excess assistance paid will be made to the date of change which affects the improper payment. The recovery shall be made when the appellant's benefits are changed due to one of the following reasons:

a. A determination is made at the hearing that the sole issue is one of state or federal law or policy or change in state or federal law or policy and not one of incorrect grant computation, and the grant is adjusted.

b. A change affecting the appellant's grant occurs while the final decision is pending and the appellant fails to request a hearing after notice of the change.

7.9(9) *Recovery of assistance when a new limited benefit plan is established.* Assistance issued pending the final decision of the appeal is not subject to recovery when a new limited benefit plan period is established. A new limited benefit plan period shall be established when the department is affirmed in a timely appeal of the establishment of the limited benefit plan. All of the following conditions shall exist:

a. The appeal is filed either:

(1) Before the effective date of the intended action on the notice of decision or notice of action establishing the beginning date of the limited benefit plan, or

(2) Within ten days from the date on which a notice establishing the beginning date of the limited benefit plan is received. The date on which notice is received is considered to be five days after the date on the notice, unless the beneficiary shows that the beneficiary did not receive the notice within the five-day period.

b. Assistance is continued pending the final decision of the appeal.

c. The department's action is affirmed.

7.9(10) *Recovery of assistance when a new ineligibility period is established for the use of an electronic access card at a prohibited location.* Assistance issued pending the final decision of the appeal is not subject to recovery when a new ineligibility period is established for the use of an electronic access card at a prohibited location. A new ineligibility period pursuant to 441—paragraph 41.25(11) "e" shall be established when the department is affirmed in an appeal of the establishment of an ineligibility period for the use of an electronic access card at a prohibited location. All of the following conditions shall exist:

a. The appeal is filed either:

(1) Before the effective date of the intended action on the notice of decision or notice of action establishing the beginning date of the ineligibility period, or

(2) Within ten days from the date on which a notice establishing the beginning date of the ineligibility period is received. The date on which notice is received is considered to be five days after the date on the notice, unless the beneficiary shows that the beneficiary did not receive the notice within the five-day period.

b. Assistance is continued pending the final decision of the appeal.

c. The department's action is affirmed.

[ARC 8003B, IAB 7/29/09, effective 9/2/09; ARC 1261C, IAB 1/8/14, effective 3/1/14; ARC 1478C, IAB 6/11/14, effective 8/1/14; ARC 1694C, IAB 10/29/14, effective 1/1/15; ARC 3093C, IAB 6/7/17, effective 7/12/17; ARC 3871C, IAB 7/4/18, effective 8/8/18]

441—7.10(17A) Procedural considerations.

7.10(1) Registration. Upon receipt of the notice of appeal, the appeals section shall register the appeal.

7.10(2) Acknowledgment.

a. Upon receipt of the notice of appeal, the appeals section shall send an acknowledgment of receipt of the appeal to the appellant, representative, or both. A copy of the acknowledgment of receipt of appeal will be sent to the appropriate departmental office.

b. For an appeal regarding child abuse, all subjects other than the person alleged responsible (appellant) will be notified of the opportunity to file a motion to intervene as provided in Iowa Code section 235A.19.

c. The department shall advise the person of any legal services which may be available and that the person may be represented by counsel at the person's own expense.

7.10(3) Granting a hearing. The appeals section shall determine whether an appellant may be granted a hearing and the issues to be discussed at that hearing in accordance with the applicable rules, state statutes, or federal regulations.

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 appeals section shall indicate at the time of certification the issues to be discussed at that hearing.

b. The appeals of those appellants who are denied a hearing shall not be closed until issuance of a letter to the appellant and the appellant's representative, advising of the denial of hearing and the basis upon which that denial is made. Any appellant that disagrees with a denial of hearing may present additional information relative to the reason for denial and request reconsideration by the appeals section or a hearing over the denial.

7.10(4) 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 481—Chapter 10 of the department of inspections and appeals' rules unless otherwise designated by federal or state statute or regulation.

a. In cases involving individual appellants, the hearing shall be held by teleconference call or in the appropriate department office.

b. In cases of appeals by agencies, the hearing shall be scheduled by teleconference call or at the most appropriate department office.

c. 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.

d. 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.

e. Emergency assistance appeals shall be expedited.

f. In cases involving appellants who indicate that their lives, physical or mental health, or ability to attain, maintain or regain maximum function could seriously be jeopardized if they wait for standard resolution of their appeals, the hearing shall be held within three working days of the date on the appeal request if:

(1) The managed care organization handled the first-level review expeditiously; and

(2) The appellant or a provider acting on the appellant's behalf requested an expedited appeal hearing.

7.10(5) 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. Upon advance request, a witness shall be permitted to appear by teleconference unless the administrative law judge determines that the physical presence of the witness is necessary for the administration of justice and does not impose an undue burden on the witness. All parties shall be granted the same rights during a teleconference hearing as specified in rule 441—7.13(17A). The appellant may request to have a presiding officer render a decision for attribution appeals through an administrative hearing.

7.10(6) Reschedule requests. Requests 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 directly except as otherwise noted. The granting of the requests will be at the discretion of the department of inspections and appeals.

a. The appellant may request that the teleconference hearing be rescheduled as an in-person hearing. All requests made to the appeals section or to the department of inspections and appeals for a teleconference hearing to be rescheduled as an in-person hearing shall be granted. Any appellant request for an in-person hearing made to the appeals section shall be communicated to the department of inspections and appeals immediately.

b. For food assistance appeals, the hearing may be rescheduled if requested by the appellant; however, the postponement shall not exceed 30 days.

c. For intentional program violation appeals, the hearing may be rescheduled provided that the request for postponement is made at least ten days in advance of the date of the scheduled hearing. The hearing shall not be postponed for more than a total of 30 days.

d. Reschedule requests made by the department shall only be granted in instances of inclement weather when the department office is closed. The department's representative shall arrange coverage by a coworker in instances including, but not limited to, when inclement weather is present, but the department office remains open or when a family emergency, sudden illness or death occurs.

e. All other requests, subject to paragraph 7.10(6) "a," concerning the scheduling of a hearing shall be made to the department of inspections and appeals directly.

7.10(7) 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, as prescribed in Iowa Code section 17A.12(2), shall set forth:

(1) The date, time, method and place of the hearing;

(2) That evidence may be presented orally or documented to establish pertinent facts; and

(3) That the appellant may question or refute any testimony, may bring witnesses of the appellant's choice and may be represented by others, including an attorney, subject to federal law and state statute. The department will not pay for the cost of legal representation.

b. A copy of this notice shall be forwarded to the department employee who took the action and to other persons when circumstances peculiar to the case indicate that the notification may be desirable.

c. Notices of hearing regarding an intentional program violation shall be served upon the appellant by first-class mail, postage prepaid, addressed to the appellant at the last-known address at least 30 days in advance of the date the hearing is scheduled. All other notices of hearing shall be mailed by first-class mail, postage prepaid, addressed to the appellant at the appellant's last-known address.

[ARC 8003B, IAB 7/29/09, effective 9/2/09; ARC 0487C, IAB 12/12/12, effective 2/1/13; ARC 1261C, IAB 1/8/14, effective 3/1/14; ARC 3093C, IAB 6/7/17, effective 7/12/17]

441—7.11(17A) Information and referral for legal services. The local office shall advise persons appealing any agency decision of legal services in the community that are willing to assist them.

441—7.12(17A) Subpoenas. The department shall have all subpoena power conferred upon it by statute. Departmental subpoenas shall be issued to a party on request or will be served by the department when requested at least one week in advance of the hearing date.

441—7.13(17A) Rights of appellants during hearings.

7.13(1) Examination of the evidence. The department shall provide the appellant, or representative, opportunity prior to, as well as during, the hearing, to examine all materials permitted under rule 441—9.1(17A,22) or to be offered as evidence. Off the record, or confidential information which the appellant or representative does not have the opportunity to examine shall not be included in the record of the proceedings or considered in reaching a decision.

7.13(2) Conduct of hearing.

a. The hearing shall be conducted by an administrative law judge designated by the department of inspections and appeals. It shall be an informal rather than a formal judicial procedure and shall be

designed to serve the best interest of the appellant. The appellant shall have the right to introduce any evidence on points at issue believed necessary, to challenge and cross-examine any statement made by others, and to present evidence in rebuttal. A verbatim record shall be kept of the evidence presented.

b. For an appeal hearing regarding child abuse, the administrative law judge, upon request of any party to the hearing, may stay the hearing until the conclusion of the adjudicatory phase of a pending juvenile or district court case relating to the data or findings as provided in Iowa Code section 235A.19.

7.13(3) Opportunity for response. Opportunity shall be afforded all parties to respond and present evidence and arguments on all issues involved and to be represented by counsel at their own expense.

7.13(4) Default. If a party to the appeal fails to appear or participate in a contested case proceeding after proper service of notice, the presiding officer may, if no adjournment is granted, enter a default decision or proceed with the hearing pursuant to subrules 7.13(1), 7.13(2) and 7.13(3) and render a proposed decision on the merits in the absence of the defaulting party.

a. Where appropriate and not contrary to law, any party may move for a default decision against a party who has failed to file a required pleading or has failed to appear after proper service for a hearing. A proposed decision on the merits may be issued in the absence of a defaulting party.

b. A default decision or a proposed decision rendered on the merits in the absence of the defaulting party may award any relief against the defaulting party consistent with the relief requested before the default, but the relief awarded against the defaulting party may not exceed the requested relief before the default.

c. Proceedings after a default decision are specified in subrule 7.13(5).

d. Proceedings after a hearing and a proposed decision on the merits in the absence of a defaulting party are specified in subrule 7.13(6).

7.13(5) Proceedings after default decision.

a. Default decisions or decisions rendered on the merits after a party has failed to appear or participate in a contested case proceeding become final agency action unless a motion to vacate the decision is filed within the time allowed for an appeal of a proposed decision by subrule 7.16(5).

b. A motion to vacate must state all facts relied upon by the moving party which establish that good cause existed for the party's failure to appear or participate at the contested case proceeding. A party must file the motion with the Department of Human Services, Appeals Section, Fifth Floor, 1305 East Walnut Street, Des Moines, Iowa 50319-0114. The department or its representative shall file a motion to vacate as specified in subrule 7.16(6). Each fact so stated must be substantiated by at least one sworn affidavit of a person with personal knowledge of each such fact. Each affidavit must be attached to the motion. In lieu of submitting an affidavit, the moving party may submit business records or other acceptable documentation from a disinterested third party that substantiates the claim of good cause.

(1) The appeals section shall be responsible for serving all parties with the motion to vacate. All parties to the appeal shall have ten days from service by the appeals section to respond to the motion to vacate. All parties to the appeal shall be allowed to conduct discovery as to the issue of good cause and shall be allowed to present evidence on the issue before a decision on the motion, if a request to do so is included in that party's response. If the department responds to any party's motion to vacate, all parties shall be allowed another ten days to respond to the appeals section.

(2) The appeals section shall certify the motion to vacate to the department of inspections and appeals for the presiding officer to review the motion, hold any additional proceedings, as appropriate, and determine if good cause exists to set aside the default.

c. Properly substantiated and timely filed motions to vacate shall be granted only for good cause shown. The burden of proof as to good cause is on the moving party.

d. "Good cause" for purposes of this rule is defined as an emergency circumstance that is beyond the control of the party and that prevents the party from being able to participate in the hearing.

(1) Examples of good cause include, but are not limited to:

1. Sudden, severe illness or accident involving the party or the party's immediate family (spouse, partner, children, parents, sibling).

2. Death or serious illness in the party's immediate family.

3. Other circumstances evidencing an emergency situation which was beyond the party's control and was not reasonably foreseeable.

(2) Examples of circumstances that do not constitute good cause include, but are not limited to:

1. A lost or misplaced notice of hearing.
2. Confusion as to the date and time for the hearing.
3. Failure to follow the directions on the notice of hearing.
4. Oversleeping.
5. Other acts demonstrating a lack of due care by the party.

e. Upon determining whether good cause exists, the presiding officer shall issue a proposed decision on the motion to vacate, which shall be subject to review by the director pursuant to rule 441—7.16(17A).

f. Once the time limit to appeal a proposed decision has expired, the contested case hearing shall proceed accordingly, after proper service of notice to all parties. The situation shall be treated as the filing of a new appeal for purposes of calculating time limits, with the filing date being the date the decision granting the motion to vacate became final.

g. Upon a final decision denying a motion to vacate, the default decision becomes final agency action.

7.13(6) Proceedings after hearing and proposed decision on the merits in the absence of a defaulting party.

a. Proposed decisions on the merits after a party has failed to appear or participate in a contested case become final agency action unless:

(1) A motion to vacate the proposed decision is filed by the defaulting party based on good cause for the failure to appear or participate, within the time allowed for an appeal of a proposed decision by subrule 7.16(5); or

(2) Any party requests review on the merits by the director pursuant to rule 441—7.16(17A).

b. If a motion to vacate and a request for review on the merits are both made in a timely manner after a proposed decision on the merits in the absence of a defaulting party, the review by the director on the merits of the appeal shall be stayed pending the outcome of the motion to vacate.

c. A motion to vacate must state all facts relied upon by the moving party which establish that good cause existed for the party's failure to appear or participate at the contested case proceeding. A party must file a motion with the Department of Human Services, Appeals Section, Fifth Floor, 1305 East Walnut Street, Des Moines, Iowa 50319-0114.

(1) The appeals section shall be responsible for serving all parties with the motion to vacate. All parties to the appeal shall have ten days from service by the appeals section to respond to the motion to vacate. All parties to the appeal shall be allowed to conduct discovery as to the issue of good cause and shall be allowed to present evidence on the issue before a decision on the motion, if a request to do so is included in that party's response. If the department responds to any party's motion to vacate, all parties shall be allowed another ten days to respond to the appeals section.

(2) The appeals section shall certify the motion to vacate to the department of inspections and appeals for the presiding officer to review the motion, hold any additional proceedings, as appropriate, and determine if good cause exists to set aside the default.

d. Properly substantiated and timely filed motions to vacate shall be granted only for good cause shown. The burden of proof as to good cause is on the moving party.

e. "Good cause" for purposes of this rule is defined as an emergency circumstance that is beyond the control of the party and that prevents the party from being able to participate in the hearing.

(1) Examples of good cause include, but are not limited to:

1. Sudden, severe illness or accident involving the party or the party's immediate family (spouse, partner, children, parents, sibling).
2. Death or serious illness in the party's immediate family.
3. Other circumstances evidencing an emergency situation which was beyond the party's control and was not reasonably foreseeable.

(2) Examples of circumstances that do not constitute good cause include, but are not limited to:

1. A lost or misplaced notice of hearing.
 2. Confusion as to the date and time for the hearing.
 3. Failure to follow the directions on the notice of hearing.
 4. Oversleeping.
 5. Other acts demonstrating a lack of due care by the party.
- f.* Upon determining whether good cause exists, the presiding officer shall issue a proposed decision on the motion to vacate, which shall be subject to review by the director pursuant to rule 441—7.16(17A).
- g.* Once the time limit to appeal a proposed decision has expired, a new contested case hearing shall be held after proper service of notice to all parties. The situation shall be treated as the filing of a new appeal for purposes of calculating time limits, with the filing date being the date the decision granting the motion to vacate became final.
- h.* Upon a final decision denying a motion to vacate, the proposed decision on the merits in the absence of a defaulting party becomes final unless there is request for review on the merits by the director made pursuant to paragraph 7.13(6) “a” or “j.”
- i.* Any review on the merits by the director requested pursuant to paragraph 7.13(6) “a” and stayed pursuant to paragraph 7.13(6) “b” pending a decision on a motion to vacate shall be conducted upon a final decision denying the motion to vacate.
- j.* Upon a final decision denying a motion to vacate a proposed decision issued in the absence of a defaulting party, any party to the contested case proceeding may request a review on the merits by the director pursuant to rule 441—7.16(17A), treating the date that the denial of the motion to vacate became final as the date of the proposed decision.
- [ARC 8003B, IAB 7/29/09, effective 9/2/09; ARC 0304C, IAB 9/5/12, effective 11/1/12; ARC 0487C, IAB 12/12/12, effective 2/1/13; ARC 3093C, IAB 6/7/17, effective 7/12/17]

441—7.14(17A) Limitation of persons attending.

7.14(1) The hearing shall be limited in attendance to the following persons, unless otherwise specified by statute or federal regulations: appellant, appellant’s representative, agency employees, agency’s legal representatives, other persons present for the purpose of offering testimony pertinent to the issues in controversy, and others upon mutual agreement of the parties. The administrative law judge may sequester witnesses during the hearing. Nothing in this rule shall be construed to allow members of the press, news media, or any other citizens’ group to attend the hearing without the written consent of the appellant.

7.14(2) For an appeal hearing regarding child abuse:

- a.* Subjects who file a motion to intervene, as provided in Iowa Code section 235A.19, will have the opportunity to appear at the prehearing conference. Any motion to intervene shall be considered by the administrative law judge at the prehearing conference.
 - b.* The department shall not be considered to be a party who can adequately represent the interests of any other subject.
 - c.* Subjects allowed to intervene as specified in subrule 7.5(4) will be considered parties to the hearing and will be allowed to attend the proceedings as provided in Iowa Code section 235A.19.
- [ARC 0487C, IAB 12/12/12, effective 2/1/13]

441—7.15(17A) Medical examination. When the hearing involves medical issues, a medical assessment or examination by a person or physician other than the one involved in the decision under question shall be obtained and the report made a part of the hearing record when the administrative law judge or appellant considers it necessary. Any medical examination required shall be performed by a physician satisfactory to the appellant and the department at agency expense.

Forms 470-0502, Authorization for Examination and Claim for Payment, and 470-0447, Report on Incapacity, shall be utilized in obtaining medical information to be used in the appeal and to authorize payment for the examination.

441—7.16(17A) The appeal decision.

7.16(1) Record. The record in a contested case shall include, in addition to those materials specified in Iowa Code section 17A.12(6):

a. The notice of appeal.

b. All evidence received or considered and all other submissions, including the verbatim record of the hearing.

7.16(2) Findings of fact. Any party may submit proposed findings of fact. The presiding officer will rule on the proposed findings of fact. Findings of fact shall be based solely on the evidence in the record and on matters officially noticed in the record. The findings of fact and conclusions of law in the proposed or final decision shall be limited to contested issues of fact, policy, or law.

7.16(3) Proposed decision. Following the reception of evidence, the presiding officer shall issue a proposed decision, consisting of the issues of the appeal, the decision, the findings of fact and the conclusions of law. Each item shall be separately stated under individual headings. The proposed decision shall be sent by first-class mail, postage prepaid, addressed to the appellant at the appellant's last-known address.

7.16(4) Appeal of the proposed decision. After issuing a proposed decision, the administrative law judge shall submit it to the appeals section with copies to the appeals advisory committee.

a. The appellant, appellant's representative, a subject allowed to intervene as specified in subrule 7.5(4), the representative of a subject allowed to intervene as specified in subrule 7.5(4), or the department may appeal for the director's review of the proposed decision.

b. When the appellant, a subject allowed to intervene as specified in subrule 7.5(4), or the department has not appealed the proposed decision or when an appeal for the director's review of the proposed decision is not granted, the proposed decision shall become the final decision.

c. The director's review on appeal of the proposed decision shall be on the basis of the record as defined in subrule 7.16(1), except that the director need not listen to the verbatim record of the hearing in a review or appeal. The review or appeal shall be limited to issues raised prior to that time and specified by the party requesting the appeal or review. The director may designate another to act on the director's behalf in making final decisions.

7.16(5) Time limit for appeal of a proposed decision. Appeal for the director's review of the proposed decision must be made in writing to the director. The written request must be mailed or submitted in person or through an electronic delivery method, such as electronic mail, submission of an online form, or facsimile. The request must be postmarked or received within ten calendar days of the date on which the proposed decision was sent. The day after the proposed decision is sent is the first day of the time period within which a request for review must be filed. When the time limit for filing falls on a holiday or a weekend, the time will be extended to the next workday.

7.16(6) Appeal of the proposed decision by the department. The appeals advisory committee acts as an initial screening device for the director and may recommend that the director review a proposed decision. That recommendation is not binding upon the director, and the director may decide to review a proposed decision without that committee's recommendation.

A request by the department for director's review of the proposed decision must be made in writing. The written request must be submitted to the appeals advisory committee in person or submitted through an electronic delivery method, such as electronic mail or facsimile, within ten calendar days of the date on which the proposed decision was sent. The day after the proposed decision is sent is the first day of the time period within which a request for director's review must be filed. When the time limit for filing falls on a holiday or a weekend, the time will be extended to the next workday.

When the director grants a review of a proposed decision on the department's request, the appeals section shall notify all other parties to the appeal of the review and send a copy of the request to all other parties. All other parties shall be provided ten calendar days from the date of notification to submit further written arguments or objections for consideration upon review.

Written arguments or objections must be mailed or submitted in person to the appeals section or submitted through an electronic delivery method, such as electronic mail, submission of an online form, or facsimile.

The day after the notification is sent is the first day of the time period within which a response to the department's request for review must be filed. When the time limit for responding falls on a holiday or a weekend, the time will be extended to the next workday.

7.16(7) *Appeal of the proposed decision by the managed care organization.* The appeals advisory committee acts as an initial screening device for the director and may recommend that the director review a proposed decision. That recommendation is not binding upon the director, and the director may decide to review a proposed decision without that committee's recommendation.

A request by the managed care organization for director's review of the proposed decision must be made in writing. The written request must be submitted to the appeals advisory committee in person or submitted through an electronic delivery method, such as electronic mail or facsimile, within 72 hours of the date on which the proposed decision was sent. The day after the proposed decision is sent is the first day of the time period within which a request for director's review must be filed.

When the director grants a review of a proposed decision on the managed care organization's request, the appeals section shall notify all other parties to the appeal of the review and send a copy of the request to all other parties. All other parties shall be provided ten calendar days from the date of notification to submit further written arguments or objections for consideration upon review.

Written arguments or objections must be mailed or submitted in person to the appeals section or submitted through an electronic delivery method, such as electronic mail, submission of an online form, or facsimile.

The day after the notification is sent is the first day of the time period within which a response to the department's request for review must be filed. When the time limit for responding falls on a holiday or a weekend, the time will be extended to the next workday.

7.16(8) *Appeal of the proposed decision by the appellant.* When the director grants a review of a proposed decision, all other parties shall be so notified.

7.16(9) *Opportunity for oral presentation of appeal of the proposed decision.* In cases where there is an appeal of a proposed decision, each party shall be afforded an opportunity to present oral arguments with the consent of the director. Any party wishing oral argument shall specifically request it. When granted, all parties shall be notified of the time and place.

7.16(10) *Time limits.*

a. A final decision on the appeal shall be issued within the following time frames:

(1) Appeals for all programs, except food assistance, shall be rendered within 90 days from the date of the appeal.

(2) Food assistance-only decisions shall be rendered within 60 days.

(3) PROMISE JOBS displacement grievance decisions shall be rendered within 90 days from the date the displacement grievance was filed with the PROMISE JOBS contractee.

b. Failure to reach a decision within the time frames set forth in paragraph 7.16(10) "a" shall not affect the merits of the appellant's appeal.

c. Time frames may be extended based on continuances or additional time frames as approved by the presiding officer. Should the appellant request a delay in the hearing in order to prepare the case or for other essential reasons, reasonable time, not to exceed 30 days except with the approval of the administrative law judge, shall be granted and the extra time shall be added to the maximum for final administrative action.

d. For an appeal regarding child abuse, if the proposed decision is not appealed within 10 days from the date of the proposed decision, the proposed decision shall be the final agency action. If a party files an appeal within 10 days from the date of the proposed decision, the director has 45 days from the date of the proposed decision to issue a ruling. If the director does not rule within that 45-day period, the proposed decision becomes the final decision as provided in Iowa Code section 235A.19.

e. The department shall take prompt, definite and final administrative action to carry out the decision rendered within seven calendar days of receipt of a copy of the final decision for all programs, except as provided in paragraph 7.6(10) "f."

f. If the administrative law judge reverses a decision 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 appellant's health condition requires but no later than 72 hours from the date on the proposed decision.

If the administrative law judge reverses a decision to deny authorization of services and the appellant received the disputed services while the appeal was pending, the managed care organization must pay for those services pursuant to subrules 7.9(5) and 7.9(6).

g. When the final decision is favorable to the appellant or when the department decides in favor of the appellant before the hearing, the department shall make any additional corrective payments due, retroactive to the date of the incorrect action.

7.16(11) Final decision. The department shall mail the final decision to the appellant at the appellant's last-known address by first-class mail, postage prepaid.

[ARC 8003B, IAB 7/29/09, effective 9/2/09; ARC 0487C, IAB 12/12/12, effective 2/1/13; ARC 1261C, IAB 1/8/14, effective 3/1/14; ARC 1611C, IAB 9/3/14, effective 11/1/14; ARC 3093C, IAB 6/7/17, effective 7/12/17; ARC 3787C, IAB 5/9/18, effective 7/1/18]

441—7.17(17A) Exhausting administrative remedies. To have exhausted all adequate administrative remedies, a party need not request a rehearing under Iowa Code section 17A.16(2) where the party accepts the findings of fact as prepared by the administrative law judge, but wishes to challenge the conclusions of law, or departmental policy.

441—7.18(17A) Ex parte communication.

7.18(1) Prohibited communication. There shall be no written, oral, or other type of communication between the presiding officer and any party or representative of any party or any other person with a direct or indirect interest in the case while an appeal is pending, without all parties being notified of an opportunity to participate, unless specifically authorized by statute or rule.

a. This provision does not prevent the presiding officer from communicating with members of the agency or seeking the advice or help of persons other than those defined in paragraph "c."

b. Persons described in paragraph "c" shall not directly or indirectly communicate to the presiding officer any ex parte communications they have received of a type that the presiding officer would be prohibited from receiving or that furnish, augment, diminish, or modify the evidence in the record.

c. For purposes of this rule:

(1) People with a direct or indirect interest in a case include any member of the appeals advisory committee and any person engaged in personally investigating, prosecuting, or advocating in either the case under appeal or a pending factually related case involving the same parties.

(2) The term "personally investigating" means taking affirmative steps to interview witnesses directly or to obtain documents or other information directly. The term does not include general direction and supervision of assigned investigators, unsolicited receipt of information which is relayed to assigned investigators, review of another person's investigative work product in the course of determining whether there is probable cause to initiate a proceeding, or exposure to factual information while performing other agency functions, including fact gathering for purposes other than investigation of the matter which culminates in a contested case.

7.18(2) Commencement of prohibition. Prohibitions on ex parte communications commence with the issuance of the notice of hearing in a contested case and continue for as long as the case is pending.

7.18(3) When communication is ex parte. Rescinded IAB 4/30/03, effective 7/1/03.

7.18(4) Avoidance of ex parte communication. To avoid prohibited ex parte communications, notice must be given in a manner reasonably calculated to give all parties a fair opportunity to participate. Written communications shall be provided to all parties to the appeal.

7.18(5) Communications not prohibited. Communications with the presiding officer involving uncontested scheduling or procedural matters do not require notice or opportunity for parties to participate. Parties should notify other parties prior to initiating such contact with the presiding officer when feasible, and shall notify other parties when seeking to continue hearings or other deadlines.

7.18(6) Disclosure of prohibited communications. A presiding officer who receives a prohibited ex parte communication during the pendency of a contested case must initially determine if the effect of the communication is so prejudicial that the presiding officer should be disqualified from the case. If the presiding officer determines that disqualification is warranted, a copy of any prohibited written

communication, all written responses to the communication, a written summary stating the substance of any prohibited oral or other communication not available in written form for disclosure, all responses made, and the identity of each person from whom the presiding officer received a prohibited ex parte communication shall be disclosed. If the presiding officer determines that disqualification is not warranted, such documents shall be submitted for inclusion in the record and served on all parties. Any party desiring to rebut the prohibited communication must be allowed the opportunity to do so upon written request filed within ten days after notice of communication.

7.18(7) *Disclosure of prior receipt of information through ex parte communication.* Promptly after being assigned to serve as presiding officer at any stage in a contested case proceeding, a presiding officer shall disclose to all parties material factual information received through ex parte communication prior to such assignment unless the factual information has already been or shortly will be disclosed pursuant to Iowa Code section 17A.13(2) or through discovery. Factual information contained in an investigative report or similar document need not be separately disclosed by the presiding officer as long as such documents have been or will shortly be provided to the parties.

7.18(8) *Imposition of sanctions.* The presiding officer may render a proposed or final decision imposing appropriate sanctions for violations of this rule, including default, a decision against the offending party, censure, or suspension or revocation of the privilege to practice before the agency. Violation of ex parte communication prohibitions by department personnel shall be reported to the department for possible sanctions, including censure, suspension, dismissal, or other disciplinary action.

441—7.19(17A) Accessibility of hearing decisions. Summary reports of all hearing decisions shall be made available to local offices and the public upon request. The information shall be presented in a manner consistent with requirements for safeguarding personal information concerning applicants and recipients.

[ARC 3093C, IAB 6/7/17, effective 7/12/17]

441—7.20(17A) Right of judicial review and stays of agency action.

7.20(1) *Right of judicial review.* If a director's review is requested, the final decision shall advise the appellant or the appellant's representative of the right to judicial review by the district court. When the appellant or the appellant's representative is dissatisfied with the final decision and requests judicial review of the decision to the district court, the department shall furnish copies of the documents or supporting papers to district court, including a written transcript of the hearing. An appeal of the final decision to district court does not itself stay execution or enforcement of an agency action.

7.20(2) *Stays of agency action.*

a. Any party to a contested case proceeding may petition the director for a stay or other temporary remedies pending judicial review, of all or part of that proceeding. The petition shall state the reasons justifying a stay or other temporary remedy.

b. In determining whether to grant a stay pending judicial review, the director shall consider the factors listed in Iowa Code section 17A.19(5) "c."

c. A stay may be vacated by the director pending judicial review upon application of the department or any other party.

441—7.21(17A) Food assistance hearings and appeals.

7.21(1) *Appeal hearings.* All appeal hearings in the food assistance program shall be conducted in accordance with 7 CFR 273.15.

7.21(2) *Food assistance administrative disqualification hearings.* All food assistance administrative disqualification hearings shall be conducted in accordance with 7 CFR 273.16.

7.21(3) *Conduct of a food assistance administrative disqualification hearing.* Hearings over disqualification of a household member for an intentional program violation shall be conducted by a presiding officer.

a. The department of inspections and appeals shall serve an Intentional Program Violation Hearing Notice upon the household member by first-class mail, postage prepaid, addressed to household member at the last-known address 30 calendar days before the initial hearing date.

b. The household member or that person's representative may request to postpone the hearing for up to 30 days, provided the request is made at least 10 calendar days before the scheduled hearing date.

c. At the hearing, the presiding officer shall advise the household member or that person's representative that the household member has the right to refuse to answer questions during the hearing and that the state or federal government may use the information in a civil or criminal action.

7.21(4) Consolidating hearings. Appeal hearings and food assistance administrative disqualification hearings may be consolidated if the issues arise out of the same or related circumstances, and the household member has been provided with notice of the consolidation by the department of inspections and appeals.

a. If the hearings are combined, the time frames for conducting a food assistance administrative disqualification hearing shall apply.

b. If the hearings are combined for the purpose of setting the amount of the overpayment at the same time as determining whether or not an intentional program violation has occurred, the household shall lose its right to a subsequent hearing on the amount of the overpayment.

7.21(5) Attendance at hearing. The household member shall be allowed ten days from the scheduled hearing to present reasons indicating good cause for not attending the hearing.

a. The appeals section shall certify the motion to vacate to the department of inspections and appeals for the presiding officer to review the motion, hold any additional proceedings, as appropriate, and determine if good cause exists for the default as specified in subrule 7.13(5). Timely filed motions to vacate shall be granted only for good cause shown. The burden of proof as to good cause is on the moving party.

b. Unless good cause is determined, when the household member or that person's representative cannot be located or fails to appear at the scheduled hearing, the hearing shall be conducted without that person. In that instance, the presiding officer shall consider the evidence and determine if the evidence is clear and convincing that an intentional program violation was committed.

c. If the household member who failed to appear at the hearing is found to have committed an intentional program violation, but the presiding officer later determines that this person or the person's representative had good cause for not appearing, the previous hearing decision shall no longer be valid. A new hearing shall be conducted.

7.21(6) Food assistance administrative disqualification hearing decisions. The presiding officer shall base the determination of an intentional program violation on clear and convincing evidence that demonstrates the person committed, and intended to commit, an intentional program violation.

a. The proposed and final hearing decisions shall be made in accordance with rule 441—7.16(17A) unless otherwise specified.

b. The appeals section shall notify the household member and the local office of the final decision within 90 days of the date the household member is notified in writing that the hearing has been scheduled. If the hearing was postponed pursuant to subrule 7.21(3), paragraph "b," the 90 days for notifying the household member of the final decision shall be extended for as many days as the hearing is postponed.

c. The department shall take no action to disqualify a person from receiving food assistance before receiving the final appeal decision finding that the person has committed an intentional program violation.

d. No further administrative appeal procedure shall exist after the final decision is issued. The determination of an intentional program violation shall not be reversed by a subsequent hearing decision. However, the person may appeal the case to the Iowa district court.

e. When a court decision reverses a determination of an intentional program violation, the appeals section shall notify the local office of the specifics of the court decision.

[ARC 8003B, IAB 7/29/09, effective 9/2/09; ARC 3093C, IAB 6/7/17, effective 7/12/17; ARC 3787C, IAB 5/9/18, effective 7/1/18]

441—7.22(17A) FIP disqualification hearings. Rescinded IAB 4/30/03, effective 7/1/03.

441—7.23(17A) 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.

441—7.24(17A) Emergency adjudicative proceedings.

7.24(1) Necessary emergency action. To the extent necessary to prevent or avoid immediate danger to the public health, safety, or welfare, and consistent with the United States Constitution and the Iowa Constitution and other provisions of law, the department of inspections and appeals may issue a written order in compliance with Iowa Code section 17A.18 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 agency by emergency adjudicative order. Before issuing an emergency adjudicative order, the department of inspections and appeals shall consider factors including, but not limited to, the following:

- a. Whether there has been sufficient factual investigation to ensure that the agency is proceeding on the basis of reliable information.
- b. Whether the specific circumstances which pose immediate danger to the public health, safety or welfare have been identified and determined to be continuing.
- c. Whether the person required to comply with the emergency adjudicative order may continue to engage in other activities without posing immediate danger to the public health, safety or welfare.
- d. Whether imposition of monitoring requirements or other interim safeguards would be sufficient to protect the public health, safety or welfare.
- e. Whether the specific action contemplated by the agency is necessary to avoid the immediate danger.

7.24(2) Issuance of order.

a. An emergency adjudicative order shall contain findings of fact, conclusions of law, and policy reasons to justify the determination of an immediate danger and the department's decision to take immediate action.

b. The written emergency adjudicative order shall be immediately delivered to persons who are required to comply with the order by using one or more of the following procedures:

- (1) Personal delivery.
- (2) Certified mail, return receipt requested, to the last address on file with the department.
- (3) Certified mail to the last address on file with the department.
- (4) First-class mail to the last address on file with the department.
- (5) Fax. Fax may be used as the sole method of delivery if the person required to comply with the order has filed a written request that department orders be sent by fax and has provided a fax number for that purpose.

c. To the degree practicable, the agency shall select the procedure for providing written notice that best ensures prompt, reliable delivery.

7.24(3) Oral notice. Unless the written emergency adjudicative order is provided by personal delivery on the same day that the order issues, the department shall make reasonable immediate efforts to contact by telephone the persons who are required to comply with the order.

7.24(4) Completion of proceedings. After the issuance of an emergency adjudicative order, the agency shall proceed as quickly as feasible to complete any proceedings that would be required if the matter did not involve an immediate danger. Issuance of a written emergency adjudicative order shall include notification of the date on which agency proceedings are scheduled for completion. After issuance of an emergency adjudicative order, continuance of further agency proceedings to a later date will be granted only in compelling circumstances upon application in writing.

[ARC 3093C, IAB 6/7/17, effective 7/12/17]

441—7.25 to 7.40 Reserved.

DIVISION II
APPEALS BASED ON THE COMPETITIVE PROCUREMENT BID PROCESS

441—7.41(17A) Scope and applicability. The rules in Division II apply to appeals based on the department's competitive procurement bid process.
[ARC 1206C, IAB 12/11/13, effective 1/15/14]

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—7.13(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]

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 the 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 subrules 7.16(5) to 7.16(8).

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

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 pursuant to rule 441—7.3(17A).

7.47(3) Rights of appellants during hearings. All rights afforded appellants at rule 441—7.13(17A) shall apply.

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

441—7.48(17A) Appeal record.

7.48(1) The appeal record shall consist of all items specified in subrule 7.16(1).

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]

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 listed at 441—7.18(17A) apply.
[ARC 1206C, IAB 12/11/13, effective 1/15/14]

441—7.51(17A) Right of judicial review. The rules regarding right of judicial review listed at 441—7.20(17A) apply.
[ARC 1206C, IAB 12/11/13, effective 1/15/14]

These rules are intended to implement Iowa Code chapter 17A.

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[◇] Two or more ARCs

CHAPTER 36
FACILITY ASSESSMENTS

DIVISION I
ASSESSMENT FEE FOR INTERMEDIATE CARE FACILITIES FOR PERSONS WITH AN INTELLECTUAL DISABILITY

PREAMBLE

These rules describe the assessment of the fee authorized by Iowa Code section 249A.21. The rules explain how the fee is determined and paid, and under what conditions collection of the fee will be terminated.

441—36.1(249A) Assessment of fee. Intermediate care facilities for persons with an intellectual disability (ICFs/ID) licensed in Iowa under 481—Chapter 64, including facilities not certified to participate in the Medicaid program, shall pay a quarterly fee to the department. Effective July 1, 2016, the fee shall equal 5.5 percent of actual paid claims, from all sources, for the facility's preceding quarter. [ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 2886C, IAB 1/4/17, effective 2/8/17]

441—36.2(249A) Determination and payment of fee. For all ICFs/ID licensed in Iowa under 481—Chapter 64, including facilities not certified to participate in the Medicaid program, the fee shall be determined and paid as follows:

36.2(1) Each facility shall pay the assessment to the department on a quarterly basis. The facility shall:

a. Use Form 470-5422, Intermediate Care Facilities for Individuals with an Intellectual Disability Assessment Calculation Worksheet, to calculate the quarterly fee due.

b. Submit Form 470-5422 and the quarterly fee no later than 30 days following the end of each calendar quarter.

36.2(2) The facility shall calculate the amount of the quarterly fee due by multiplying 5.5 percent by the facility's total ICF/ID payments for services received from all sources during the preceding quarter, including but not limited to:

- a.* Medicaid managed care payments.
- b.* Client participation payments.
- c.* Medicaid fee-for-service payments.
- d.* Private pay/insurance payments.
- e.* Ancillary service payments.

36.2(3) If the department determines that an ICF/ID has underpaid or overpaid the fee, the department shall notify the ICF/ID of the amount of the unpaid fee or refund due. Such amount shall be due or refunded within 30 days of the issuance of the notice.

36.2(4) An ICF/ID that fails to pay the fee within the time frame specified in subrule 36.2(3) shall pay a penalty in the amount of 1.5 percent of the unpaid fee due for each month or portion of a month that the unpaid fee is overdue.

a. If the ICF/ID substantiates good cause beyond the facility's control for failure to make timely payment of the fee, the department shall waive the penalty or a portion of the penalty. For purposes of this subrule, "good cause" shall have the same meaning as "good cause" for setting aside a default judgment under Iowa Rule of Civil Procedure 1.977.

b. Requests for a good-cause waiver must be submitted to the Iowa Medicaid enterprise, provider cost audit and rate setting unit, within 30 days of notice to the facility that the penalty is due.

36.2(5) If a fee has not been received by the department by the last day of the third month after the fee is due, the department shall suspend payment due the ICF/ID under the medical assistance program, including payments made on behalf of the medical assistance program by a contracted managed care organization.

[ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 2886C, IAB 1/4/17, effective 2/8/17]

441—36.3(249A) Determination and payment of fee for facilities not certified to participate in the Medicaid program. Rescinded ARC 2886C, IAB 1/4/17, effective 2/8/17.

441—36.4(249A) Termination of fee assessment. If federal financial participation to match the assessed fee becomes unavailable under federal law, the assessment terminates on the date the federal statutory, regulatory, or interpretive change takes effect.

441—36.5 Reserved.

These rules are intended to implement Iowa Code section 249A.21.

DIVISION II
QUALITY ASSURANCE ASSESSMENT FOR NURSING FACILITIES

PREAMBLE

These rules describe the nursing facility quality assurance assessment authorized by Iowa Code chapter 249L. The rules explain how the assessment is determined and paid.

[ARC 8894B, IAB 6/30/10, effective 7/1/10; ARC 9127B, IAB 10/6/10, effective 11/10/10; ARC 9892B, IAB 11/30/11, effective 2/1/12]

441—36.6(249L) Assessment.

36.6(1) Applicability. All nursing facilities as defined in Iowa Code section 135C.1 that are free-standing facilities or are operated by a hospital licensed pursuant to Iowa Code chapter 135B shall pay a quarterly assessment to the department, as determined under this division, with the exception of:

- a. Nursing facilities operated by the state.
- b. Non-state government-owned or government-operated nursing facilities.
- c. Distinct-part skilled nursing units and swing-bed units operated by a hospital.

36.6(2) Assessment level. Effective July 1, 2012, the assessment level for each nursing facility shall be determined on an annual basis and shall be effective for the state fiscal year.

a. Effective July 1, 2015, nursing facilities with 46 or fewer licensed beds are required to pay a quality assurance assessment of \$1.36 per non-Medicare patient day. Effective with assessment for the state fiscal year beginning July 1, 2012, the number of licensed beds on file with the department of inspections and appeals as of May 1 of each year shall be used to determine the assessment level for the following state fiscal year.

b. Effective July 1, 2015, nursing facilities designated as continuing care retirement centers (CCRCs) by the insurance division of the Iowa department of commerce are required to pay a quality assurance assessment of \$1.36 per non-Medicare patient day. Effective with assessment for the state fiscal year beginning July 1, 2012, continuing care retirement center designations as of May 1 of each year shall be used to determine the assessment level for the following state fiscal year.

c. Effective July 1, 2015, nursing facilities with annual Iowa Medicaid patient days of 26,500 or more are required to pay a quality assurance assessment of \$1.36 per non-Medicare patient day. Effective with assessment for the state fiscal year beginning July 1, 2012, the annual number of Iowa Medicaid patient days reported in the most current cost report submitted to the Iowa Medicaid enterprise as of May 1 of each year shall be used to determine the assessment level for the following state fiscal year.

d. Effective July 1, 2015, all other nursing facilities are required to pay a quality assurance assessment of \$7.13 per non-Medicare patient day.

[ARC 8258B, IAB 11/4/09, effective 1/1/10; ARC 8894B, IAB 6/30/10, effective 7/1/10; ARC 9127B, IAB 10/6/10, effective 11/10/10; ARC 9892B, IAB 11/30/11, effective 2/1/12; ARC 3872C, IAB 7/4/18, effective 9/1/18]

441—36.7(249L) Determination and payment of assessment. The assessment shall be determined and paid as follows:

36.7(1) Each nursing facility shall pay the quality assurance assessment to the department on a quarterly basis. The facility shall:

a. Use Form 470-4836, Nursing Facility Quality Assurance Assessment Calculation Worksheet, to calculate the quarterly assessment amount due.

b. Submit Form 470-4836 and the quarterly assessment payment no later than 30 days following the end of each calendar quarter.

36.7(2) The facility shall calculate the amount of the quarterly assessment due by multiplying the facility's total non-Medicare patient days for the preceding quarter by the applicable assessment level as determined in subrule 36.6(2).

36.7(3) If the department determines that a nursing facility has underpaid or overpaid the quality assurance assessment, the department shall notify the nursing facility of the amount of the unpaid quality assurance assessment or refund due. Such amount shall be due or refunded within 30 days of the issuance of the notice.

36.7(4) A nursing facility that fails to pay the quality assurance assessment within the time frame specified above shall pay a penalty in the amount of 1.5 percent of the quality assurance assessment amount owed for each month or portion of a month that the payment is overdue.

a. If the facility substantiates good cause beyond the facility's control for failure to comply with payment of the quality assurance assessment, the department shall waive the penalty or a portion of the penalty. For purposes of this subrule, "good cause" shall have the same meaning as "good cause" for setting aside a default judgment under Iowa Rule of Civil Procedure 1.977.

b. Requests for a good cause waiver must be submitted to the Iowa Medicaid Enterprise, Provider Cost Audit and Rate Setting Unit, 100 Army Post Road, Des Moines, Iowa 50315, within 30 days of notice to the facility that the penalty is due.

36.7(5) For facilities certified to participate in the Medicaid program, the department shall deduct the quarterly amount due from Medicaid payments to the facility if the department has not received the quality assurance assessment amount due by the last day of the month in which the payment is due. The department shall also withhold an amount equal to the penalty owed from any payment due.

[ARC 8258B, IAB 11/4/09, effective 1/1/10; ARC 8894B, IAB 6/30/10, effective 7/1/10; ARC 9127B, IAB 10/6/10, effective 11/10/10; ARC 9892B, IAB 11/30/11, effective 2/1/12]

441—36.8 and 36.9 Reserved.

These rules are intended to implement Iowa Code chapter 249L.

DIVISION III
HEALTH CARE ACCESS ASSESSMENT FOR HOSPITALS

PREAMBLE

These rules describe the hospital health care access assessment authorized by Iowa Code chapter 249M. The rules explain how the assessment is determined and paid.

[ARC 8894B, IAB 6/30/10, effective 7/1/10; ARC 9127B, IAB 10/6/10, effective 11/10/10; ARC 9892B, IAB 11/30/11, effective 2/1/12]

441—36.10(249M) Application of assessment.

36.10(1) Participating hospitals. For the purpose of the health care access assessment program, a "participating hospital" is defined as a non-state-owned hospital licensed under Iowa Code chapter 135B that is paid on a prospective payment system basis by Medicare and the medical assistance programs for inpatient and outpatient services.

36.10(2) Assessment. Participating hospitals are required to pay a quarterly health care access assessment equal to 1.26 percent of net patient revenue as specified in the hospital's fiscal year 2008 Medicare cost report. "Net patient revenue" means all revenue reported for acute patient care and services but does not include:

- a.* Contractual adjustments,
- b.* Charity care,
- c.* Bad debt,
- d.* Medicare revenue, or
- e.* Other revenue derived from sources other than hospital operations including but not limited to:
 - (1) Nonoperating revenue,

- (2) Other operating revenue,
- (3) Skilled nursing facility revenue,
- (4) Physician revenue, and
- (5) Long-term care revenue.

[ARC 8894B, IAB 6/30/10, effective 7/1/10; ARC 9127B, IAB 10/6/10, effective 11/10/10; ARC 9892B, IAB 11/30/11, effective 2/1/12]

441—36.11(249M) Determination and payment of assessment. The assessment shall be determined and paid as follows:

36.11(1) The department shall calculate the annual amount of the health care access assessment as 1.26 percent of net patient revenue as specified in the participating hospital's fiscal year 2008 Medicare cost report. The annual amount shall be divided by four to calculate the quarterly amount.

36.11(2) Each participating hospital shall pay the health care access assessment to the department on a quarterly basis. The hospital shall submit the quarterly assessment payment no later than 30 days following the end of each calendar quarter.

36.11(3) A participating hospital shall retain and preserve the Medicare cost report and financial statements used to prepare the cost report for a period of three years.

36.11(4) If the department determines that a participating hospital has underpaid or overpaid the health care access assessment, the department shall notify the hospital of the amount of the unpaid health care access assessment or refund due. Such amount shall be due or refunded within 30 days of the issuance of the notice.

36.11(5) A participating hospital that fails to pay the health care access assessment within the time frame specified in subrule 36.11(2) shall pay a penalty in the amount of 1.5 percent of the health care access assessment amount owed for each month or portion of a month that the payment is overdue.

a. If the department determines that good cause is shown for failure to comply with payment of the health care access assessment, the department shall waive the penalty or a portion of the penalty.

b. Requests for a good cause waiver must be submitted to the Iowa Medicaid Enterprise, Provider Cost Audit and Rate Setting Unit, 100 Army Post Road, Des Moines, Iowa 50315, within 30 days of notice to the facility that the penalty is due.

36.11(6) The department shall deduct the quarterly amount due from Medicaid payments to the participating hospital if the department has not received the health care access assessment by the last day of the month in which the payment is due. The department shall also withhold an amount equal to the penalty owed from any payment due.

[ARC 8894B, IAB 6/30/10, effective 7/1/10; ARC 9127B, IAB 10/6/10, effective 11/10/10; ARC 9892B, IAB 11/30/11, effective 2/1/12]

441—36.12(249M) Termination of health care access assessment. If the federal government fully funds Iowa's medical assistance program, if federal law changes to negatively impact the assessment program as determined by the department, or if a federal audit determines the assessment program is invalid, the assessment shall terminate on the date the federal statutory, regulatory, or interpretive change takes effect.

[ARC 8894B, IAB 6/30/10, effective 7/1/10; ARC 9127B, IAB 10/6/10, effective 11/10/10; ARC 9892B, IAB 11/30/11, effective 2/1/12]

These rules are intended to implement Iowa Code chapter 249M.

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CHAPTER 75
CONDITIONS OF ELIGIBILITY

[Ch 75, 1973 IDR, renumbered as Ch 90]
[Prior to 7/1/83, Social Services[770] Ch 75]
[Prior to 2/11/87, Human Services[498]]

PREAMBLE

This chapter establishes the conditions of eligibility for the medical assistance program administered by the department of human services pursuant to Iowa Code chapter 249A and addresses related matters. This chapter shall be construed to comply with all requirements for federal funding under Title XIX of the Social Security Act or under the terms of any applicable waiver of Title XIX requirements granted by the Secretary of the U.S. Department of Health and Human Services. To the extent this chapter is inconsistent with any applicable federal funding requirement under Title XIX or the terms of any applicable waiver, the requirements of Title XIX or the terms of the waiver shall prevail.
[ARC 1134C, IAB 10/30/13, effective 10/2/13]

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

441—75.1(249A) Persons covered.

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

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

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

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

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

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

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

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

- a. Subject to paragraphs “b” and “c” below, Medicaid shall be available to persons who:
 - (1) Meet level of care requirements as set forth in rules 441—78.3(249A), 441—81.3(249A), and 441—82.7(249A).
 - (2) Receive care in a hospital, nursing facility, psychiatric medical institution, intermediate care facility for the mentally retarded, or Medicare-certified skilled nursing facility.

(3) Have gross countable monthly income that does not exceed 300 percent of the federal supplemental security income benefits for one.

(4) Either meet all supplemental security income (SSI) eligibility requirements except for income or are under age 21. FMAP policies regarding income and age do not apply when determining eligibility for persons under the age of 21.

b. For all persons in this coverage group, income shall be considered as provided for SSI-related coverage groups under subrule 75.13(2). In establishing eligibility for persons aged 21 or older for this coverage group, resources shall be considered as provided for SSI-related coverage groups under subrule 75.13(2).

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

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

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

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

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

75.1(9) *Individuals receiving state supplemental assistance.* Medical assistance shall be available to all recipients of state supplemental assistance as authorized by Iowa Code chapter 249.

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

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

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

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

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

(1) Failure to provide information, or

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

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

- (1) Failure to provide information, or
- (2) Failure to comply with other procedural requirements.

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

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

- a. They were entitled to and received concurrently in any month after April 1977 supplemental security income and social security or state supplementary assistance and social security, and
- b. They subsequently lost eligibility for supplemental security income or state supplementary assistance, and
- c. They would be eligible for supplemental security income or state supplementary assistance if all of the social security cost-of-living increases which they and their financially responsible spouses, parents, and dependent children received since they were last eligible for and received social security and supplemental security income (or state supplementary assistance) concurrently were deducted from their income. Spouses, parents, and dependent children are considered financially responsible if their income would be considered in determining the applicant's eligibility.

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

- a. In establishing eligibility of specified relatives for this coverage group, resources are considered in accordance with the provisions of rule 441—75.56(249A) and shall not exceed \$2,000 for applicant households or \$5,000 for member households. In establishing eligibility for children for this coverage group, resources of all persons in the eligible group, regardless of age, shall be disregarded.
- b. Income is considered in accordance with rule 441—75.57(249A) and does not exceed needs standards established in rule 441—75.58(249A).
- c. Rescinded IAB 11/1/00, effective 1/1/01.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

d. The state with the adoption assistance agreement:

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

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

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

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

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

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

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

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

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

with the month of the birth and continues through the month of the first birthday as long as the child remains an Iowa resident.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

a. Income.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1. Outpatient hospital services.
2. Rural health clinic services (if contained in the state plan).
3. Clinic services furnished by or under the direction of a physician, without regard to whether the clinic itself is administered by a physician.

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

(3) Meets one of the following:

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

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

3. Participates in a state perinatal program.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

a. Increased income from employment includes:

(1) Beginning employment.

(2) Increased rate of pay.

(3) Increased hours of employment.

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

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

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

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

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

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

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

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

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

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

(1) The department does not receive a complete Notice of Decision/Quarterly Income Report, Form 470-2663 or 470-2663(S), by the twenty-first day of the first month or the fourth month of the additional

six-month period as required in paragraph 75.1(31)“h,” unless the family establishes good cause for failure to report on a timely basis. Good cause shall be established when the family demonstrates that one or more of the following conditions exist:

1. There was a serious illness or death of someone in the family.
2. There was a family emergency or household disaster, such as a fire, flood, or tornado.
3. The family offers a good cause beyond the family’s control.
4. There was a failure to receive the department’s notification for a reason not attributable to the family. Lack of a forwarding address is attributable to the family.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

75.1(35) Medically needy persons.

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

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

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

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

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

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

b. Resources and income of all persons considered.

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

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

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

c. Resources.

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

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

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

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

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

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

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

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

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

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

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

e. Medically needy income level (MNIL).

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

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

Each additional person \$116

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

(3) The MNIL for the certification period shall be determined by adding both months’ MNIL to arrive at a total. The MNIL for the retroactive certification period, when applicable, shall be determined by adding each month of the retroactive period to arrive at a total.

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

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

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

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

f. Verification of medical expenses to be used in spenddown calculation. The applicant or member shall submit evidence of medical expenses that are for noncovered Medicaid services and for covered services incurred prior to the certification period to the department on a claim form, which shall be completed by the medical provider. In cases where the provider is uncooperative or where returning to the provider would constitute an unreasonable requirement on the applicant or member, the form shall be completed by the worker. Verification of medical expenses for the applicant or member that are covered Medicaid services and occurred during the certification period shall be submitted by the provider to the Iowa Medicaid enterprise on a claim form. The applicant or member shall inform the

provider of the applicant's or member's spenddown obligation at the time services are rendered or at the time the applicant or member receives notification of a spenddown obligation. Verification of allowable expenses incurred for transportation to receive medical care as specified in rule 441—78.13(249A) shall be verified on Form 470-0394, Medical Transportation Claim.

Applicants who have not established that they met spenddown in the current certification period shall be allowed 12 months following the end of the certification period to submit medical expenses for that period or 12 months following the date of the notice of decision when the certification period had ended prior to the notice of decision.

g. Spenddown calculation.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(1) Care in a nursing facility or an intermediate care facility for the mentally retarded.

(2) Care in an institution for mental disease.

(3) Care in a Medicare-certified skilled nursing facility.

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

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

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

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

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

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

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

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

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

1. Form 470-2465, Disability Report for Adults, if the applicant is aged 18 or over; or
2. Form 470-3912, Disability Report for Children, if the applicant is under the age of 18.
- (3) In connection with any independent determination of disability, the department shall determine whether reexamination of the person's medical condition will be necessary for periodic redeterminations of eligibility. When reexamination is required, the member or the member's authorized representative shall complete and submit the same forms as required in subparagraph (2).

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

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

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

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

75.1(39) Working persons with disabilities.

- a. Medical assistance shall be available to all persons who meet all of the following conditions:
 - (1) They are disabled as determined pursuant to rule 441—75.20(249A), except that being engaged in substantial gainful activity will not preclude a determination of disability.
 - (2) They are less than 65 years of age.
 - (3) They are members of families (including families of one) whose income is less than 250 percent of the most recently revised official federal poverty level for the family. Family income shall include gross income of all family members, less supplemental security income program disregards, exemptions, and exclusions, including the earned income disregards. However, income attributable to a social security cost-of-living adjustment shall be included only in determining eligibility based on a subsequently published federal poverty level.
 - (4) They receive earned income from employment or self-employment or are eligible under paragraph 75.1(39)“c.”
 - (5) They would be eligible for medical assistance under another coverage group set out in this rule (other than the medically needy coverage groups at subrule 75.1(35)), disregarding all income, up to \$10,000 of available resources, and any additional resources held by the disabled individual in a retirement account, a medical savings account, or an assistive technology account. For this purpose, disability shall be determined as under subparagraph 75.1(39)“a”(1) above.
 - (6) They have paid any premium assessed under paragraph 75.1(39)“b” below.
- b. Eligibility for a person whose gross income is greater than 150 percent of the federal poverty level for an individual is conditional upon payment of a premium. Gross income includes all earned and unearned income of the conditionally eligible person, except that income attributable to a social

security cost-of-living adjustment shall be included only in determining premium liability based on a subsequently published federal poverty level. A monthly premium shall be assessed at the time of application and at the annual review. The premium amounts and the federal poverty level increments above 150 percent of the federal poverty level used to assess premiums will be adjusted annually on August 1.

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

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

(3) Premiums shall be assessed as follows:

IF THE INCOME OF THE APPLICANT IS ABOVE:	THE MONTHLY PREMIUM IS:
150% of Federal Poverty Level	\$34
165% of Federal Poverty Level	\$47
180% of Federal Poverty Level	\$56
200% of Federal Poverty Level	\$66
225% of Federal Poverty Level	\$77
250% of Federal Poverty Level	\$89
300% of Federal Poverty Level	\$112
350% of Federal Poverty Level	\$137
400% of Federal Poverty Level	\$161
450% of Federal Poverty Level	\$186
550% of Federal Poverty Level	\$232
650% of Federal Poverty Level	\$280
750% of Federal Poverty Level	\$329
850% of Federal Poverty Level	\$389
1000% of Federal Poverty Level	\$467
1150% of Federal Poverty Level	\$547
1300% of Federal Poverty Level	\$631
1480% of Federal Poverty Level	\$729
1550% of Federal Poverty Level	\$768

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

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

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

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

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

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

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

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

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

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

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

(7) An individual's case may be reopened when Medicaid eligibility is canceled for nonpayment of premium. However, the full premium must be received by the department on or before the last day of the month following the month the premium is to cover.

(8) Premiums may be submitted in the form of money orders or personal checks to the address printed on the coupon attached to Form 470-3902, MEPD Billing Statement.

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

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

(11) Form 470-3902, MEPD Billing Statement, shall be used for billing and collection.

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

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

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

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

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

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

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

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

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

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

a. Medical assistance shall be available to people who:

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

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

(3) Are under the age of 65.

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

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

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

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

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

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

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

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

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

2. Either:

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

- Has a cooperative agreement with the department of public health under the Centers for Disease Control and Prevention Breast and Cervical Cancer Early Detection Program established under Title

XV of the Public Health Service Act to receive reimbursement for providing breast or cervical cancer screening or diagnostic services to participants in the Care for Yourself Breast and Cervical Cancer Early Detection Program; and

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

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

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

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

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

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

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

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

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

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

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

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

1. Denied presumptive eligibility by a qualified provider.

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

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

75.1(41) *Persons eligible for family planning services under demonstration waiver.* Rescinded IAB 10/11/17, effective 10/1/17.

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

- a. The person is at least 18 years of age and under 21 years of age.
- b. On the person's eighteenth birthday, the person resided in foster care and Iowa was responsible for the foster care payment pursuant to Iowa Code section 234.35.
- c. The person is not a mandatory household member or receiving Medicaid benefits under another coverage group.
- d. The person has income below 200 percent of the most recently revised federal poverty level for the person's household size.

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

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

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

(2) The department shall determine the household's countable income pursuant to rule 441—75.57(249A). Twenty percent of earned income shall be disregarded.

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

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

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

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

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

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

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

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

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

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

(1) Has been determined by the department to be capable of making presumptive determinations of eligibility, and

(2) Has signed an agreement with the department as a qualified entity.

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

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

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

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

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

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

(1) Age. The child must be under the age of 19.

(2) Household income. Household income must be less than 300 percent of the federal poverty level for a household of the same size. For this purpose, the household shall include the applicant child and any sibling (of whole or half blood, or adoptive), spouse, parent, or stepparent living with the applicant child. This determination shall be based on the household’s gross income, with no deductions, diversions, or disregards.

(3) Citizenship or qualified alien status. The child must be a citizen of the United States or a qualified alien as defined in subrule 75.11(2).

(4) Iowa residency. The child must be a resident of Iowa.

(5) Prior presumptive eligibility. A child shall not be determined presumptively eligible more than once in a 12-month period. The first month of the 12-month period begins with the month the application is received by the qualified entity.

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

(1) The last day of the next calendar month;

(2) The day the child is determined eligible for Medicaid;

(3) The last day of the month that the child is determined eligible for HAWK-I; or

(4) The day the child is determined ineligible for Medicaid and HAWK-I. Withdrawal of the Medicaid or HAWK-I application before eligibility is determined shall not affect the child’s eligibility during the presumptive period.

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

75.1(45) Medicaid for former foster care youth. Effective January 1, 2014, medical assistance shall be available to a person who meets all of the following conditions:

a. The person is at least 18 years of age (or such higher age to which foster care is provided to the person) and under 26 years of age;

b. The person is not described in or enrolled under any of Subclauses (I) through (VII) of Section 1902(a)(10)(A)(i) of Title XIX of the Social Security Act or is described in any of such subclauses but has income that exceeds the level of income applicable under Iowa's state Medicaid plan for eligibility to enroll for medical assistance under such subclause;

c. The person was in foster care under the responsibility of Iowa on the date of attaining 18 years of age or such higher age to which foster care is provided; and

d. The person was enrolled in the Iowa Medicaid program under Title XIX of the Social Security Act while in such foster care.

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

[**ARC 7741B**, IAB 5/6/09, effective 7/1/09; **ARC 7833B**, IAB 6/3/09, effective 8/1/09; **ARC 7929B**, IAB 7/1/09, effective 7/1/09; **ARC 7931B**, IAB 7/1/09, effective 7/1/09; **ARC 8095B**, IAB 9/9/09, effective 10/14/09; **ARC 8260B**, IAB 11/4/09, effective 1/1/10; **ARC 8261B**, IAB 11/4/09, effective 10/15/09; **ARC 8439B**, IAB 1/13/10, effective 3/1/10; **ARC 8503B**, IAB 2/10/10, effective 1/13/10; **ARC 8713B**, IAB 5/5/10, effective 8/1/10; **ARC 8897B**, IAB 6/30/10, effective 9/1/10; **ARC 9581B**, IAB 6/29/11, effective 8/3/11; **ARC 9647B**, IAB 8/10/11, effective 8/1/11; **ARC 9956B**, IAB 1/11/12, effective 1/1/12; **ARC 0149C**, IAB 6/13/12, effective 8/1/12; **ARC 0579C**, IAB 2/6/13, effective 4/1/13; **ARC 0820C**, IAB 7/10/13, effective 8/1/13; **ARC 0990C**, IAB 9/4/13, effective 1/1/14; **ARC 1134C**, IAB 10/30/13, effective 10/2/13; **ARC 1482C**, IAB 6/11/14, effective 8/1/14; **ARC 2029C**, IAB 6/10/15, effective 8/1/15; **ARC 2557C**, IAB 6/8/16, effective 8/1/16; **ARC 3094C**, IAB 6/7/17, effective 8/1/17; **ARC 3353C**, IAB 10/11/17, effective 10/1/17; **ARC 3354C**, IAB 10/11/17, effective 10/1/17; **ARC 3549C**, IAB 1/3/18, effective 2/7/18; **ARC 3550C**, IAB 1/3/18, effective 2/7/18; **ARC 3873C**, IAB 7/4/18, effective 8/8/18]

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

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

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

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

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

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

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

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

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

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

a. Physical or emotional harm to the member for whom medical resources are being sought.

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

75.2(4) Failure to cooperate as required in subrule 75.2(2) without good cause as defined in subrule 75.2(3) shall result in the termination of medical assistance benefits. The department shall make the

determination of good cause based on information and evidence provided by the member or by one acting on the member's behalf.

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

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

This rule is intended to implement Iowa Code sections 249A.4, 249A.5 and 249A.6.
[ARC 7546B, IAB 2/11/09, effective 4/1/09; ARC 8503B, IAB 2/10/10, effective 1/13/10; ARC 8785B, IAB 6/2/10, effective 8/1/10]

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

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

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

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

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

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

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

441—75.4(249A) Medical assistance lien.

75.4(1) When the medical assistance program pays for a member's medical care or expenses, the department shall have a lien upon all monetary claims which the member may have against third parties for those expenses. Monetary claims shall include medical malpractice claims for injuries sustained on or after July 1, 2011. The lien shall be to the extent of the medical assistance payments only.

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

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

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

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

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

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

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

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

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

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

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

- (1) The date that health insurance begins, changes, or ends.
- (2) The date that eligibility begins for care through the Department of Veterans Affairs, specialized child health services, Title XVIII of the Social Security Act (Medicare) and other resources.
- (3) The date the client, or one acting on the client's behalf, files an insurance claim against an insured third party, for the payment of medical expenses that otherwise would be paid by Medicaid.
- (4) The date the member, or one acting on the member's behalf, retains an attorney with the expectation of seeking restitution for injuries from a possibly liable third party, and the medical expenses resulting from those injuries would otherwise be paid by Medicaid.
- (5) The date that the member, or one acting on the member's behalf, receives a partial or total settlement for the payment of medical expenses that would otherwise be paid by Medicaid.

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

d. The member, or one acting on the member's behalf, shall complete the Priority Leads Letter, Form 470-0398, when the department has reason to believe that the member has sustained

an accident-related injury. Failure to cooperate in completing and returning this form, or in giving complete and accurate information, shall result in the termination of Medicaid benefits.

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

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

75.4(4) Third party and provider responsibilities.

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

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

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

75.4(5) Department's lien.

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

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

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

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

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

75.4(6) For purposes of this rule, the term “third party” includes an attorney, individual, institution, corporation, or public or private agency which is or may be liable to pay part or all of the medical costs incurred as a result of injury, disease or disability by or on behalf of an applicant for medical assistance or a past or present Medicaid member.

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

This rule is intended to implement Iowa Code sections 249A.4, 249A.5, and 249A.6.
[ARC 9696B, IAB 9/7/11, effective 9/1/11; ARC 9881B, IAB 11/30/11, effective 1/4/12]

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

75.5(1) Determining income from property.

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

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

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

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

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

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

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

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

75.5(3) Attribution of resources to institutionalized spouse and community spouse. The department shall determine the attribution of a couple’s resources to the institutionalized spouse and to the community spouse when the institutionalized spouse is expected to remain in a medical institution at

least 30 consecutive days on or after September 30, 1989, at the beginning of the first continuous period of institutionalization.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

d. Method of attribution. The resources attributed to the institutionalized spouse shall be one-half of the documented resources of both the institutionalized spouse and the community spouse as of the first moment of the first day of the month of the spouse's first entry to a medical facility. However, if one-half of the resources is less than \$24,000, then \$24,000 shall be protected for the community

spouse. Also, when one-half of the resources attributed to the community spouse exceeds the maximum amount allowed as a community spouse resource allowance by Section 1924(f)(2)(A)(i) of the Social Security Act (42 U.S.C. § 1396r-5(f)(2)(A)(i)), the amount over the maximum shall be attributed to the institutionalized spouse. (The maximum limit is indexed annually according to the consumer price index.)

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

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

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

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

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

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

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

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

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

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

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

(7) If the appellant provides a statement from an insurance company that it will not provide an estimate due to the potential annuitant's age, the amount to be set aside shall be determined using the following calculation: The difference between the community spouse's gross monthly income not generated by countable resources (times 12) and the minimum monthly maintenance needs allowance (times 12) shall be multiplied by the annuity factor for the age of the community spouse in the Table for an Annuity for Life published at the end of Iowa Code chapter 450. This amount shall be substituted for the amount of resources attributed to the community spouse pursuant to subparagraph 75.5(3) "f"(5).

75.5(4) Consideration of resources of married people.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

441—75.7(249A) Furnishing of social security number.

75.7(1) As a condition of eligibility, except as provided by subrule 75.7(2), all social security numbers issued to each individual (including children) for whom Medicaid is sought must be furnished to the department.

75.7(2) The requirement of subrule 75.7(1) does not apply to an individual who:

a. Is not eligible to receive a social security number;

b. Does not have a social security number and may only be issued a social security number for a valid nonwork reason in accordance with 20 CFR § 422.104; or

c. Refuses to obtain a social security number because of a well-established religious objection.

For this purpose, a well-established religious objection means that the individual:

(1) Is a member of a recognized religious sect or division of the sect; and

(2) Adheres to the tenets or teachings of the sect or division of the sect and for that reason is conscientiously opposed to applying for or using a national identification number.

75.7(3) If a social security number has not been issued or is not known, the individual seeking Medicaid must cooperate with the department in applying for a social security number with the Social Security Administration or in requesting the Social Security Administration to furnish the number.

[ARC 1134C, IAB 10/30/13, effective 10/2/13]

441—75.8(249A) Medical assistance corrective payments. If a decision by the department or the Social Security Administration following an appeal on a denied application for any of the categories

of medical assistance eligibility set forth in rule 441—75.1(249A) is favorable to the claimant, reimbursement will be made to the claimant for any medical bills paid by the claimant during the period between the date of the denial on the initial application and the date regular medical assistance coverage began when the bills were for medical services rendered in the period now determined to be an eligible period based on the following conditions:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

75.10(1) Definitions.

a. *Institutions.* For purposes of this rule, "institution" means an "institution" or a "medical institution" as those terms are defined in 42 CFR § 435.1010 as amended to July 13, 2007. For purposes of state placement, "institution" also includes foster care homes licensed as set forth in 45 CFR § 1355.20 as amended to January 6, 2012, and providing food, shelter and supportive services to one or more persons unrelated to the proprietor.

b. *Incapable of expressing intent regarding residency.* For purposes of this rule, an individual is considered to be "incapable of indicating intent regarding residency" if the individual:

1. Has an IQ of 49 or less or has a mental age of seven or less;
2. Has been judged legally incompetent; or

3. Has been determined to be incapable of indicating intent regarding residency by a physician, psychologist or other person licensed by the state in the field of intellectual disability.

75.10(2) Determination of residency. State residency is determined according to the following criteria. If more than one criterion applies, the applicable criterion listed first determines the individual's residency:

a. Cases of disputed residency. If two or more states do not agree on an individual's state of residence, the state where the individual is physically located is the state of residence.

b. Temporary absence from state of residence. An individual who was a resident of a state pursuant to the other criteria of this rule, who is temporarily absent from that state, and who intends to return to that state when the purpose of the absence has been accomplished remains a resident of that state during the absence, unless another state has determined that the person is a resident there for Medicaid purposes.

c. Individuals placed by a state in an out-of-state institution. If any agency of a state, including an entity recognized under state law as being under contract with the state for such purposes, arranges for an individual to be placed in an institution located in another state, the state arranging or actually making the placement is considered the individual's state of residence during that placement.

(1) Any action beyond providing information to the individual and the individual's family constitutes arranging or making a placement. However, the following actions do not constitute arranging or making a placement:

1. Providing basic information to individuals about another state's Medicaid program and information about the availability of health care services and facilities in another state.

2. Assisting an individual in locating an institution in another state, provided the individual is not incapable of indicating intent regarding residency and independently decides to move.

(2) When a competent individual leaves an out-of-state institution in which the individual was placed by a state, that individual's state of residence is the state where the individual is physically located.

d. Individuals receiving a state supplementary assistance payment. Individuals who are receiving a state supplementary assistance payment pursuant to 42 U.S.C. § 1382e (including payments from Iowa pursuant to rules 441—50.1(249) through 441—54.8(249), 441—81.23(249A), 441—82.19(249A), 441—85.47(249A), or 441—177.1(249) through 441—177.11(249)) are considered to be residents of the state paying the supplementary assistance.

e. Individuals receiving Title IV-E payments. Individuals who are receiving federal foster care or adoption assistance payments for a child under Title IV-E of the Social Security Act are considered to be residents of the state where the child lives.

f. Individuals aged 21 and over who are residing in an institution and who are capable of indicating intent regarding residency. For an individual aged 21 or over who is residing in an institution and who is not incapable of indicating intent regarding residency, the state of residence is the state where the individual is living and intends to reside.

g. Individuals aged 21 and over who are residing in an institution and who became incapable of indicating intent regarding residency before the age of 21. For an individual aged 21 or over who is residing in an institution and who became incapable of indicating intent regarding residency before the age of 21, the state of residence is:

(1) That of the parent applying for Medicaid on the individual's behalf if the parents reside in separate states (if a legal guardian has been appointed and parental rights are terminated, the state of residence of the guardian is used instead of that of the parent);

(2) The parent's or legal guardian's state of residence at the time of placement (if a legal guardian has been appointed and parental rights are terminated, the state of residence of the guardian is used instead of that of the parent);

(3) The current state of residence of the parent or legal guardian who files the application if the individual is residing in an institution in that state (if a legal guardian has been appointed and parental rights are terminated, the state of residence of the guardian is used instead of that of the parent); or

(4) The state of residence of the individual or party who files an application if the individual has been abandoned by the individual's parent(s), does not have a legal guardian, and is residing in an institution in that state.

h. Individuals aged 21 and over who are residing in an institution and who became incapable of indicating intent regarding residency at or after the age of 21. For an individual aged 21 or over who is residing in an institution and who became incapable of indicating intent regarding residency at or after the age of 21, the state of residence is the state in which the individual is physically present.

i. Individuals aged 21 and over who are not residing in an institution and who are incapable of indicating intent regarding residency. For an individual aged 21 or over who is not residing in an institution and who is incapable of indicating intent regarding residency, the state of residence is the state where the individual is living.

j. Individuals aged 21 and over who are not residing in an institution and who are capable of indicating intent regarding residency. For an individual aged 21 or over who is not residing in an institution and who is not incapable of indicating intent regarding residency, the state of residence is the state where the individual is living and either:

- (1) Intends to reside, with or without a fixed address; or
- (2) Entered with a job commitment or to seek employment, whether or not currently employed.

k. Individuals under the age of 21 who are residing in an institution and who are not married or emancipated. For an individual under the age of 21 who is residing in an institution and who is neither married nor emancipated, the state of residence is:

(1) The parent's or legal guardian's state of residence at the time of placement (if a legal guardian has been appointed and parental rights are terminated, the state of residence of the guardian is used instead of that of the parent);

(2) The current state of residence of the parent or legal guardian who files the application if the individual is residing in an institution in that state (if a legal guardian has been appointed and parental rights are terminated, the state of residence of the guardian is used instead of that of the parent); or

(3) The state of residence of the individual or party who files an application if the individual has been abandoned by the individual's parent(s), does not have a legal guardian, and is residing in an institution in that state.

l. Individuals under the age of 21 who are capable of indicating intent regarding residency and who are married or emancipated. For an individual under the age of 21 who is not incapable of indicating intent regarding residency and who is married or emancipated from the individual's parent, the state of residence is determined in accordance with paragraph 75.10(2) "j."

m. Other individuals under the age of 21. For an individual under the age of 21 who is not described in paragraph 75.10(2) "k" or "l," the state of residence is:

- (1) The state where the individual resides, with or without a fixed address; or
- (2) The state of residency of the parent or caretaker, determined in accordance with paragraph 75.10(2) "j," with whom the individual resides.

This rule is intended to implement Iowa Code section 249A.3.
[ARC 1134C, IAB 10/30/13, effective 10/2/13]

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

75.11(1) Definitions.

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

"Emergency medical condition" means a medical condition of sudden onset (including labor and delivery) manifesting itself by acute symptoms of sufficient severity (including severe pain) that the absence of immediate medical attention could reasonably be expected to result in one or more of the following:

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

“*Federal means-tested program*” means all federal programs that are means-tested with the exception of:

1. Medical assistance for care and services necessary for the treatment of an emergency medical condition not related to an organ transplant procedure furnished on or after August 10, 1993.
2. Short-term, non-cash, in-kind emergency disaster relief.
3. Assistance or benefits under the National School Lunch Act.
4. Assistance or benefits under the Child Nutrition Act of 1966.
5. Public health assistance (not including any assistance under Title XIX of the Social Security Act) for immunizations with respect to immunizable diseases and for testing and treatment of symptoms of communicable diseases whether or not the symptoms are caused by a communicable disease.
6. Payments of foster care and adoption assistance under Parts B and E of Title IV of the Social Security Act for a parent or a child who would, in the absence of numbered paragraph “1,” be eligible to have payments made on the child’s behalf under such part, but only if the foster or adoptive parent (or parents) of the child is a qualified alien (as defined in Section 431).
7. Programs, services, or assistance (such as soup kitchens, crisis counseling and intervention, and short-term shelter) specified by the attorney general of the United States in the attorney general’s sole and unreviewable discretion after consultation with appropriate federal agencies and departments, that:
 - Deliver in-kind services at the community level, including through public or private nonprofit agencies;
 - Do not condition the provision of assistance, the amount of assistance provided, or the cost of assistance provided on the individual recipient’s income or resources; and
 - Are necessary for the protection of life or safety.
8. Programs of student assistance under Titles IV, V, IX, and X of the Higher Education Act of 1965, and Titles III, VII, and VIII of the Public Health Services Act.
9. Means-tested programs under the Elementary and Secondary Education Act of 1965.
10. Benefits under the Head Start Act.
11. Benefits funded through an employment and training program of the U.S. Department of Labor.

“*Qualified alien*” means an alien:

1. Who is lawfully admitted for permanent residence in the United States under the Immigration and Nationality Act (INA);
2. Who is granted asylum in the United States under Section 208 of the INA;
3. Who is a refugee admitted to the United States under Section 207 of the INA;
4. Who is paroled into the United States under Section 212(d)(5) of the INA for a period of at least one year;
5. Whose deportation from the United States is withheld under Section 243(h) of the INA as in effect before April 1, 1997, or under Section 241(b)(3) of the INA as amended to December 20, 2010;
6. Who is granted conditional entry to the United States pursuant to Section 203(a)(7) of the INA as in effect before April 1, 1980;
7. Who is an Amerasian admitted to the United States as described in 8 U.S.C. Section 1612(b)(2)(A)(i)(V);
8. Who is a Cuban/Haitian entrant to the United States as described in 8 U.S.C. Section 1641(b)(7);
9. Who is a battered alien as described in 8 U.S.C. Section 1641(c);
10. Who is certified as a victim of trafficking as described in Section 107(b)(1)(A) of Public Law 106-386 as amended to December 20, 2010;
11. Who is an American Indian born in Canada to whom Section 289 of the INA applies or is a member of a federally recognized Indian Tribe as defined in 25 U.S.C. Section 450b(e); or
12. Who is under the age of 21 and is lawfully residing in the United States as allowed by 42 U.S.C. Section 1396b(v)(4)(A)(ii).

“*Qualifying quarters*” includes all of the qualifying quarters of coverage as defined under Title II of the Social Security Act worked by a parent of an alien while the alien was under age 18 and all of the qualifying quarters worked by a spouse of the alien during their marriage if the alien remains married to the spouse or the spouse is deceased. No qualifying quarter of coverage that is creditable under Title II

of the Social Security Act for any period beginning after December 31, 1996, may be credited to an alien if the parent or spouse of the alien received any federal means-tested public benefit during the period for which the qualifying quarter is so credited.

75.11(2) Citizenship and alienage.

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

- (1) A citizen or national of the United States.
- (2) A qualified alien residing in the United States before August 22, 1996.
- (3) A qualified alien under the age of 21.
- (4) A refugee admitted to the United States under Section 207 of the Immigration and Nationality Act (INA).
- (5) An alien who has been granted asylum under Section 208 of the INA.
- (6) An alien whose deportation is withheld under Section 243(h) or Section 241(b)(3) of the INA.
- (7) A qualified alien veteran who has an honorable discharge that is not due to alienage.
- (8) A qualified alien who is on active duty in the Armed Forces of the United States other than active duty for training.
- (9) A qualified alien who is the spouse or unmarried dependent child of a qualified alien described in subparagraph (7) or (8), including a surviving spouse who has not remarried.
- (10) A qualified alien who has resided in the United States for a period of at least five years.
- (11) An Amerasian admitted as described in 8 U.S.C. Section 1612(b)(2)(A)(i)(V).
- (12) A Cuban/Haitian entrant as described in 8 U.S.C. Section 1641(b)(7).
- (13) A certified victim of trafficking as described in Section 107(b)(1)(A) of Public Law 106-386 as amended to December 20, 2010.
- (14) An American Indian born in Canada to whom Section 289 of the INA applies or who is a member of a federally recognized Indian Tribe as defined in 25 U.S.C. Section 450b(e).
- (15) An Iraqi or Afghan immigrant treated as a refugee pursuant to Section 1244(g) of Public Law 110-181 as amended to December 20, 2010, or to Section 602(b)(8) of Public Law 111-8 as amended to December 20, 2010.

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

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

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

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

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

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

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

(2) Medicaid shall be approved for new applicants and continue for members not previously required to provide documentation of citizenship or nationality until the end of the reasonable period to obtain and provide required documentation of citizenship or nationality. However, the receipt of Medicaid or HAWK-I benefits pending documentation of citizenship or nationality is limited to one reasonable period of up to 90 days under either program for each individual. An applicant or member who has already received benefits during any portion of a reasonable period shall not be granted coverage for a second reasonable period except as required to protect the confidentiality of an individual who received only limited Medicaid benefits provided pursuant to subrule 75.1(41) during the first period.

(3) Retroactive eligibility pursuant to 441—subrule 76.13(3) is available only after documentation of citizenship or nationality has been provided pursuant to paragraph 75.11(2) “d,” “e,” or “i.” The retroactive months are outside the “reasonable period” during which Medicaid coverage may be provided without required documentation of citizenship or nationality.

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

(1) A United States passport.

(2) Form N-550 or N-570 (Certificate of Naturalization) issued by the U.S. Citizenship and Immigration Services.

(3) Form N-560 or N-561 (Certificate of United States Citizenship) issued by the U.S. Citizenship and Immigration Services.

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

1. Requires proof of United States citizenship before issuance of the license or document; or

2. Obtains a social security number from the applicant and verifies before certification that the number is valid and is assigned to the applicant who is a citizen.

(5) Documentation issued by a federally recognized Indian Tribe showing membership or enrollment in or affiliation with that Tribe.

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

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

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

(2) Any one of the following:

1. A certificate of birth in the United States.

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

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

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

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

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

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

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

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

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

(5) The person is receiving foster care maintenance or adoption assistance payments funded under Part E of Title IV of the federal Social Security Act.

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

(7) The person is or was eligible for medical assistance pursuant to 42 U.S.C. Section 1396a(e)(4) as the newborn of a Medicaid-eligible mother.

(8) The person is or was eligible for medical assistance pursuant to 42 U.S.C. Section 1397ll(e) as the newborn of a mother eligible for assistance under a State Children's Health Insurance Program (SCHIP) pursuant to Title XXI of the Social Security Act.

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

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

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

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

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

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

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

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

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

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

a. When an alien admitted for lawful permanent residence is sponsored by a person who executed an affidavit of support as described in 8 U.S.C. Section 1631(a)(1) on behalf of the alien, the income

and resources of the alien shall be deemed to include the income and resources of the sponsor (and of the sponsor's spouse if living with the sponsor). The amount deemed to the sponsored alien shall be the total gross countable income and resources of the sponsor and the sponsor's spouse for the FMAP-related or SSI-related coverage group applicable to the sponsored alien's household as described in 441—75.13(249A) less the following deductions:

(1) For FMAP-related coverage groups: The same income deductions, diversions, and disregards allowed for stepparent cases as described at 75.57(8) "b" and a \$1,500 resource deduction.

(2) For SSI-related coverage groups: The deductions described at 20 CFR 416.1166a and 416.1204, as amended to April 1, 2010.

b. An indigent alien is exempt from the deeming of a sponsor's income and resources for 12 months after indigence is determined. An alien shall be considered indigent if the following are true:

(1) The alien does not live with the sponsor; and

(2) The alien's gross income, including any income actually received from or made available by the sponsor, is less than 100 percent of the federal poverty level for the sponsored alien's household size.

c. A battered alien as described in 8 U.S.C. Section 1641(c) is exempt from the deeming of a sponsor's income and resources for 12 months.

d. Deeming of the sponsor's income and resources does not apply when:

(1) The sponsored alien attains citizenship through naturalization pursuant to Chapter 2 of Title II of the Immigration and Nationality Act.

(2) The sponsored alien has earned 40 qualifying quarters of coverage as defined in Title II of the Social Security Act or can be credited with 40 qualifying quarters as defined at subrule 75.11(1).

(3) The sponsored alien or the sponsor dies.

(4) The sponsored alien is a child under age 21.

(5) For SSI-related Medicaid, the sponsored alien becomes blind or disabled as defined under Title XVI of the Social Security Act after admission to the United States as a lawful permanent resident.

(6) For SSI-related Medicaid, three years after the date the sponsored alien was admitted to the United States as a lawful permanent resident.

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

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

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

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

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

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

[ARC 7932B, IAB 7/1/09, effective 7/1/09; ARC 8096B, IAB 9/9/09, effective 10/14/09; ARC 8642B, IAB 4/7/10, effective 6/1/10; ARC 8786B, IAB 6/2/10, effective 6/1/10; ARC 9439B, IAB 4/6/11, effective 6/1/11; ARC 3353C, IAB 10/11/17, effective 10/1/17; ARC 3549C, IAB 1/3/18, effective 2/7/18]

441—75.12(249A) Inmates of public institutions. A person is not eligible for medical assistance for any care or services received while the person is an inmate of a public institution. For the purpose of this rule, "inmate of a public institution" and "public institution" are defined by 42 CFR Section 435.1010 as amended to August 25, 2011.

75.12(1) Suspension. Medical assistance shall be suspended, rather than canceled, for the first 12 continuous calendar months that a person is an inmate of a public institution if all of the following conditions are met:

a. The department is notified of the person's entry into the public institution through either:

(1) A monthly report which is provided to the department by the public institution and includes the person's name, date of birth, and social security number and the date the person entered the institution; or

(2) Other verified notice received by the department.

b. The person has entered a public institution on or after January 1, 2012, and has been in the public institution for 30 days or more.

c. On the date of entry into the public institution, the person was a Medicaid member.

d. The person is eligible for medical assistance as an individual except for institutional status.

75.12(2) Coverage during suspension. While medical assistance is suspended, payment will be made only for services received while the person is not an inmate of a public institution.

75.12(3) Reinstatement. The Medicaid case for an inmate who is released from a public institution while Medicaid is suspended will be reopened without an application if both of the following conditions are met:

a. The department is notified of the person's release from the public institution through either:

(1) A monthly report which is provided to the department by the public institution and includes the person's name, date of birth, and social security number and the date the person was released from the institution; or

(2) Other verified notice received by the department.

b. All information available to the department indicates that the person is currently eligible for Iowa Medicaid as an individual.

This rule is intended to implement Iowa Code section 249A.3 and 2011 Iowa Acts, Senate File 482, division IX.

[ARC 9957B, IAB 1/11/12, effective 1/1/12]

441—75.13(249A) Categorical relatedness.

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

75.13(2) SSI-related Medicaid. Except as otherwise provided in 441—Chapters 75 and 76, persons who are 65 years of age or older, blind, or disabled are eligible for Medicaid only if eligible for the Supplemental Security Income (SSI) program administered by the United States Social Security Administration.

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

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

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

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

e. Valuation of life estates and remainder interests. In the absence of other evidence, the value of a life estate or remainder interest in property shall be determined using the following table by

multiplying the fair market value of the entire underlying property (including all life estates and all remainder interests) by the life estate or remainder interest decimal corresponding to the age of the life estate holder or other person whose life controls the life estate.

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

Age	Life Estate	Remainder	Age	Life Estate	Remainder	Age	Life Estate	Remainder
0	.97188	.02812	37	.93026	.06974	74	.53862	.46138
1	.98988	.01012	38	.92567	.07433	75	.52149	.47851
2	.99017	.00983	39	.92083	.07917	76	.51441	.49559
3	.99008	.00992	40	.91571	.08429	77	.48742	.51258
4	.98981	.01019	41	.91030	.08970	78	.47049	.52951
5	.98938	.01062	42	.90457	.09543	79	.45357	.54643
6	.98884	.01116	43	.89855	.10145	80	.43569	.56341
7	.98822	.01178	44	.89221	.10779	81	.41967	.58033
8	.98748	.01252	45	.88558	.11442	82	.40295	.59705
9	.98663	.01337	46	.87863	.12137	83	.38642	.61358
10	.98565	.01435	47	.87137	.12863	84	.36998	.63002
11	.98453	.01547	48	.86374	.13626	85	.35359	.64641
12	.98329	.01671	49	.85578	.14422	86	.33764	.66236
13	.98198	.01802	50	.84743	.15257	87	.32262	.67738
14	.98066	.01934	51	.83674	.16126	88	.30859	.69141
15	.97937	.02063	52	.82969	.17031	89	.29526	.70474
16	.97815	.02185	53	.82028	.17972	90	.28221	.71779
17	.97700	.02300	54	.81054	.18946	91	.26955	.73045
18	.97590	.02410	55	.80046	.19954	92	.25771	.74229
19	.97480	.02520	56	.79006	.20994	93	.24692	.75308
20	.97365	.02635	57	.77931	.22069	94	.23728	.76272
21	.97245	.02755	58	.76822	.23178	95	.22887	.77113
22	.97120	.02880	59	.75675	.24325	96	.22181	.77819
23	.96986	.03014	60	.74491	.25509	97	.21550	.78450
24	.96841	.03159	61	.73267	.26733	98	.21000	.79000
25	.96678	.03322	62	.72002	.27998	99	.20486	.79514
26	.96495	.03505	63	.70696	.29304	100	.19975	.80025
27	.96290	.03710	64	.69352	.30648	101	.19532	.80468
28	.96062	.03938	65	.67970	.32030	102	.19054	.80946
29	.95813	.04187	66	.66551	.33449	103	.18437	.81563
30	.95543	.04457	67	.65098	.343902	104	.17856	.82144
31	.95254	.04746	68	.63610	.363690	105	.16962	.83038
32	.94942	.05058	69	.62086	.37914	106	.15488	.84512
33	.94608	.05392	70	.60522	.39478	107	.13409	.86591
34	.94250	.05750	71	.58914	.41086	108	.10068	.89932
35	.93868	.06132	72	.57261	.42739	109	.04545	.95455
36	.93460	.06540	73	.55571	.44429			

75.13(3) *Resource eligibility for SSI-related Medicaid for children.* Resources of all household members shall be disregarded when determining eligibility for children under any SSI-related coverage group except for those groups at subrules 75.1(3), 75.1(4), 75.1(6), 75.1(9), 75.1(10), 75.1(12), 75.1(13), 75.1(23), 75.1(25), 75.1(29), 75.1(33), 75.1(34), 75.1(36), 75.1(37), and 75.1(38).

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

441—75.14(249A) Establishing paternity and obtaining support.

75.14(1) As a condition of eligibility, adult Medicaid applicants and members in households with an absent parent shall cooperate in obtaining medical support for themselves and for any other person in the household for whom Medicaid is requested and for whom the applicant or member can legally assign rights for medical support, except when the applicant or member has good cause for refusal to cooperate as defined in subrule 75.14(8).

a. The adult applicant or member shall cooperate in the following:

- (1) Identifying and locating the parent of the child for whom Medicaid is requested.
- (2) Establishing the paternity of a child born out of wedlock for whom Medicaid is requested.
- (3) Obtaining medical support and payments for medical care for the applicant or member and for a child for whom Medicaid is requested.
- (4) Rescinded IAB 2/3/93, effective 4/1/93.

b. Cooperation is defined as including the following actions by the adult applicant or member upon request:

(1) Appearing at the income maintenance unit or the child support recovery unit to provide verbal or written information or documentary evidence known to, possessed by or reasonably obtainable by the applicant or member that is relevant to achieving the objectives of the child support recovery program.

(2) Appearing as a witness at judicial or other hearings or proceedings.

(3) Providing information, or attesting to the lack of information, under penalty of perjury.

c. Upon request, the adult applicant or member shall cooperate with the department in supplying information with respect to the absent parent, the receipt of medical support or payments for medical care, and the establishment of paternity, to the extent necessary to establish eligibility for assistance and permit an appropriate referral to the child support recovery unit.

d. Upon request, the adult applicant or member shall cooperate with the child support recovery unit to the extent of supplying all known information and documents pertaining to the location of the absent parent and taking action as may be necessary to secure medical support and payments for medical care or to establish paternity. This includes completing and signing documents determined to be necessary by the state's attorney for any relevant judicial or administrative process.

e. The child support recovery unit shall make the determination of whether or not the adult applicant or member has cooperated for the purposes of this rule.

75.14(2) Failure of an adult applicant or member to cooperate shall result in denial or cancellation of the noncooperating adult's Medicaid benefits. In family medical assistance program (FMAP)-related Medicaid cases, all deductions and disregards described at paragraphs 75.57(2) "a," "b," and "c" shall be allowed when otherwise applicable.

75.14(3) Each Medicaid applicant or member who is required to cooperate with the child support recovery unit shall have the opportunity to claim good cause for refusing to cooperate in establishing paternity or securing medical support and payments for medical care. The provisions set forth in subrules 75.14(8) to 75.14(12) shall be used when making a determination of the existence of good cause.

75.14(4) Each Medicaid applicant or member shall assign to the department any rights to medical support and payments for medical care from any other person for which the person can legally make assignment. This shall include rights to medical support and payments for medical care on the applicant's or member's own behalf or on behalf of any other family member for whom the applicant or member is applying. An assignment is effective the same date the eligibility information is entered into the automated benefit calculation system and is effective for the entire period for which eligibility is granted. Support payments not intended for medical support shall not be assigned to the department.

75.14(5) Rescinded IAB 6/2/10, effective 8/1/10.

75.14(6) Pregnant women establishing eligibility under the mothers and children (MAC) coverage group as provided at subrule 75.1(28) shall be exempt from the provisions in this rule for any born child for whom the pregnant woman applies for or receives Medicaid. Additionally, any previously pregnant woman eligible for postpartum coverage under the provision of subrule 75.1(24) shall not be subject to the provisions in this rule until after the end of the month in which the 60-day postpartum period expires. Pregnant women establishing eligibility under any other coverage groups except those set forth in subrule 75.1(24) or 75.1(28) shall be subject to the provisions in this rule when establishing eligibility for born children. However, when a pregnant woman who is subject to these provisions fails to cooperate, the woman shall lose eligibility under her current coverage group and her eligibility for Medicaid shall be automatically redetermined under subrule 75.1(28).

75.14(7) Notwithstanding subrule 75.14(6), any pregnant woman or previously pregnant woman establishing eligibility under subrule 75.1(28) or 75.1(24) shall not be exempt from the provisions of 75.14(4) that require an adult applicant or member to assign any rights to medical support and payments for medical care.

75.14(8) Good cause for refusal to cooperate. Good cause shall exist when it is determined that cooperation in establishing paternity and securing support is against the best interests of the child.

a. The income maintenance unit shall determine that cooperation is against the child's best interest when the applicant's or member's cooperation in establishing paternity or securing support is reasonably anticipated to result in:

- (1) Physical or emotional harm to the child for whom support is to be sought; or
- (2) Physical or emotional harm to the parent or specified relative with whom the child is living which reduces the person's capacity to care for the child adequately.
- (3) Physical harm to the parent or specified relative with whom the child is living which reduces the person's capacity to care for the child adequately; or
- (4) Emotional harm to the parent or specified relative with whom the child is living of a nature or degree that it reduces the person's capacity to care for the child adequately.

b. The income maintenance unit shall determine that cooperation is against the child's best interest when at least one of the following circumstances exists, and the income maintenance unit believes that because of the existence of that circumstance, in the particular case, proceeding to establish paternity or secure support would be detrimental to the child for whom support would be sought.

- (1) The child was conceived as the result of incest or forcible rape.
- (2) Legal proceedings for the adoption of the child are pending before a court of competent jurisdiction.
- (3) The applicant or member is currently being assisted by a public or licensed private social agency to resolve the issue of whether to keep the child or relinquish the child for adoption, and the discussions have not gone on for more than three months.

c. Physical harm and emotional harm shall be of a serious nature in order to justify a finding of good cause. A finding of good cause for emotional harm shall be based only upon a demonstration of an emotional impairment that substantially affects the individual's functioning.

d. When the good cause determination is based in whole or in part upon the anticipation of emotional harm to the child, the parent, or the specified relative, the following shall be considered:

- (1) The present emotional state of the individual subject to emotional harm.
- (2) The emotional health history of the individual subject to emotional harm.
- (3) Intensity and probable duration of the emotional impairment.
- (4) The degree of cooperation required.
- (5) The extent of involvement of the child in the paternity establishment or support enforcement activity to be undertaken.

75.14(9) Claiming good cause. Each Medicaid applicant or member who is required to cooperate with the child support recovery unit shall have the opportunity to claim good cause for refusing to cooperate in establishing paternity or securing support payments.

a. Before requiring cooperation, the department shall notify the applicant or member using Form 470-0169 or 470-0169(S), Requirements of Support Enforcement, of the right to claim good cause as

an exception to the cooperation requirement and of all the requirements applicable to a good cause determination.

b. The initial notice advising of the right to refuse to cooperate for good cause shall:

(1) Advise the applicant or member of the potential benefits the child may derive from the establishment of paternity and securing support.

(2) Advise the applicant or member that by law cooperation in establishing paternity and securing support is a condition of eligibility for the Medicaid program.

(3) Advise the applicant or member of the sanctions provided for refusal to cooperate without good cause.

(4) Advise the applicant or member that good cause for refusal to cooperate may be claimed and that if the income maintenance unit determines, in accordance with these rules, that there is good cause, the applicant or member will be excused from the cooperation requirement.

(5) Advise the applicant or member that upon request, or following a claim of good cause, the income maintenance unit will provide further notice with additional details concerning good cause.

c. When the applicant or member makes a claim of good cause or requests additional information regarding the right to file a claim of good cause, the income maintenance unit shall issue a second notice, Form 470-0170, Requirements of Claiming Good Cause. To claim good cause, the applicant or member shall sign and date Form 470-0170 and return it to the income maintenance unit. This form:

(1) Indicates that the applicant or member must provide corroborative evidence of good cause circumstance and must, when requested, furnish sufficient information to permit the county office to investigate the circumstances.

(2) Informs the applicant or member that, upon request, the income maintenance unit will provide reasonable assistance in obtaining the corroborative evidence.

(3) Informs the applicant or member that on the basis of the corroborative evidence supplied and the agency's investigation when necessary, the income maintenance unit shall determine whether cooperation would be against the best interests of the child for whom support would be sought.

(4) Lists the circumstances under which cooperation may be determined to be against the best interests of the child.

(5) Informs the applicant or member that the child support recovery unit may review the income maintenance unit's findings and basis for a good cause determination and may participate in any hearings concerning the issue of good cause.

(6) Informs the applicant or member that the child support recovery unit may attempt to establish paternity and collect support in those cases where the income maintenance unit determines that this can be done without risk to the applicant or member if done without the applicant's or member's participation.

d. The applicant or member who refuses to cooperate and who claims to have good cause for refusing to cooperate has the burden of establishing the existence of a good cause circumstance. Failure to meet these requirements shall constitute a sufficient basis for the income maintenance unit to determine that good cause does not exist. The applicant or member shall:

(1) Specify the circumstances that the applicant or member believes provide sufficient good cause for not cooperating.

(2) Corroborate the good cause circumstances.

(3) When requested, provide sufficient information to permit an investigation.

75.14(10) Determination of good cause. The income maintenance unit shall determine whether good cause exists for each Medicaid applicant or member who claims to have good cause.

a. The income maintenance unit shall notify the applicant or member of its determination that good cause does or does not exist. The determination shall:

(1) Be in writing.

(2) Contain the income maintenance unit's findings and basis for determination.

(3) Be entered in the case record.

b. The determination of whether or not good cause exists shall be made within 45 days from the day the good cause claim is made. The income maintenance unit may exceed this time standard only when:

(1) The case record documents that the income maintenance unit needs additional time because the information required to verify the claim cannot be obtained within the time standard, or

(2) The case record documents that the claimant did not provide corroborative evidence within the time period set forth in subrule 75.14(11).

c. When the income maintenance unit determines that good cause does not exist:

(1) The applicant or member shall be so notified and be afforded an opportunity to cooperate, withdraw the application for assistance, or have the case closed; and

(2) Continued refusal to cooperate will result in the loss of Medicaid for the person who refuses to cooperate.

d. The income maintenance unit shall make a good cause determination based on the corroborative evidence supplied by the applicant or member only after the income maintenance unit has examined the evidence and found that it actually verifies the good cause claim.

e. Before making a final determination of good cause for refusing to cooperate, the income maintenance unit shall:

(1) Afford the child support recovery unit the opportunity to review and comment on the findings and basis for the proposed determination, and

(2) Consider any recommendation from the child support recovery unit.

f. The child support recovery unit may participate in any appeal hearing that results from an applicant's or member's appeal of an agency action with respect to a decision on a claim of good cause.

g. Assistance shall not be denied, delayed, or discontinued pending a determination of good cause for refusal to cooperate when the applicant or member has specified the circumstances under which good cause can be claimed and provided the corroborative evidence and any additional information needed to establish good cause.

h. The income maintenance unit shall:

(1) Periodically, but not less frequently than every six months, review those cases in which the agency has determined that good cause exists based on a circumstance that is subject to change.

(2) When it determines that circumstances have changed so that good cause no longer exists, rescind its findings and proceed to enforce the requirements pertaining to cooperation in establishing paternity and securing support.

75.14(11) Proof of good cause. The applicant or member who claims good cause shall provide corroborative evidence within 20 days from the day the claim was made. In exceptional cases where the income maintenance unit determines that the applicant or member requires additional time because of the difficulty in obtaining the corroborative evidence, the income maintenance unit shall allow a reasonable additional period upon approval by the worker's immediate supervisor.

a. A good cause claim may be corroborated with the following types of evidence:

(1) Birth certificates or medical or law enforcement records which indicate that the child was conceived as the result of incest or forcible rape.

(2) Court documents or other records which indicate that legal proceedings for adoption are pending before a court of competent jurisdiction.

(3) Court, medical, criminal, child protective services, social services, psychological, or law enforcement records which indicate that the putative father or absent parent might inflict physical or emotional harm on the child or specified relative.

(4) Medical records which indicate emotional health history and present emotional health status of the specified relative or the children for whom support would be sought; or written statements from a mental health professional indicating a diagnosis or prognosis concerning the emotional health of the specified relative or the child for whom support would be sought.

(5) A written statement from a public or licensed private social agency that the applicant or member is being assisted by the agency to resolve the issue of whether to keep the child or relinquish the child for adoption.

(6) Sworn statements from individuals other than the applicant or member with knowledge of the circumstances which provide the basis for the good cause claim.

b. When, after examining the corroborative evidence submitted by the applicant or member, the income maintenance unit wishes to request additional corroborative evidence which is needed to permit a good cause determination, the income maintenance unit shall:

- (1) Promptly notify the applicant or member that additional corroborative evidence is needed, and
- (2) Specify the type of document which is needed.

c. When the applicant or member requests assistance in securing evidence, the income maintenance unit shall:

- (1) Advise the applicant or member how to obtain the necessary documents, and
- (2) Make a reasonable effort to obtain any specific documents which the applicant or member is not reasonably able to obtain without assistance.

d. When a claim is based on the applicant's or member's anticipation of physical harm and corroborative evidence is not submitted in support of the claim:

(1) The income maintenance unit shall investigate the good cause claim when the office believes that the claim is credible without corroborative evidence and corroborative evidence is not available.

(2) Good cause shall be found when the claimant's statement and investigation which is conducted satisfies the county office that the applicant or member has good cause for refusing to cooperate.

(3) A determination that good cause exists shall be reviewed and approved or disapproved by the worker's immediate supervisor and the findings shall be recorded in the case record.

e. The income maintenance unit may further verify the good cause claim when the applicant's or member's statement of the claim together with the corroborative evidence do not provide sufficient basis for making a determination. When the income maintenance unit determines that it is necessary, the unit may conduct an investigation of good cause claims to determine that good cause does or does not exist.

f. When it conducts an investigation of a good cause claim, the income maintenance unit shall:

(1) Contact the absent parent or putative father from whom support would be sought when the contact is determined to be necessary to establish the good cause claim.

(2) Before making the necessary contact, notify the applicant or member so the applicant or member may present additional corroborative evidence or information so that contact with the parent or putative father becomes unnecessary, withdraw the application for assistance or have the case closed, or have the good cause claim denied.

75.14(12) Enforcement without specified relative's cooperation. When the income maintenance unit makes a determination that good cause exists, the unit shall also make a determination of whether or not child support enforcement can proceed without risk of harm to the child or specified relative when the enforcement or collection activities do not involve their participation.

a. The child support recovery unit shall have an opportunity to review and comment on the findings and basis for the proposed determination and the income maintenance unit shall consider any recommendations from the child support recovery unit.

b. The determination shall be in writing, contain the income maintenance unit's findings and basis for the determination, and be entered into the case record.

c. When the income maintenance unit excuses cooperation but determines that the child support recovery unit may proceed to establish paternity or enforce support, the income maintenance unit shall notify the applicant or member to enable the individual to withdraw the application for assistance or have the case closed.

This rule is intended to implement Iowa Code sections 249A.3 and 249A.4.
[ARC 8785B, IAB 6/2/10, effective 8/1/10]

441—75.15(249A) Disqualification for long-term care assistance due to substantial home equity. Notwithstanding any other provision of this chapter, if an individual's equity interest in the individual's home exceeds \$500,000, the individual shall not be eligible for medical assistance with respect to nursing facility services or other long-term care services except as provided in 75.15(2). This provision is effective for all applications or requests for payment of long-term care services filed on or after January 1, 2006.

75.15(1) The limit on the equity interest in the individual's home for purposes of this rule shall be increased from year to year, beginning with 2011, based on the percentage increase in the consumer price index for all urban consumers (all items; United States city average), rounded to the nearest \$1,000.

75.15(2) Disqualification based on equity interest in the individual's home shall not apply when one of the following persons is lawfully residing in the home:

- a. The individual's spouse; or
- b. The individual's child who is under age 21 or is blind or disabled as defined in Section 1614 of the federal Social Security Act.

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

441—75.16(249A) Client participation in payment for medical institution care. Medicaid clients are required to participate in the cost of medical institution care. However, no client participation is charged when the combination of Medicare payments and the Medicaid benefits available to qualified Medicare beneficiaries covers the cost of institutional care.

75.16(1) *Income considered in determining client participation.* The department determines the amount of client participation based on the client's total monthly income, with the following exceptions:

a. *FMAP-related clients.* The income of a client and family whose eligibility is FMAP-related is not available for client participation when both of the following conditions exist:

- (1) The client has a parent or child at home.
- (2) The family's income is considered together in determining eligibility.

b. *SSI-related clients who are employed.* If a client receives SSI and is substantially gainfully employed, as determined by the Social Security Administration, the client shall have the SSI and any mandatory state supplementary assistance payment exempt from client participation for the two full months after entry to a medical institution.

c. *SSI-related clients returning home within three months.* If the Social Security Administration continues a client's SSI or federally administered state supplementary assistance payments for three months because it is expected that the client will return home within three months, these payments shall be exempt from client participation.

d. *Married couples.*

(1) Institutionalized spouse and community spouse. If there is a community spouse, only the institutionalized person's income shall be considered in determining client participation.

(2) Both spouses institutionalized. Client participation for each partner in a marriage shall be based on one-half of the couple's combined income when the partners are considered together for eligibility. Client participation for each partner who is considered individually for eligibility shall be determined individually from each person's income.

(3) Rescinded, IAB 7/11/90, effective 7/1/90.

e. *State supplementary assistance recipients.* The amount of client participation that a client paid under the state supplementary assistance program is not available for Medicaid client participation in the month of the client's entry to a medical institution.

f. *Foster care recipients.* The amount of income paid for foster care for the days that a child is in foster care in the same month as entry to a medical institution is not available for client participation.

g. *Clients receiving a VA pension.* The amount of \$90 of veteran's pension income shall be exempt from client participation if the client is a veteran or a surviving spouse of a veteran who:

- (1) Receives a reduced pension pursuant to 38 U.S.C. Section 5503(d)(2), or
- (2) Resides at the Iowa Veterans Home and does not have a spouse or minor child.

75.16(2) *Allowable deductions from income.* In determining the amount of client participation, the department allows the following deductions from the client's income, taken in the order they appear:

a. *Ongoing personal needs allowance.* All clients shall retain \$50 of their monthly income for a personal needs allowance. (See rules 441—81.23(249A), 441—82.19(249A), and 441—85.47(249A) regarding potential state-funded personal needs supplements.)

(1) If the client has a trust described in Section 1917(d)(4) of the Social Security Act (including medical assistance income trusts and special needs trusts), a reasonable amount paid or set aside for

necessary expenses of the trust is added to the personal needs allowance. This amount shall not exceed \$10 per month except with court approval.

(2) If the client has earned income, an additional \$65 is added to the ongoing personal needs allowance from the earned income only.

(3) Rescinded IAB 7/4/07, effective 7/1/07.

b. Personal needs in the month of entry.

(1) Single person. A single person shall be given an allowance for stated home living expenses during the month of entry, up to the amount of the SSI benefit for a single person.

(2) Spouses entering institutions together and living together. Partners in a marriage who enter a medical institution in the same month and live in the same room shall be given an allowance for stated home living expenses during the month of entry, up to the amount of the SSI benefit for a couple.

(3) Spouses entering an institution together but living apart. Partners in a marriage who enter a medical institution during the same month and who are considered separately for eligibility shall each be given an allowance for stated home living expenses during the month of entry, up to one-half of the amount of the SSI benefit for a married couple. However, if the income of one spouse is less than one-half of the SSI benefit for a couple, the remainder of the allowance shall be given to the other spouse. If the couple's eligibility is determined together, an allowance for stated home living expenses shall be given to them during the month of entry up to the SSI benefit for a married couple.

(4) Community spouse enters a medical institution. When the second member of a married couple enters a medical institution in a later month, that spouse shall be given an allowance for stated expenses during the month of entry, up to the amount of the SSI benefit for one person.

c. Personal needs in the month of discharge. The client shall be allowed a deduction for home living expenses in the month of discharge. The amount of the deduction shall be the SSI benefit for one person (or for a couple, if both members are discharged in the same month). This deduction does not apply when a spouse is at home.

d. Maintenance needs of spouse and other dependents.

(1) Persons covered. An ongoing allowance shall be given for the maintenance needs of a community spouse. The allowance is limited to the extent that income of the institutionalized spouse is made available to or for the benefit of the community spouse. If there are minor or dependent children, dependent parents, or dependent siblings of either spouse who live with the community spouse, an ongoing allowance shall also be given to meet their needs.

(2) Income considered. The verified gross income of the spouse and dependents shall be considered in determining maintenance needs. The gross income of the spouse and dependent shall include all monthly earned and unearned income and assistance from the family investment program (FIP), supplemental security income (SSI), and state supplementary assistance (SSA). It shall also include the proceeds of any annuity or contract for sale of real property. Otherwise, the income shall be considered as the SSI program considers income. In addition, the spouse and dependents shall be required to apply for every income benefit for which they are eligible except that they shall not be required to accept SSI, FIP or SSA in lieu of the maintenance needs allowance. Failure to apply for all benefits shall mean reduction of the maintenance needs allowance by the amount of the anticipated income from the source not applied for.

(3) Needs of spouse. The maintenance needs of the spouse shall be determined by subtracting the spouse's gross income from the maximum amount allowed as a minimum monthly maintenance needs allowance for the community spouse by Section 1924(d)(3)(C) of the Social Security Act (42 U.S.C. § 1396r-5(d)(3)(C)). (This amount is indexed for inflation annually according to the consumer price index.)

However, if either spouse has established through the appeal process that the community spouse needs income above the minimum monthly maintenance needs allowance, due to exceptional circumstances resulting in significant financial duress, an amount adequate to provide additional income as is necessary shall be substituted.

Also, if a court has entered an order against an institutionalized spouse for monthly income to support the community spouse, then the community spouse income allowance shall not be less than this amount.

(4) Needs of other dependents. The maintenance needs of the other dependents shall be established by subtracting each person's gross income from 133 percent of the monthly federal poverty level for a family of two and dividing the result by three. (Effective July 1, 1992, the percent shall be 150 percent.)

e. Maintenance needs of children (without spouse). When the client has children under 21 at home, an ongoing allowance shall be given to meet the children's maintenance needs.

The income of the children is considered in determining maintenance needs. The children's countable income shall be their gross income less the disregards allowed in the FIP program.

The children's maintenance needs shall be determined by subtracting the children's countable income from the FIP payment standard for that number of children. (However, if the children receive FIP, no deduction is allowed for their maintenance needs.)

f. Client's medical expenses. A deduction shall be allowed for the client's incurred expenses for medical or remedial care that are not subject to payment by a third party and were not incurred for long-term care services during the imposition of a transfer of assets penalty period pursuant to rule 441—75.23(249A). This includes Medicare premiums and other health insurance premiums, deductibles or coinsurance, and necessary medical or remedial care recognized under state law but not covered under the state Medicaid plan.

This rule is intended to implement Iowa Code sections 249A.3 and 249A.4.
[ARC 8444B, IAB 1/13/10, effective 3/1/10]

441—75.17(249A) Verification of pregnancy. For the purpose of establishing Medicaid eligibility for pregnant women under this chapter, the applicant's self-declaration of the pregnancy and the date of conception shall serve as verification of pregnancy, unless questionable.

75.17(1) Multiple pregnancy. If the pregnant woman claims to be carrying more than one fetus, a medical professional who has examined the woman must verify the number of fetuses in order for more than one to be considered in the household size.

75.17(2) Cost of examination. When an examination is required and other medical resources are not available to meet the expense of the examination, the provider shall be authorized to make the examination and submit the claim for payment.

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

441—75.18(249A) Continuous eligibility for pregnant women. A pregnant woman who applies for Medicaid prior to the end of her pregnancy and subsequently establishes initial Medicaid eligibility under the provisions of this chapter shall remain continuously eligible throughout the pregnancy and the 60-day postpartum period, as provided in subrule 75.1(24), regardless of any changes in family income.

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

441—75.19(249A) Continuous eligibility for children. A child under the age of 19 who is determined eligible for ongoing Medicaid shall retain that eligibility for up to 12 months regardless of changes in family circumstances except as described in this rule.

75.19(1) Exceptions to coverage. This rule does not apply to the following children:

a. Children whose eligibility was determined under the newborn coverage group described at subrule 75.1(20).

b. Children whose eligibility was determined under the medically needy coverage group described at subrule 75.1(35).

c. Children whose medical assistance is state-funded only.

d. Children whose citizenship is not verified within the "reasonable period" described at paragraph 75.11(2)"c."

e. Children who are eligible only in a retroactive month.

75.19(2) Duration of coverage. Coverage under this rule shall extend through the earliest of the following months:

a. The month of the household's annual eligibility review;

b. The month when the child reaches the age of 19; or

c. The month when the child moves out of Iowa.

75.19(3) *Assignment of review date.* Children entering an existing Medicaid household shall be assigned the same annual eligibility review date as that established for the household.

This rule is intended to implement Iowa Code Supplement section 249A.3 as amended by 2008 Iowa Acts, House File 2539.

[ARC 8786B, IAB 6/2/10, effective 6/1/10; ARC 3353C, IAB 10/11/17, effective 10/1/17; ARC 3549C, IAB 1/3/18, effective 2/7/18]

441—75.20(249A) Disability requirements for SSI-related Medicaid.

75.20(1) *Applicants receiving federal benefits.* An applicant receiving supplemental security income on the basis of disability, social security disability benefits under Title II of the Social Security Act, or railroad retirement benefits based on the Social Security law definition of disability by the Railroad Retirement Board, shall be deemed disabled without further determination of disability.

75.20(2) *Applicants not receiving federal benefits.* When disability has not been established based on the receipt of social security disability or railroad retirement benefits based on the same disability criteria as used by the Social Security Administration, the department shall determine eligibility for SSI-related Medicaid based on disability as follows:

a. A Social Security Administration (SSA) disability determination under either a social security disability (Title II) application or a supplemental security income application is binding on the department until changed by SSA unless the applicant meets one of the following criteria:

(1) The applicant alleges a disabling condition different from, or in addition to, that considered by SSA in making its determination.

(2) The applicant alleges more than 12 months after the most recent SSA determination denying disability that the applicant's condition has changed or deteriorated since that SSA determination and alleges a new period of disability which meets the durational requirements, and has not applied to SSA for a determination with respect to these allegations.

(3) The applicant alleges less than 12 months after the most recent SSA determination denying disability that the applicant's condition has changed or deteriorated since that SSA determination, alleges a new period of disability which meets the durational requirements, and:

1. The applicant has applied to SSA for reconsideration or reopening of its disability decision and SSA refused to consider the new allegations, or

2. The applicant no longer meets the nondisability requirements for SSI but may meet the department's nondisability requirements for Medicaid eligibility.

b. When there is no binding SSA decision and the department is required to establish eligibility for SSI-related Medicaid based on disability, initial determinations shall be made by disability determination services, a bureau of the Iowa department of education under the division of vocational rehabilitation services. The applicant or the applicant's authorized representative shall complete and submit Form 470-4459 or 470-4459(S), Authorization to Disclose Information to the Department of Human Services, and either:

(1) Form 470-2465, Disability Report for Adults, if the applicant is aged 18 or over; or

(2) Form 470-3912, Disability Report for Children, if the applicant is under the age of 18.

c. When an SSA decision on disability is pending when the person applies for Medicaid or when the person applies for either Title II benefits or SSI within ten working days of the Medicaid application, the department shall stay a decision on disability pending the SSA decision on disability.

75.20(3) *Time frames for decisions.* Determination of eligibility based on disability shall be completed within 90 days unless the applicant or an examining physician delays or fails to take a required action, or there is an administrative or other emergency beyond the department's or applicant's control.

75.20(4) *Reviews of disability.* In connection with any independent determination of disability, the department will determine whether reexamination of the member's disability will be required for periodic eligibility reviews. When a disability review is required, the member or the member's authorized representative shall complete and submit the same forms as required in paragraph 75.20(2) "b."

75.20(5) *Members whose disability was determined by the department.* When a Medicaid member has been approved for Medicaid based on disability determined by the department and later is determined by SSA not to be disabled for SSI, the member shall continue to be considered disabled for Medicaid eligibility purposes for 65 days from the date of the SSA denial. If at the end of the 65 days there is no appeal to the SSA, Medicaid shall be canceled with timely notice. If there is an appeal within 65 days, the member shall continue to be considered disabled for Medicaid eligibility purposes until a final SSA decision.

75.20(6) *Disability redeterminations for members who attain age 18.* If a member is eligible based on an independent determination of disability made under the standards applicable to persons under 18 years of age, the department shall redetermine the member's disability after the member attains the age of 18 years. The member's disability shall be redetermined:

- a. Using the standards applicable to persons who are 18 years of age or older, and
- b. Regardless of whether a review of the member's disability would otherwise be due.

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

[ARC 9044B, IAB 9/8/10, effective 11/1/10]

441—75.21(249A) Health insurance premium payment (HIPP) program. Under the HIPP program, the department shall pay for the cost of premiums, coinsurance, copayments, and deductibles for Medicaid-eligible individuals when the department determines that those costs will be less than the cost of paying for the individual's care through Medicaid including managed care capitation fees. Payment shall include only the cost to the Medicaid-eligible individual or household.

75.21(1) Definitions.

"Absent parent" means a noncustodial parent, or a parent who is not living with the member.

"Authorized representative" means an individual or organization authorized by a competent applicant or member, authorized by a responsible person acting for an incompetent applicant or member pursuant to 441—subrule 76.9(2), or with other legal authority to represent the applicant or member in the application process, renewal of eligibility and other ongoing communications with the department.

"Capitation payment" means a monthly payment to the managed care contractor on behalf of each member for the provision of health services under the managed care entity contract. Payment is made by the department regardless of whether the member receives services during the month. The managed care capitation payment varies based on the eligible member's sex, age, and eligibility aid type.

"Cost-effective" means a determination has been made that a savings will accrue to the department by paying the insurance premium, cost sharing, wrap benefits, and administrative cost.

"Cost sharing" means the member's portions of in-network health care costs not covered by an insurance plan. "Cost sharing" includes copayments, coinsurance and deductibles, which vary among health care plans.

"Custodian" means the person recognized as representing the interests of the member for Medicaid assistance. When the member reaches the age of 18 and the custodian is not used in determining Medicaid eligibility, there shall be legal documentation in place that the custodian is now the responsible person or authorized representative.

"Department" means the Iowa department of human services.

"Employer-sponsored insurance" or *"ESI"* means any health insurance plan paid for by a business on behalf of its employees.

"High-deductible health plan" or *"HDHP"* means a health insurance plan that meets the definition found in Section 223(c)(2) of the Internal Revenue Code.

"HIPP-eligible member" means a person whose Medicaid eligibility is calculated in the cost-effective determination for HIPP. "HIPP-eligible member" is also referred to as HIPP enrollee.

"Household" means the group of people who are used in the budgeting and size when determining Medicaid eligibility.

"Individual plan" means an insurance plan purchased through a government-run health insurance marketplace or through a local broker or agent.

“Insurance plan” means major medical comprehensive health coverage provided through an employer, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), a government-run health insurance marketplace, or a local broker or agent. Dental and vision plans are not considered to be insurance plans for purposes of this definition.

“Member” means an individual who has been determined eligible for Medicaid assistance and is enrolled to receive assistance.

“Policyholder” means the person in whose name an insurance policy is registered.

“Responsible person” means an individual recognized by the department pursuant to 441—subrule 76.9(1) as acting for an applicant or member who is unable to act on the applicant’s or member’s own behalf because the applicant or member is a minor or is incompetent, incapacitated, or deceased.

“Wrap benefits” means the services covered under the Medicaid state plans that are not paid for by insurance plans (i.e., waiver services, transportation).

75.21(2) Insurance plans. Participation in an insurance plan is not a condition of Medicaid eligibility. The department shall pay for the cost of the insurance plan premiums, coinsurance, copayment, and deductibles of an insurance plan for a member if:

- a. A member is enrolled in or can be added to the insurance plan; and
- b. The insurance plan is cost-effective as defined in subrule 75.21(3).

75.21(3) Cost-effectiveness. An insurance plan shall be considered cost-effective when the amount the department would pay for the member’s insurance premiums, cost sharing, wrap benefits, and administrative costs is likely to be less than the amount the department would pay through Medicaid including managed care capitation fees. When determining the cost-effectiveness of an insurance plan, the following data shall be considered:

- a. The cost to the member or household for the insurance premium, coinsurance, copayments and deductibles. No costs paid by an employer or other plan sponsor shall be considered in the cost-effectiveness determination.
- b. The cost of care through Medicaid including managed care capitation fees the department would pay for the member.
- c. The estimated cost of wrap benefits per member based on the member’s sex, age, and eligibility aid type.

d. The specific health-related circumstances of the members covered under the health plan. Form 470-2868, HIPP Medical History Questionnaire, shall be used to obtain this information. When the information indicates any health conditions that could be expected to result prospectively in higher-than-average bills for any Medicaid member:

(1) If the member is currently covered by the insurance plan, the department shall request from the policyholder, or the responsible person for the member, an insurance summary of the member’s paid claims for the previous 12 months. If there is sufficient evidence to indicate that such claims can be expected to continue in the next 12 months, the claims will be considered in determining the cost-effectiveness of the insurance plan. The cost of the insurance plan premium, member’s cost sharing, and administrative cost are compared to the actual claims to determine the cost-effectiveness of providing the coverage.

(2) If the member was not covered by the health plan in the previous 12 months, fee-for-service paid Medicaid claims may be used to project the cost-effectiveness of the plan.

- e. Annual administrative expenditures of \$150 per HIPP member covered under the health plan.
- f. Whether the estimated savings to the department for members covered under the health insurance plan is at least \$5 per month per household.

75.21(4) Coverage of non-Medicaid-eligible family members. When an insurance plan is determined to be cost-effective, the department shall pay for insurance premiums for non-Medicaid-eligible family members if a non-Medicaid-eligible family member must be enrolled in the insurance plan in order to obtain coverage for the Medicaid-eligible family members. However:

- a. The needs of the non-Medicaid-eligible family members shall not be taken into consideration when determining cost-effectiveness; and

b. Payments for deductibles, coinsurances or other cost-sharing obligations shall not be made on behalf of family members who are not Medicaid-eligible.

75.21(5) Insurance plans ineligible for reimbursement. Premiums shall not be paid for insurance plans under any of the following circumstances:

- a. The insurance plan is that of an absent parent.
- b. The insurance plan is an indemnity policy which supplements the policyholder's income or pays only a predetermined amount for services covered under the policy (e.g., \$50 per day for hospital services instead of 80 percent of the charge).
- c. The insurance plan is a school plan offered on the basis of attendance or enrollment at the school.
- d. The insurance premium is used to meet a spenddown obligation under the medically needy program, as provided in subrule 75.1(35), when all persons in the household are eligible or potentially eligible only under the medically needy program. When some of the household members are eligible for full Medicaid benefits under coverage groups other than medically needy, the premium shall be paid if it is determined to be cost-effective when considering only the persons receiving full Medicaid coverage. In those cases, the insurance premium shall not be allowed as a deduction to meet the spenddown obligation for those persons in the household participating in the medically needy program.
- e. The insurance plan is designed to provide coverage only for a temporary period of time (e.g., 30 to 180 days).
- f. The persons covered under the insurance plan are not Medicaid-eligible on the date the decision regarding eligibility for the HIPP program is made. No retroactive payments shall be made if the case is not Medicaid-eligible on the date of decision.
- g. The person is eligible only for a coverage group that does not provide full Medicaid services.
- h. Insurance coverage is provided through the health insurance plan of Iowa (HIPIOWA), in accordance with Iowa Code chapter 514E.
- i. Insurance on the member(s) is maintained by someone who does not live with the member(s), is not the legal guardian of the member(s), is not a responsible person, or does not have legal permission to access the Medicaid information of the member(s) (e.g., self-supporting adult children).
- j. The member has Medicare. If other members in the household are covered by the insurance plan, cost-effectiveness is determined without including the Medicare-covered member.
- k. The insurance plan does not provide major medical coverage but pays only for specific situations (i.e., accident plans) or illnesses (i.e., cancer policy).
- l. The health plan pays secondary to another plan.
- m. The only Medicaid member is in foster care.
- n. The member is active for Medicaid under Medicaid for children with disabilities (i.e., Medicaid for kids with special needs (MKSNI)), pursuant to subrule 75.1(43). Any other Medicaid members in the household who are covered by the health plan shall be determined for cost-effectiveness.
- o. The insurance plan is limited due to preexisting conditions.
- p. The insurance plan is a subsidized insurance plan purchased through a government-run health insurance exchange.
- q. On the date the decision regarding eligibility for the HIPP program is made, the insurance is no longer available.
- r. The insurance plan is an HDHP.

75.21(6) Department evaluation of ESI plans. When evaluating ESI plans available through an employer, if there is more than one cost-effective insurance plan available, the department shall pay the premium for only one plan. The member may choose the cost-effective plan in which to enroll.

75.21(7) Effective date of premium payment. The effective date of premium payments for a cost-effective health plan shall be determined as follows:

- a. Premium payments shall begin the later of:
 - (1) The first day of the month in which Form 470-2844, Employer's Statement of Earnings; Form 470-2875, Health Insurance Premium Payment (HIPP) Program Application; or Form H301-1, the automated HIPP referral; is received by the HIPP unit; or

(2) The first day of the first month in which the health plan is determined to be cost-effective.

b. If the person is not enrolled in the insurance plan when eligibility for participation in the HIPP program is established, premium payments shall begin in the month in which the first premium payment is due after enrollment occurs.

c. If there was a lapse in coverage during the application process (e.g., the health plan is dropped and reenrollment occurs at a later date), premium payments shall not be made for any period of time before the current effective date of coverage.

d. In no case shall payments be made for premiums that were used as a deduction to income for determining client participation or the amount of the spenddown obligation.

e. Form 470-3036, Employer Verification of Insurance Coverage, shall be used to verify the effective date of coverage and costs for persons enrolled in group health plans through an employer.

f. The effective date of coverage of an insurance plan not obtained through an employer shall be verified by a copy of the certificate of coverage for the plan or by some other verification from the insurer.

75.21(8) Method of premium payment. Payments of premiums will be made directly to the insurance carrier except as follows:

a. The department may arrange for payment to an employer in order to circumvent a payroll deduction.

b. When an employer will not agree to accept premium payments from the department in lieu of a payroll deduction to the employee's wages, the department shall reimburse the employee directly for payroll deductions or for payments made directly to the employer for the payment of premiums. The department shall issue reimbursement to the employee five working days before the employee's pay date.

c. When premium payments are occurring through an automatic withdrawal from a bank account by the insurance carrier, the department may reimburse the policyholder for those withdrawals.

d. Payments for COBRA coverage shall be made directly to the insurance carrier, the COBRA administrator, or the former employer. Payments may be made directly to the former employee only in those cases where:

(1) Information cannot be obtained for direct payment; or

(2) The department pays for only part of the total premium.

75.21(9) Payment of claims. Claims from medical providers for persons participating in this program shall be paid in the same manner as claims are paid for other persons with a third-party resource in accordance with the provisions of 441—Chapters 79 and 80.

75.21(10) Reviews of cost-effectiveness and eligibility. Reviews of cost-effectiveness and eligibility shall be completed annually and may be conducted more frequently at the discretion of the department.

a. Annual review of ESI cost-effectiveness and eligibility shall be completed using Form 470-3016, Health Insurance Premium Payment (HIPP) Program Review.

b. Annual review of individual health plan cost-effectiveness and eligibility shall be completed using Form 470-3017, HIPP Private Policy Review.

c. Failure of the household to cooperate in the annual review process shall result in cancellation of premium payment.

d. Redeterminations shall be completed whenever:

(1) A premium rate, copayment, deductible, or coinsurance changes;

(2) A person covered under the policy loses full Medicaid eligibility;

(3) Changes in employment or hours of employment affect the availability of an insurance plan;

(4) The insurance carrier changes;

(5) The policyholder leaves the Medicaid home;

(6) There is a decrease in the services covered under the policy; or

(7) The Medicaid category of coverage changes.

e. The policyholder shall report changes that may affect the availability of the insurance plan reimbursed by the HIPP program, or changes that affect the cost-effectiveness of the policy, within ten calendar days from the date of the change.

f. If a change in the number of members in the Medicaid household causes the health plan not to be cost-effective, lesser health plan options, as defined in paragraph 75.21(15)“*a*,” shall be considered if available and cost-effective.

g. When employment ends, hours of employment are reduced, or some other qualifying event affecting the availability of the group health plan occurs, the department shall verify whether coverage may be continued under the provisions of COBRA.

(1) Form 470-3037, Employer Verification of COBRA Eligibility, may be used for this purpose.

(2) If cost-effective to do so, the department shall pay premiums to maintain insurance coverage for members after the occurrence of the event which would otherwise result in termination of coverage.

75.21(11) *Time frames for determining cost-effectiveness.* The department shall determine cost-effectiveness of the insurance plan and notify the applicant of the decision regarding payment of the premiums within 65 calendar days from the date an application or referral (as defined in subrule 75.21(7)) is received. Additional time may be taken when, for reasons beyond the control of the department or the applicant, information needed to establish cost-effectiveness cannot be obtained within the 65-day period.

75.21(12) *Notices.*

a. Adequate notice shall be provided to the household under the following circumstances:

(1) To inform the household of the initial decision on cost-effectiveness and premium payment.

(2) To inform the household that premium payments are being discontinued because Medicaid eligibility has been lost by all persons covered under the health plan.

(3) The insurance plan is no longer available to the family (e.g., the employer no longer provides health insurance coverage or the policy is terminated by the insurance company).

b. The department shall provide timely and adequate notice as defined in 441—subrule 7.7(1) to inform the household of a decision to discontinue payment of the health insurance premium because:

(1) The department has determined the insurance plan is no longer cost-effective; or

(2) The member has failed to cooperate in providing information necessary to establish continued eligibility for the HIPP program.

75.21(13) *Rate refund.* The department shall be entitled to any rate refund made when the insurance carrier determines a return of premiums to the policyholder is due for any time period for which the department paid the premium.

75.21(14) *Reinstatement of HIPP eligibility.*

a. When eligibility for the HIPP program is canceled because the persons covered under the insurance plan lose Medicaid eligibility, HIPP eligibility shall be reinstated when Medicaid eligibility is reestablished if all other eligibility factors are met.

b. When HIPP eligibility is canceled because of the policyholder’s failure to cooperate in providing information necessary to establish continued eligibility for the HIPP program, benefits shall be reinstated the first day of the first month in which cooperation occurs, if all other eligibility factors are met.

75.21(15) *Amount of insurance premium paid.*

a. For ESI plans, the policyholder shall provide verification of the cost of all possible insurance plan options (i.e., single, employee/children, family).

(1) The HIPP program shall pay only for the option that provides coverage to the cost-effective members of the household.

(2) The HIPP program shall not pay the portion of the premium cost which is the responsibility of the employer or other plan sponsor.

b. For individual health plans, the HIPP program shall pay the cost of covering the cost-effective members covered by the plan.

c. For insurance plans, if another household member must be covered to obtain coverage for the members, the HIPP program shall pay the cost of covering that household member if the coverage is cost-effective as determined pursuant to subrules 75.21(3) and 75.21(4).

75.21(16) *Reporting changes.* Failure to report and verify changes may result in cancellation of HIPP benefits.

a. The policyholder shall verify changes by providing a pay stub, a summary of benefits and coverage, a rate sheet, or a letter from the insurance carrier reflecting the change.

b. Changes in employment or the employment-related insurance carrier shall be verified by the employer.

c. Any benefits paid during a period in which there was ineligibility for HIPP due to unreported changes shall be subject to recovery in accordance with the provisions of 441—Chapter 11.

d. Any underpayment that results from an unreported change shall be paid effective the first day of the month in which the change is reported.

75.21(17) Discontinuation of premium payments.

a. When the household loses Medicaid eligibility, premium payments shall be discontinued as of the month of Medicaid ineligibility.

b. When only part of the household loses Medicaid eligibility, the department shall complete a review in order to ascertain whether payment of the health insurance premium continues to be cost-effective. If the department determines that the insurance plan is no longer cost-effective, premium payment shall be discontinued pending timely and adequate notice.

c. If the household fails to cooperate in providing information necessary to establish ongoing eligibility for the HIPP program, the department shall discontinue premium payment after timely and adequate notice. The department shall request all information in writing and allow the household ten calendar days in which to provide it.

d. If the policyholder leaves the Medicaid household, premium payments shall be discontinued pending timely and adequate notice.

e. If the insurance plan is no longer available or the policy has lapsed, premium payments shall be discontinued as of the effective date of the termination of the coverage.

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

[ARC 3493C, IAB 12/6/17, effective 1/10/18]

441—75.22(249A) AIDS/HIV health insurance premium payment program. For the purposes of this rule, “AIDS” and “HIV” are defined in accordance with Iowa Code section 141A.1.

75.22(1) Conditions of eligibility. The department shall pay for the cost of continuing health insurance coverage to persons with AIDS or HIV-related illnesses when the following criteria are met:

a. The person with AIDS or HIV-related illness shall be the policyholder, or the spouse of the policyholder, of an individual or group health plan.

b. The person shall be a resident of Iowa in accordance with the provisions of rule 441—75.10(249A).

c. The person shall not be eligible for Medicaid. The person shall be required to apply for Medicaid benefits when it appears Medicaid eligibility may exist. Persons who are required to meet a spenddown obligation under the medically needy program, as provided in subrule 75.1(35), are not considered Medicaid-eligible for the purpose of establishing eligibility under these provisions.

When Medicaid eligibility is attained, premium payments shall be made under the provisions of rule 441—75.21(249A) if all criteria of that rule are met.

d. A physician’s statement shall be provided verifying the policyholder or the spouse of the policyholder suffers from AIDS or an HIV-related illness. The physician’s statement shall also verify that the policyholder or the spouse of the policyholder is or will be unable to continue employment in the person’s current position or that hours of employment will be significantly reduced due to AIDS or HIV-related illness. The Physician’s Verification of Diagnosis, Form 470-2958, shall be used to obtain this information from the physician.

e. Gross income shall not exceed 300 percent of the federal poverty level for a family of the same size. The gross income of all family members shall be counted using the definition of gross income under the supplemental security income (SSI) program.

f. Liquid resources shall not exceed \$10,000 per household. The following are examples of countable resources:

(1) Unobligated cash.

- (2) Bank accounts.
- (3) Stocks, bonds, certificates of deposit, excluding Internal Revenue Service defined retirement plans.

g. The health insurance plan must be cost-effective based on the amount of the premium and the services covered.

75.22(2) Application process.

a. *Application.* Persons applying for participation in this program shall complete the AIDS/HIV Health Insurance Premium Payment Application, Form 470-2953. The applicant shall be required to provide documentation of income and assets. The application shall be available from and may be filed at any county departmental office or at the Division of Medical Services, Department of Human Services, Hoover State Office Building, 1305 East Walnut, Des Moines, Iowa 50319-0114.

An application shall be considered as filed on the date an AIDS/HIV Health Insurance Premium Payment Application, Form 470-2953, containing the applicant's name, address and signature is received and date-stamped in any county departmental office or the division of medical services.

b. *Time limit for decision.* Every reasonable effort will be made to render a decision within 30 days. Additional time for rendering a decision may be taken when, due to circumstances beyond the control of the applicant or the department, a decision regarding the applicant's eligibility cannot be reached within 30 days (e.g., verification from a third party has not been received).

c. *Eligible on the day of decision.* No payments will be made for current or retroactive premiums if the person with AIDS or an HIV-related illness is deceased prior to a final eligibility determination being made on the application, if the insurance plan has lapsed, or if the person has otherwise lost coverage under the insurance plan.

d. *Waiting list.* After funds appropriated for this purpose are obligated, pending applications shall be denied by the division of medical services. A denial shall require a notice of decision to be mailed within ten calendar days following the determination that funds have been obligated. The notice shall state that the applicant meets eligibility requirements but no funds are available and that the applicant will be placed on the waiting list, or that the applicant does not meet eligibility requirements. Applicants not awarded funding who meet the eligibility requirements will be placed on a statewide waiting list according to the order in which the completed applications were filed. In the event that more than one application is received at one time, applicants shall be entered on the waiting list on the basis of the day of the month of the applicant's birthday, lowest number being first on the waiting list. Any subsequent tie shall be decided by the month of birth, January being month one and the lowest number.

75.22(3) Presumed eligibility The applicant may be presumed eligible to participate in the program for a period of two calendar months or until a decision regarding eligibility can be made, whichever is earlier. Presumed eligibility shall be granted when:

a. The application is accompanied by a completed Physician's Verification of Diagnosis, Form 470-2958.

b. The application is accompanied by a premium statement from the insurance carrier indicating the policy will lapse before an eligibility determination can be made.

c. It can be reasonably anticipated that the applicant will be determined eligible from income and resource statements on the application.

75.22(4) Family coverage. When the person is enrolled in a policy that provides health insurance coverage to other members of the family, only that portion of the premium required to maintain coverage for the policyholder or the policyholder's spouse with AIDS or an HIV-related illness shall be paid under this rule unless modification of the policy would result in a loss of coverage for the person with AIDS or an HIV-related illness.

75.22(5) Method of premium payment. Premiums shall be paid in accordance with the provisions of subrule 75.21(8).

75.22(6) Effective date of premium payment. Premium payments shall be effective with the month of application or the effective date of eligibility, whichever is later.

75.22(7) Reviews. The circumstances of persons participating in the program shall be reviewed quarterly to ensure eligibility criteria continues to be met. The AIDS/HIV Health Insurance Premium

Payment Program Review, Form 470-2877, shall be completed by the recipient or someone acting on the recipient's behalf for this purpose.

75.22(8) Termination of assistance. Premium payments for otherwise eligible persons shall be paid under this rule until one of the following conditions is met:

- a. The person becomes eligible for Medicaid. In which case, premium payments shall be paid in accordance with the provisions of rule 441—75.21(249A).
- b. The insurance coverage is no longer available.
- c. Maintaining the insurance plan is no longer considered the most cost-effective way to pay for medical services.
- d. Funding appropriated for the program is exhausted.
- e. The person with AIDS or an HIV-related illness dies.
- f. The person fails to provide requested information necessary to establish continued eligibility for the program.

75.22(9) Notices.

a. An adequate notice as defined in 441—subrule 7.7(1) shall be provided under the following circumstances:

- (1) To inform the applicant of the initial decision regarding eligibility to participate in the program.
- (2) To inform the recipient that premium payments are being discontinued under these provisions because Medicaid eligibility has been attained and premium payments will be made under the provisions of rule 441—75.21(249A).

(3) To inform the recipient that premium payments are being discontinued because the policy is no longer available.

(4) To inform the recipient that premium payments are being discontinued because funding for the program is exhausted.

(5) The person with AIDS or an HIV-related illness dies.

b. A timely and adequate notice as defined in 441—subrule 7.7(1) shall be provided to the recipient informing the recipient of a decision to discontinue payment of the health insurance premium when the recipient no longer meets the eligibility requirements of the program or fails to cooperate in providing information to establish eligibility.

75.22(10) Confidentiality. The department shall protect the confidentiality of persons participating in the program in accordance with Iowa Code section 141A.9. When it is necessary for the department to contact a third party to obtain information in order to determine initial or ongoing eligibility, a Consent to Obtain and Release Information, Form 470-0429, shall be signed by the recipient authorizing the department to make the contact.

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

441—75.23(249A) Disposal of assets for less than fair market value after August 10, 1993. In determining Medicaid eligibility for persons described in 441—Chapters 75 and 83, a transfer of assets occurring after August 10, 1993, will affect Medicaid payment for medical services as provided in this rule.

75.23(1) Ineligibility for services. When an individual or spouse has transferred or disposed of assets for less than fair market value as defined in 75.23(11) on or after the look-back date specified in 75.23(2), the individual shall be ineligible for medical assistance as provided in this subrule.

a. *Institutionalized individual.* When an institutionalized individual or the spouse of the individual disposed of assets for less than fair market value on or after the look-back date, the institutionalized individual is ineligible for medical assistance payment for nursing facility services, a level of care in any institution equivalent to that of nursing facility services, and home- and community-based waiver services. The period of ineligibility is equal to the number of months specified in 75.23(3). The department shall determine the beginning of the period of ineligibility as follows:

(1) Transfer before February 8, 2006. When the transfer of assets was made before February 8, 2006, the period of ineligibility shall begin on the first day of the first month during which the assets were transferred, except as provided in subparagraph (3).

(2) Transfer on or after February 8, 2006. Within the limits of subparagraph (3), when the transfer of assets was made on or after February 8, 2006, the period of ineligibility shall begin on the later of:

1. The first day of the first month during which the assets were transferred; or
2. The date on which the individual is eligible for medical assistance under this chapter and would be receiving nursing facility services, a level of care in any institution equivalent to that of nursing facility services, or home- and community-based waiver services, based on an approved application for such care, but for the application of this rule.

(3) Exclusive period. The period of ineligibility due to the transfer shall not begin during any other period of ineligibility under this rule.

b. Noninstitutionalized individual. When a noninstitutionalized individual or the spouse of the individual disposed of assets for less than fair market value on or after the look-back date, the individual is ineligible for medical assistance payment for home health care services, home and community care for functionally disabled elderly individuals, personal care services, and other long-term care services. The period of ineligibility is equal to the number of months specified in 75.23(3). The department shall determine the beginning of the period of ineligibility as follows:

(1) Transfer before February 8, 2006. When the transfer of assets was made before February 8, 2006, the period of ineligibility shall begin on the first day of the first month during which the assets were transferred, except as provided in subparagraph (3).

(2) Transfer on or after February 8, 2006. Within the limits of subparagraph (3), when the transfer of assets was made on or after February 8, 2006, the period of ineligibility shall begin on the later of:

1. The first day of the first month during which the assets were transferred; or
2. The date on which the individual is eligible for medical assistance under this chapter and would be receiving home health care services, home and community care for functionally disabled elderly individuals, personal care services, or other long-term care services, based on an approved application for such care, but for the application of this rule.

(3) Exclusive period. The period of ineligibility due to the transfer shall not begin during any other period of ineligibility under this rule.

c. Client participation after period of ineligibility. Expenses incurred for long-term care services during a transfer of assets penalty period may not be deducted as medical expenses in determining client participation pursuant to subrule 75.16(2).

75.23(2) Look-back date.

a. Transfer before February 8, 2006. For transfers made before February 8, 2006, the look-back date is the date that is 36 months (or, in the case of payments from a trust or portion of a trust that are treated as assets disposed of by the individual, 60 months) before:

- (1) The date an institutionalized individual is both an institutionalized individual and has applied for medical assistance; or
- (2) The date a noninstitutionalized individual applies for medical assistance.

b. Transfer on or after February 8, 2006. For transfers made on or after February 8, 2006, the look-back date is the date that is 60 months before:

- (1) The date an institutionalized individual is both an institutionalized individual and has applied for medical assistance; or
- (2) The date a noninstitutionalized individual applies for medical assistance.

75.23(3) Period of ineligibility. The number of months of ineligibility shall be equal to the total cumulative uncompensated value of all assets transferred by the individual (or the individual's spouse) on or after the look-back date specified in subrule 75.23(2), divided by the statewide average private-pay rate for nursing facility services at the time of application. The department shall determine the average statewide cost to a private-pay resident for nursing facilities and update the cost annually. For the period from July 1, 2018, through June 30, 2019, this average statewide cost shall be \$6,447.54 per month or \$212.09 per day.

75.23(4) Reduction of period of ineligibility. The number of months of ineligibility otherwise determined with respect to the disposal of an asset shall be reduced by the months of ineligibility applicable to the individual prior to a change in institutional status.

75.23(5) Exceptions. An individual shall not be ineligible for medical assistance, under this rule, to the extent that:

a. The assets transferred were a home and title to the home was transferred to either:

(1) A spouse of the individual.

(2) A child of the individual who is under the age of 21 or is blind or permanently and totally disabled as defined in 42 U.S.C. Section 1382c.

(3) A sibling of the individual who has an equity interest in the home and who was residing in the individual's home for a period of at least one year immediately before the individual became institutionalized.

(4) A son or daughter of the individual who was residing in the individual's home for a period of at least two years immediately before the date of institutionalization and who provided care to the individual which permitted the individual to reside at home rather than in an institution or facility.

b. The assets were transferred:

(1) To the individual's spouse or to another for the sole benefit of the individual's spouse.

(2) From the individual's spouse to another for the sole benefit of the individual's spouse.

(3) To a child of the individual who is blind or permanently and totally disabled as defined in 42 U.S.C. Section 1382c or to a trust established solely for the benefit of such a child.

(4) To a trust established solely for the benefit of an individual under 65 years of age who is disabled as defined in 42 U.S.C. Section 1382c.

c. A satisfactory showing is made that one of the following is true:

(1) The individual intended to dispose of the assets either at fair market value, or for other valuable consideration.

(2) The assets were transferred exclusively for a purpose other than to qualify for medical assistance.

(3) All assets transferred for less than fair market value have been returned to the individual.

d. The denial of eligibility would work an undue hardship. Undue hardship shall exist only when all of the following conditions are met:

(1) Application of the transfer of asset penalty would deprive the individual of medical care such that the individual's health or life would be endangered or of food, clothing, shelter, or other necessities of life.

(2) The person who transferred the resource or the person's spouse has exhausted all means including legal remedies and consultation with an attorney to recover the resource.

(3) The person's remaining available resources (after the attribution for the community spouse) are less than the monthly statewide average cost of nursing facility services to a private pay resident, counting the value of all resources except for:

1. The home if occupied by a dependent relative or if a licensed physician verifies that the person is expected to return home.

2. Household goods.

3. A vehicle required by the client for transportation.

4. Funds for burial of \$4,000 or less.

Hardship will not be found if the resource was transferred to a person who was handling the financial affairs of the client or to the spouse or children of a person handling the financial affairs of the client unless the client demonstrates that payments cannot be obtained from the funds of the person who handled the financial affairs to pay for long-term care services.

75.23(6) Assets held in common. In the case of an asset held by an individual in common with another person or persons in a joint tenancy, tenancy in common, or similar arrangement, the asset, or the affected portion of the asset, shall be considered to be transferred by the individual when any action is taken, either by the individual or by any other person, that reduces or eliminates the individual's ownership or control of the asset.

75.23(7) Transfer by spouse. In the case of a transfer by a spouse of an individual which results in a period of ineligibility for medical assistance under the state plan for the individual, the period of ineligibility shall be apportioned between the individual and the individual's spouse if the spouse

otherwise becomes eligible for medical assistance under the state plan. The remaining penalty period shall be evenly divided on a monthly basis, with any remaining month of penalty (prorated as a half month to each spouse) applied to the spouse who initiated the transfer action.

If a spouse subsequently dies prior to the end of the penalty period, the remaining penalty period shall be applied to the surviving spouse's period of ineligibility.

75.23(8) Definitions. In this rule the following definitions apply:

"Assets" shall include all income and resources of the individual and the individual's spouse, including any income or resources which the individual or the individual's spouse is entitled to but does not receive because of action by:

1. The individual or the individual's spouse.
2. A person, including a court or administrative body, with legal authority to act in place of or on behalf of the individual or the individual's spouse.
3. Any person, including any court or administrative body, acting at the direction or upon the request of the individual or the individual's spouse.

"Income" shall be defined by 42 U.S.C. Section 1382a.

"Institutionalized individual" shall mean an individual who is an inpatient in a nursing facility, who is an inpatient in a medical institution and with respect to whom payment is made based on a level of care provided in a nursing facility or who is eligible for home- and community-based waiver services.

"Resources" shall be defined by 42 U.S.C. Section 1382b without regard (in the case of an institutionalized individual) to the exclusion of the home and land appertaining thereto.

"Transfer or disposal of assets" means any transfer or assignment of any legal or equitable interest in any asset as defined above, including:

1. Giving away or selling an interest in an asset;
 2. Placing an interest in an asset in a trust that is not available to the grantor (see 75.24(2) "b"(2));
 3. Removing or eliminating an interest in a jointly owned asset in favor of other owners;
 4. Disclaiming an inheritance of any property, interest, or right pursuant to Iowa Code section 633.704 on or after July 1, 2000 (see Iowa Code section 249A.3(11) "c");
 5. Failure to take a share of an estate as a surviving spouse (also known as "taking against a will") on or after July 1, 2000, to the extent that the value received by taking against the will would have exceeded the value of the inheritance received under the will (see Iowa Code section 249A.3(11) "d");
- or
6. Transferring or disclaiming the right to income not yet received.

75.23(9) Purchase of annuities. Funds used to purchase an annuity for more than its fair market value shall be treated as assets transferred for less than fair market value regardless of when the annuity was purchased or whether the conditions described in this subrule were met.

a. The entire amount used to purchase an annuity on or after February 8, 2006, with a Medicaid applicant or member as the annuitant shall be treated as assets transferred for less than fair market value unless the annuity meets one of the conditions described in paragraph 75.23(9) "b" and also meets the condition described in paragraph 75.23(9) "c."

b. To be exempted from treatment as an asset transferred at less than fair market value, an annuity described in paragraph 75.23(9) "a" must meet one of the following conditions:

- (1) The annuity is an annuity described in Subsection (b) or (q) of Section 408 of the United States Internal Revenue Code of 1986.
- (2) The annuity is purchased with proceeds from:
 1. An account or trust described in Subsection (a), (c), or (p) of Section 408 of the United States Internal Revenue Code of 1986;
 2. A simplified employee pension (within the meaning of Section 408(k) of the United States Internal Revenue Code of 1986); or
 3. A Roth IRA described in Section 408A of the United States Internal Revenue Code of 1986.
- (3) The annuity:
 1. Is irrevocable and nonassignable;

2. Is actuarially sound (as determined in accordance with actuarial publications of the Office of the Chief Actuary of the United States Social Security Administration); and

3. Provides for payments in equal amounts during the term of the annuity, with no deferral and no balloon payments made.

c. To be exempted from treatment as an asset transferred at less than fair market value, an annuity described in paragraph 75.23(9)“a” must have Iowa named as the remainder beneficiary for at least the total amount of medical assistance paid on behalf of the annuitant or the annuitant’s spouse, if either is institutionalized. Iowa may be named either:

(1) In the first position; or
 (2) In the second position after the spouse or minor or disabled child and in the first position if the spouse or a representative of the child disposes of any of the remainder for less than fair market value.

d. The entire amount used to purchase an annuity on or after February 8, 2006, with the spouse of a Medicaid applicant or member as the annuitant shall be treated as assets transferred for less than fair market value unless Iowa is named as the remainder beneficiary for at least the total amount of medical assistance paid on behalf of the annuitant or the annuitant’s spouse, if either is institutionalized. Iowa may be named either:

(1) In the first position; or
 (2) In the second position after the spouse or minor or disabled child and in the first position if the spouse or a representative of the child disposes of any of the remainder for less than fair market value.

75.23(10) Purchase of promissory notes, loans, or mortgages.

a. Funds used to purchase a promissory note, loan, or mortgage after February 8, 2006, shall be treated as assets transferred for less than fair market value in the amount of the outstanding balance due on the note, loan, or mortgage as of the date of the individual’s application for medical assistance for services described in 75.23(1), unless the note, loan, or mortgage meets all of the following conditions:

(1) The note, loan, or mortgage has a repayment term that is actuarially sound (as determined in accordance with actuarial publications of the Office of the Chief Actuary of the United States Social Security Administration).
 (2) The note, loan, or mortgage provides for payments to be made in equal amounts during the term of the loan, with no deferral and no balloon payments made.
 (3) The note, loan, or mortgage prohibits the cancellation of the balance upon the death of the lender.

b. Funds used to purchase a promissory note, loan, or mortgage for less than its fair market value shall be treated as assets transferred for less than fair market value regardless of whether:

(1) The note, loan, or mortgage was purchased before February 8, 2006; or
 (2) The note, loan, or mortgage was purchased on or after February 8, 2006, and the conditions described in 75.23(9)“a” were met.

75.23(11) Purchase of life estates.

a. The entire amount used to purchase a life estate in another individual’s home after February 8, 2006, shall be treated as assets transferred for less than fair market value, unless the purchaser resides in the home for at least one year after the date of the purchase.

b. Funds used to purchase a life estate in another individual’s home for more than its fair market value shall be treated as assets transferred for less than fair market value regardless of whether:

(1) The life estate was purchased before February 8, 2006; or
 (2) The life estate was purchased on or after February 8, 2006, and the purchaser resided in the home for one year after the date of purchase.

This rule is intended to implement Iowa Code sections 249A.3 and 249A.4.
 [ARC 7834B, IAB 6/3/09, effective 7/8/09; ARC 8444B, IAB 1/13/10, effective 3/1/10; ARC 8898B, IAB 6/30/10, effective 7/1/10; ARC 9404B, IAB 3/9/11, effective 5/1/11; ARC 9582B, IAB 6/29/11, effective 7/1/11; ARC 0192C, IAB 7/11/12, effective 7/1/12; ARC 0821C, IAB 7/10/13, effective 7/1/13; ARC 1484C, IAB 6/11/14, effective 7/1/14; ARC 2027C, IAB 6/10/15, effective 7/1/15; ARC 2605C, IAB 7/6/16, effective 7/1/16; ARC 3183C, IAB 7/5/17, effective 7/1/17; ARC 3869C, IAB 7/4/18, effective 7/1/18]

441—75.24(249A) Treatment of trusts established after August 10, 1993. For purposes of determining an individual’s eligibility for, or the amount of, medical assistance benefits, trusts

established after August 10, 1993, (except for trusts specified in 75.24(3)) shall be treated in accordance with 75.24(2).

75.24(1) Establishment of trust.

a. For the purposes of this rule, an individual shall be considered to have established a trust if assets of the individual were used to form all or part of the principal of the trust and if any of the following individuals established the trust other than by will: the individual, the individual's spouse, a person (including a court or administrative body, with legal authority to act in place of or on behalf of the individual or the individual's spouse), or a person (including a court or administrative body) acting at the direction or upon the request of the individual or the individual's spouse.

b. The term "assets," with respect to an individual, includes all income and resources of the individual and of the individual's spouse, including any income or resources which the individual or the individual's spouse is entitled to but does not receive because of action by the individual or the individual's spouse, by a person (including a court or administrative body, with legal authority to act in place of or on behalf of the individual's spouse), or by any person (including a court or administrative body) acting at the direction or upon the request of the individual or the individual's spouse.

c. In the case of a trust, the principal of which includes assets of an individual and assets of any other person or persons, the provisions of this rule shall apply to the portion of the trust attributable to the individual.

d. This rule shall apply without regard to:

- (1) The purposes for which a trust is established.
- (2) Whether the trustees have or exercise any discretion under the trust.
- (3) Any restrictions on when or whether distribution may be made for the trust.
- (4) Any restriction on the use of distributions from the trust.

e. The term "trust" includes any legal instrument or device that is similar to a trust, including a conservatorship.

75.24(2) Treatment of revocable and irrevocable trusts.

a. In the case of a revocable trust:

(1) The principal of the trust shall be considered an available resource.

(2) Payments from the trust to or for the benefit of the individual shall be considered income of the individual.

(3) Any other payments from the trust shall be considered assets disposed of by the individual, subject to the penalties described at rule 441—75.23(249A) and 441—Chapter 89.

b. In the case of an irrevocable trust:

(1) If there are any circumstances under which payment from the trust could be made to or for the benefit of the individual, the portion of the principal from which, or the income on the principal from which, payment to the individual could be made shall be considered an available resource to the individual and payments from that principal or income to or for the benefit of the individual shall be considered income to the individual. Payments for any other purpose shall be considered a transfer of assets by the individual subject to the penalties described at rule 441—75.23(249A) and 441—Chapter 89.

(2) Any portion of the trust from which, or any income on the principal from which, no payment could under any circumstances be made to the individual shall be considered, as of the date of establishment of the trust (or, if later, the date on which payment to the individual was foreclosed) to be assets disposed of by the individual subject to the penalties specified at 75.23(3) and 441—Chapter 89. The value of the trust shall be determined for this purpose by including the amount of any payments made from this portion of the trust after this date.

75.24(3) Exceptions. This rule shall not apply to any of the following trusts:

a. A trust containing the assets of an individual under the age of 65 who is disabled (as defined in Section 1614(a)(3) of the Social Security Act) and which is established for the benefit of the individual by a parent, grandparent, legal guardian of the individual, or a court if the state will receive all amounts remaining in the trust upon the death of the individual up to an amount equal to the total medical assistance paid on behalf of the individual.

b. A trust established for the benefit of an individual if the trust is composed only of pension, social security, and other income to the individual (and accumulated income of the trust), and the state will receive all amounts remaining in the trust upon the death of the individual up to the amount equal to the total medical assistance paid on behalf of the individual. For disposition of trust amounts pursuant to Iowa Code sections 633C.1 to 633C.5, the average statewide charges and Medicaid rates for the period from July 1, 2018, to June 30, 2019, shall be as follows:

- (1) The average statewide charge to a private-pay resident of a nursing facility is \$6,005 per month.
- (2) The maximum statewide Medicaid rate for a resident of an intermediate care facility for persons with an intellectual disability is \$31,529 per month.
- (3) The average statewide charge to a resident of a mental health institute is \$27,667 per month.
- (4) The average statewide charge to a private-pay resident of a psychiatric medical institution for children is \$9,088 per month.
- (5) The average statewide charge to a home- and community-based waiver applicant or member shall be consistent with the level of care determination and correspond with the average charges and rates set forth in this paragraph.

c. A trust containing the assets of an individual who is disabled (as defined in 1614(a)(3) of the Social Security Act) that meets the following conditions:

- (1) The trust is established and managed by a nonprofit association.
- (2) A separate account is maintained for each beneficiary of the trust, but, for purposes of investment and management of funds, the trust pools these accounts.
- (3) Accounts in the trust are established solely for the benefit of individuals who are disabled (as defined in 1614(a)(3) of the Social Security Act) by the parent, grandparent, or legal guardian of the individuals, by the individuals or by a court.
- (4) To the extent that amounts remaining in the beneficiary's account upon death of the beneficiary are not retained by the trust, the trust pays to the state from the remaining amounts in the account an amount equal to the total amount of medical assistance paid on behalf of the beneficiary.

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

[ARC 7834B, IAB 6/3/09, effective 7/8/09; ARC 8898B, IAB 6/30/10, effective 7/1/10; ARC 9582B, IAB 6/29/11, effective 7/1/11; ARC 0192C, IAB 7/11/12, effective 7/1/12; ARC 0822C, IAB 7/10/13, effective 7/1/13; ARC 0821C, IAB 7/10/13, effective 7/1/13; ARC 1484C, IAB 6/11/14, effective 7/1/14; ARC 1483C, IAB 6/11/14, effective 7/1/14; ARC 2027C, IAB 6/10/15, effective 7/1/15; ARC 2605C, IAB 7/6/16, effective 7/1/16; ARC 3182C, IAB 7/5/17, effective 7/1/17; ARC 3183C, IAB 7/5/17, effective 7/1/17; ARC 3869C, IAB 7/4/18, effective 7/1/18; ARC 3870C, IAB 7/4/18, effective 7/1/18]

441—75.25(249A) Definitions. Unless otherwise specified, the definitions in this rule shall apply to 441—Chapters 75 through 85 and 88.

“Aged” shall mean a person 65 years of age or older.

“Applicant” shall mean a person who is requesting assistance, including recertification under the medically needy program, on the person's own behalf or on behalf of another person. This also includes parents living in the home with the children and the nonparental relative who is requesting assistance for the children.

“Blind” shall mean a person with central visual acuity of 20/200 or less in the better eye with use of corrective lens or visual field restriction to 20 degrees or less.

“Break in assistance” for medically needy shall mean the lapse of more than three months from the end of the medically needy certification period to the beginning of the next current certification period.

“Central office” shall mean the state administrative office of the department of human services.

“Certification period” for medically needy shall mean the period of time not to exceed two consecutive months in which a person is conditionally eligible.

“Client” shall mean all of the following:

1. A Medicaid applicant;
2. A Medicaid member;
3. A person who is conditionally eligible for Medicaid; and
4. A person whose income or assets are considered in determining eligibility for an applicant or member.

“*CMAP-related medically needy*” shall mean those individuals under the age of 21 who would be eligible for the child medical assistance program except for excess income or resources.

“*Community spouse*” shall mean a spouse of an institutionalized spouse for the purposes of rules 441—75.5(249A), 441—75.16(249A), and 441—76.10(249A).

“*Conditionally eligible*” shall mean that a person has completed the application process and has been assigned a medically needy certification period and spenddown amount but has not met the spenddown amount for the certification period or has been assigned a monthly premium but has not yet paid the premium for that month.

“*Coverage group*” shall mean a group of persons who meet certain common eligibility requirements.

“*Department*” shall mean the Iowa department of human services.

“*Disabled*” shall mean a person who is unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which has lasted or is expected to last for a continuous period of not less than 12 months from the date of application.

“*FMAP-related medically needy*” shall mean those persons who would be eligible for the family medical assistance program except for excess income or resources.

“*Health insurance*” shall mean protection which provides payment of benefits for covered sickness or injury.

“*Incurred medical expenses*” for medically needy shall mean (1) medical bills paid by a client, responsible relative, or state or political subdivision program other than Medicaid during the retroactive certification period or the certification period, or (2) unpaid medical expenses for which the client or responsible relative remains obligated.

“*Institutionalized person*” shall mean a person who is an inpatient in a nursing facility or a Medicare-certified skilled nursing facility, who is an inpatient in a medical institution and for whom payment is made based on a level of care provided in a nursing facility, or who is a person described in 75.1(18) for the purposes of rule 441—75.5(249A).

“*Institutionalized spouse*” shall mean a married person living in a medical institution, or nursing facility, or home- and community-based waiver setting who is likely to remain living in these circumstances for at least 30 consecutive days, and whose spouse is not in a medical institution or nursing facility for the purposes of rules 441—75.5(249A), 441—75.16(249A), and 441—76.10(249A).

“*Local office*” shall mean the county office of the department of human services or the mental health institute or hospital school.

“*Medically needy income level (MNIL)*” shall mean 133 1/3 percent of the schedule of basic needs based on family size. (See subrule 75.58(2).)

“*Member*” shall mean a person who has been determined eligible for medical assistance under rule 441—75.1(249A). For the medically needy program, “member” shall mean a medically needy person who has income at or less than the medically needy income level (MNIL) or who has reduced countable income to the MNIL during the certification period through spenddown. “Member” may be used interchangeably with “recipient.” This definition does not apply to the phrase “household member.”

“*Necessary medical and remedial services*” for medically needy shall mean medical services recognized by law which are currently covered under the Iowa Medicaid program.

“*Noncovered Medicaid services*” for medically needy shall mean medical services that are not covered under Medicaid because the provider was not enrolled in Medicaid, the services are ones which are otherwise not covered under Medicaid, the bill is for a responsible relative who is not in the Medicaid-eligible group or the bill is for services delivered before the start of a certification period.

“*Nursing facility services*” shall mean the level of care provided in a medical institution licensed for nursing services or skilled nursing services for the purposes of rule 441—75.23(249A).

“*Obligated medical expense*” for medically needy shall mean a medical expense for which the client or responsible relative continues to be legally liable.

“*Ongoing eligibility*” for medically needy shall mean that eligibility continues for an SSI-related, CMAP-related, or FMAP-related medically needy person with a zero spenddown.

“*Pay and chase*” shall mean that the state pays the total amount allowed under the agency’s payment schedule and then seeks reimbursement from the liable third party. The pay and chase provision applies

to Medicaid claims for prenatal care, for preventive pediatric services, and for all services provided to a person for whom there is court-ordered medical support.

“*Payee*” refers to an SSI payee as defined in Iowa Code subsections 633.33(7) and 633.3(20).

“*Recertification*” in the medically needy coverage group shall mean establishing a new certification period when the previous period has expired and there has not been a break in assistance.

“*Recipient*” shall mean a person who is receiving assistance including receiving assistance for another person.

“*Responsible relative*” for medically needy shall mean a spouse, parent, or stepparent living in the household of the client.

“*Retroactive certification period*” for medically needy shall mean one, two, or three calendar months prior to the date of application. The retroactive certification period begins with the first month Medicaid-covered services were received and continues to the end of the month immediately prior to the month of application.

“*Retroactive period*” shall mean the three calendar months immediately preceding the month in which an application is filed.

“*Spenddown*” shall mean the process by which a medically needy person obligates excess income for allowable medical expenses to reduce income to the appropriate MNIL.

“*SSI-related*” shall mean those persons whose eligibility is derived from regulations governing the supplemental security income (SSI) program except that income shall be considered prospectively.

“*SSI-related medically needy*” shall mean those persons whose eligibility is derived from regulations governing the supplemental security income (SSI) program except for income or resources.

“*Supply*” shall mean the requested information is received by the department by the specified due date.

“*Transfer of assets*” shall mean transfer of resources or income for less than fair market value for the purposes of rule 441—75.23(249A). For example, a transfer of resources or income could include establishing a trust, contributing to a charity, removing a name from a resource or income, or reducing ownership interest in a resource or income.

“*Unborn child*” shall include an unborn child during the entire term of pregnancy.

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

[ARC 7935B, IAB 7/1/09, effective 9/1/09; ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 3353C, IAB 10/11/17, effective 10/1/17; ARC 3549C, IAB 1/3/18, effective 2/7/18]

441—75.26(249A) References to the family investment program. Rescinded IAB 10/8/97, effective 12/1/97.

441—75.27(249A) AIDS/HIV settlement payments. The following payments are exempt as income and resources when determining eligibility for or the amount of Medicaid benefits under any coverage group if the payments are kept in a separate, identifiable account:

75.27(1) Class settlement payments. Payments made from any fund established pursuant to a class settlement in the case of *Susan Walker v. Bayer Corporation, et al.*, 96-C-5024 (N.D. Ill.) are exempt.

75.27(2) Other settlement payments. Payments made pursuant to a release of all claims in a case that is entered into in lieu of the class settlement referred to in subrule 75.27(1) and that is signed by all affected parties in the cases on or before the later of December 31, 1997, or the date that is 270 days after the date on which the release is first sent to the person (or the legal representative of the person) to whom payment is to be made are exempt.

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

441—75.28(249A) Recovery.

75.28(1) Definitions.

“*Administrative overpayment*” means medical assistance incorrectly paid to or for the client because of continuing assistance during the appeal process or allowing a deduction for the Medicare Part B premium in determining client participation while the department arranges to pay the Medicare premium directly.

“*Agency error*” means medical assistance incorrectly paid to or for the client because of action attributed to the department as the result of one or more of the following circumstances:

1. Misfiling or loss of forms or documents.
2. Errors in typing or copying.
3. Computer input errors.
4. Mathematical errors.
5. Failure to determine eligibility correctly or to certify assistance in the correct amount when all essential information was available to the department.
6. Failure to make prompt revisions in medical payment following changes in policies requiring the changes as of a specific date.

“*Client*” means a current or former Medicaid member.

“*Client error*” means medical assistance incorrectly paid to or for the client because the client or client’s representative failed to disclose information, or gave false or misleading statements, oral or written, regarding the client’s income, resources, or other eligibility and benefit factors. “*Client error*” also means assistance incorrectly paid to or for the client because of failure by the client or client’s representative to timely report as defined in rule 441—76.15(249A).

“*Department*” means the department of human services.

“*Premiums paid for medical assistance*” means monthly premiums assessed to a member or household for Medicaid, IowaCare or the Iowa Health and Wellness Plan coverage.

75.28(2) Amount subject to recovery. The department shall recover from a client all Medicaid funds incorrectly expended to or on behalf of the client and all unpaid premiums assessed by the department for medical assistance. The incorrect expenditures or unpaid premiums may result from client or agency error or administrative overpayment.

75.28(3) Notification. All clients shall be promptly notified on Form 470-2891, Notice of Medical Assistance Overpayment, when it is determined that assistance was incorrectly expended or when assessed premiums are unpaid.

a. Notification of incorrect expenditures shall include:

- (1) For whom assistance was paid;
- (2) The period during which assistance was incorrectly paid;
- (3) The amount of assistance subject to recovery; and
- (4) The reason for the incorrect expenditure.

b. Notification of unpaid premiums shall include:

- (1) The amount of the premium; and
- (2) The month covered by the medical assistance premium.

75.28(4) Source of recovery. Recovery shall be made from the client or from parents of children under the age of 21 when the parents completed the application and had responsibility for reporting changes. Recovery may come from income, resources, the estate, income tax refunds, and lottery winnings of the client.

75.28(5) Repayment. The repayment of incorrectly expended Medicaid funds shall be made to the department. However, repayment of funds incorrectly paid to a nursing facility, a Medicare-certified skilled nursing facility, a psychiatric medical institution for children, an intermediate care facility for persons with an intellectual disability, or mental health institute enrolled as an inpatient psychiatric facility may be made by the client to the facility. The department shall then recover the funds from the facility through a vendor adjustment.

75.28(6) Appeals. The client shall have the right to appeal the amount of funds subject to recovery under the provisions of 441—Chapter 7.

75.28(7) Estate recovery. Medical assistance, including the amount the state paid to a managed care organization (MCO) for provision of medical services, also called capitation fees, is subject to recovery from the estate of a Medicaid member, the estate of the member’s surviving spouse, or the estate of the member’s surviving child as provided in this subrule. Effective January 1, 2010, medical assistance that has been paid for Medicare cost sharing or for benefits described in Section 1902(a)(10)(E) of the Social Security Act is not subject to recovery. All assets included in the estate of the member, the surviving

spouse, or the surviving child are subject to probate for the purposes of medical assistance estate recovery pursuant to Iowa Code section 249A.53(2) “d.” The classification of the debt is defined at Iowa Code section 633.425(7).

a. Definitions.

“*Capitated payment/rate*” means a monthly payment to the contractor on behalf of each member for the provision of health services under the contract. Payment is made regardless of whether the member receives services during the month.

“*Estate.*” For the purpose of this subrule, the “estate” of a Medicaid member, a surviving spouse, or a surviving child shall include all real property, personal property, or any other asset in which the member, spouse, or surviving child had any legal title or interest at the time of death, or at the time a child reaches the age of 21, to the extent of that interest. An estate includes, but is not limited to, interest in jointly held property, retained life estates, and interests in trusts.

“*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.

b. Debt due for member 55 years of age or older. Receipt of medical assistance when a member is 55 years of age or older creates a debt due to the department from the member’s estate upon the member’s death for all medical assistance provided on the member’s behalf on or after July 1, 1994.

c. Debt due for member under the age of 55 in a medical institution.

(1) Receipt of medical assistance creates a debt due to the department from the member’s estate upon the member’s death for all medical assistance provided on the member’s behalf on or after July 1, 1994, when the member:

1. Is under the age of 55; and
2. Is a resident of a nursing facility, an intermediate care facility for persons with an intellectual disability, or a mental health institute; and
3. Cannot reasonably be expected to be discharged and return home.

(2) If the member is discharged from the facility and returns home before staying six consecutive months, no debt will be assessed for medical assistance payments made on the member’s behalf for the time in the institution.

(3) If the member remains in the facility for six consecutive months or longer or dies before staying six consecutive months, the department shall presume that the member cannot or could not reasonably be expected to be discharged and return home and a debt due shall be established. The department shall notify the member of the presumption and the establishment of a debt due.

d. Request for a determination of ability to return home. Upon receipt of a notice of the establishment of a debt due based on the presumption that the member cannot return home, the member or someone acting on the member’s behalf may request that the department determine whether the member can or could reasonably have been expected to return home.

(1) When a written request is made within 30 days of the notice that a debt due will be established, no debt due shall be established until the department has made a decision on the member’s ability to return home. If the determination is that there is or was no ability to return home, a debt due shall be established for all medical assistance as of the date of entry into the institution.

(2) When a written request is made more than 30 days after the notice that a debt due will be established, a debt due will be established for medical assistance provided before the request even if the determination is that the member can or could have returned home.

e. Determination of ability to return home. When the member or someone acting on the member’s behalf requests that the department determine if the member can or could have returned home, the determination shall be made by the Iowa Medicaid enterprise (IME) medical services unit.

(1) The IME medical services unit cannot make a determination until the member has been in an institution at least six months or after the death of the member, whichever is earlier. The IME medical services unit will notify the member or the member’s representative and the department of the determination.

(2) If the determination is that the member can or could return home, the IME medical services unit shall establish the date the return is expected or could have been expected to occur.

(3) If the determination is that the member cannot or could not return home, a debt due will be established unless the member or the member's representative asks for a reconsideration of the decision. The IME medical services unit will notify the member or the member's representative and the department of the reconsideration decision.

(4) If the reconsideration decision is that the member cannot or could not return home, a debt due will be established against the member unless the decision is appealed pursuant to 441—Chapter 7. The appeal decision will determine the final outcome for the establishment of a debt due and the period when the debt is established.

f. Debt collection.

(1) A nursing facility participating in the medical assistance program shall notify the IME revenue collection unit upon the death of a member residing in the facility by submitting Form 470-4331, Estate Recovery Program Nursing Home Referral.

(2) Upon receipt of Form 470-4331 or a report of a member's death through other means, the IME revenue collection unit will use Form 470-4339, Medical Assistance Debt Response, to request a statement of the member's assets from the member's personal representative. The representative shall sign and return Form 470-4339 indicating whether assets remain and, if so, what the assets are and what higher priority expenses exist. EXCEPTION: The procedures in this subparagraph are not necessary when a probate estate has been opened, because probate procedures provide for an inventory, an accounting, and a final report of the estate.

g. Waiving the collection of the debt.

(1) The department shall waive the collection of the debt created under this subrule from the estate of the member to the extent that collection of the debt would result in either of the following:

1. Reduction in the amount received from the member's estate by a surviving spouse or by a surviving child who is under the age of 21, blind, or permanently and totally disabled at the time of the member's death.

2. Creation of an undue hardship for the person seeking a waiver of estate recovery. Undue hardship exists when total household income is less than 200 percent of the poverty level for a household of the same size, total household resources do not exceed \$10,000, and application of estate recovery would result in deprivation of food, clothing, shelter, or medical care such that life or health would be endangered. For this purpose, "income" and "resources" shall be defined as being under the family investment program.

(2) To apply for a waiver of estate recovery due to undue hardship, the person shall provide a written statement and supporting verification to the department within 30 days of the notice of estate recovery pursuant to Iowa Code section 249A.53(2).

(3) The department shall determine whether undue hardship exists on a case-by-case basis. Appeals of adverse decisions regarding an undue hardship determination may be filed in accordance with 441—Chapter 7.

h. Amount waived. If collection of all or part of a debt is waived pursuant to paragraph 75.28(7) "g," to the extent that the person received the member's estate, the amount waived shall be a debt due from the following:

(1) The estate of the member's surviving spouse, upon the death of the spouse.

(2) The estate of the member's surviving child who is blind or has a disability, upon the death of the child.

(3) A surviving child who was under 21 years of age at the time of the member's death, when the child reaches the age of 21.

(4) The estate of a surviving child who was under 21 years of age at the time of the member's death, if the child dies before reaching the age of 21.

(5) The hardship waiver recipient, when the hardship no longer exists.

(6) The estate of the recipient of the undue hardship waiver, at the time of death of the hardship waiver recipient.

i. Impact of asset disregard on debt due. The estate of a member who is eligible for medical assistance under subrule 75.5(5) shall not be subject to a claim for medical assistance paid on the member's behalf up to the amount of the assets disregarded by asset disregard. Medical assistance paid on behalf of the member before these conditions shall be recovered from the estate, regardless of the member's having purchased precertified or approved insurance.

j. Interest on debt. Interest shall accrue on a debt due under this subrule at the rate provided pursuant to Iowa Code section 535.3, beginning six months after the death of a Medicaid member, the surviving spouse, or the surviving child, or upon the child's reaching the age of 21.

k. Reimbursement to county. If a county reimburses the department for medical assistance provided under this subrule and the amount of medical assistance is subsequently repaid through a medical assistance income trust or a medical assistance special needs trust as defined in Iowa Code chapter 633C, the department shall reimburse the county on a proportionate basis.

[ARC 1134C, IAB 10/30/13, effective 10/2/13; ARC 2361C, IAB 1/6/16, effective 1/1/16]

441—75.29(249A) Investigation by quality control or the department of inspections and appeals. An applicant or member shall cooperate with the department when the applicant's or member's case is selected by quality control or the department of inspections and appeals for verification of eligibility unless the investigation revolves solely around the circumstances of a person whose income and resources do not affect medical assistance eligibility. (See department of inspections and appeals rules in 481—Chapter 72.) Failure to cooperate shall serve as a basis for denial of an application or cancellation of medical assistance unless the Medicaid eligibility is determined by the Social Security Administration. Once a person's eligibility is denied or canceled for failure to cooperate, the person may reapply but shall not be determined eligible until cooperation occurs.

[ARC 1134C, IAB 10/30/13, effective 10/2/13]

441—75.30(249A) Member lock-in. Rescinded ARC 2361C, IAB 1/6/16, effective 1/1/16.

441—75.31 to 75.49 Reserved.

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

441—75.50(249A) Definitions. The following definitions apply to this division in addition to the definitions in rule 441—75.25(249A).

“Applicant” shall mean a person who is requesting assistance on the person's own behalf or on behalf of another person, including recertification under the medically needy program. This also includes parents living in the home with the children and the nonparental relative who is requesting assistance for the children.

“Application period” means the months beginning with the month in which the application is considered to be filed, through and including the month in which an eligibility determination is made.

“Assistance unit” includes any person whose income is considered when determining eligibility.

“Bona fide offer” means an actual or genuine offer which includes a specific wage or a training opportunity at a specified place when used to determine whether the parent has refused an offer of training or employment.

“Central office” shall mean the state administrative office of the department of human services.

“Change in income” means a permanent change in hours worked or rate of pay, any change in the amount of unearned income, or the beginning or ending of any income.

“Change in work expenses” means a permanent change in the cost of dependent care or the beginning or ending of dependent care.

“Department” shall mean the Iowa department of human services.

“Dependent” means an individual who can be claimed by another individual as a dependent for federal income tax purposes.

“*Dependent child*” or “*dependent children*” means a child or children who meet the nonfinancial eligibility requirements of the applicable FMAP-related coverage group.

“*Income in-kind*” is any gain or benefit which is not in the form of money payable directly to the eligible group including nonmonetary benefits, such as meals, clothing, and vendor payments. Vendor payments are money payments which are paid to a third party and not to the eligible group.

“*Initial two months*” means the first two consecutive months for which eligibility is granted.

“*Medical institution,*” when used in this division, shall mean a facility which is organized to provide medical care, including nursing and convalescent care, in accordance with accepted standards as authorized by state law and as evidenced by the facility’s license. A medical institution may be public or private. Medical institutions include the following:

1. Hospitals.
2. Extended care facilities (skilled nursing).
3. Intermediate care facilities.
4. Mental health institutions.
5. Hospital schools.

“*Needy specified relative*” means a nonparental specified relative, listed in 75.55(1), who meets all the eligibility requirements of the FMAP coverage group, listed in 75.1(14).

“*Nonrecurring lump sum unearned income*” means a payment in the nature of a windfall, for example, an inheritance, an insurance settlement for pain and suffering, an insurance death benefit, a gift, lottery winnings, or a retroactive payment of benefits such as social security, job insurance or workers’ compensation.

“*Parent*” means a legally recognized parent, including an adoptive parent, or a biological father if there is no legally recognized father.

“*Prospective budgeting*” means the determination of eligibility and the amount of assistance for a calendar month based on the best estimate of income and circumstances which will exist in that calendar month.

“*Recipient*” means a person for whom Medicaid is received as well as parents living in the home with the eligible children and other specified relatives as defined in subrule 75.55(1) who are receiving Medicaid for the children. Unless otherwise specified, a person is not a recipient for any month in which the assistance issued for that person is subject to recoupment because the person was ineligible.

“*Schedule of needs*” means the total needs of a group as determined by the schedule of living costs, described at subrule 75.58(2).

“*Stepparent*” means a person who is not the parent of the dependent child, but is the legal spouse of the dependent child’s parent by ceremonial or common-law marriage.

“*Unborn child*” shall include an unborn child during the entire term of the pregnancy.

“*Uniformed service*” means the Army, Navy, Air Force, Marine Corps, Coast Guard, National Oceanographic and Atmospheric Administration, or Public Health Service of the United States.

441—75.51(249A) Reinstatement of eligibility. Rescinded IAB 2/10/10, effective 3/1/10.

441—75.52(249A) Continuing eligibility.

75.52(1) Reviews. Eligibility factors shall be reviewed at least annually for the FMAP-related programs. Reviews shall be conducted using information contained in and verification supplied with the review form specified in subrule 75.52(3).

75.52(2) Additional reviews. A redetermination of specific eligibility factors shall be made when:

a. The member reports a change in circumstances (for example, a change in income, as defined at rule 441—75.50(249A)), or

b. A change in the member’s circumstances comes to the attention of a staff member.

75.52(3) Forms.

a. Information for the annual review shall be submitted on Form 470-2881, 470-2881(M), 470-2881(S), or 470-2881(MS), Review/Recertification Eligibility Document (RRED), with the following exceptions:

(1) When the client has completed Form 470-0462 or 470-0466 (Spanish), Health and Financial Support Application, for another purpose, this form may be used as the review document for the annual review.

(2) Information for recertification of family medical assistance-related medically needy shall be submitted on Form 470-3118 or 470-3118(S), Medicaid Review.

b. The department shall supply the review form to the client as needed, or upon request, and shall pay the cost of postage to return the form.

(1) When the review form is issued in the department's regular end-of-month mailing, the client shall return the completed form to the department by the fifth calendar day of the following month.

(2) When the review form is not issued in the department's regular end-of-month mailing, the client shall return the completed form to the department by the seventh day after the date the form is mailed by the department.

(3) A copy of a review form received by fax or electronically shall have the same effect as an original form.

c. The review information for foster children or children in subsidized adoption or subsidized guardianship shall be submitted on Form 470-2914, Foster Care, Adoption, and Guardianship Medicaid Review.

75.52(4) Client responsibilities. For the purposes of this subrule, "clients" shall include persons who received assistance subject to recoupment because the persons were ineligible.

a. The client shall cooperate by giving complete and accurate information needed to establish eligibility.

b. The client shall complete the required review form when requested by the department in accordance with subrule 75.52(3). If the department does not receive a completed form, assistance shall be canceled. A completed form is one that has all items answered, is signed, is dated, and is accompanied by verification as required in paragraphs 75.57(1) "f" and 75.57(2) "l."

c. The client shall report any change in the following circumstances at the annual review or upon the addition of an individual to the eligible group:

- (1) Income from all sources, including any change in care expenses.
- (2) Resources.
- (3) Members of the household.
- (4) School attendance.
- (5) A stepparent recovering from an incapacity.
- (6) Change of mailing or living address.
- (7) Payment of child support.
- (8) Receipt of a social security number.
- (9) Payment for child support, alimony, or dependents as defined in paragraph 75.57(8) "b."
- (10) Health insurance premiums or coverage.

d. All clients shall timely report any change in the following circumstances at any time:

- (1) Members of the household.
- (2) Change of mailing or living address.
- (3) Sources of income.
- (4) Health insurance premiums or coverage.

e. Clients described at subrule 75.1(35) shall also timely report any change in income from any source and any change in care expenses at any time.

f. A report shall be considered timely when made within ten days from the date:

- (1) A person enters or leaves the household.
- (2) The mailing or living address changes.
- (3) A source of income changes.
- (4) A health insurance premium or coverage change is effective.
- (5) Of any change in income.
- (6) Of any change in care expenses.

g. When a change is not reported as required in paragraphs 75.52(4) “c” through “e,” any excess Medicaid paid shall be subject to recovery.

h. When a change in any circumstance is reported, its effect on eligibility shall be evaluated and eligibility shall be redetermined, if appropriate, regardless of whether the report of the change was required in paragraphs 75.52(4) “c” through “e.”

75.52(5) Effective date. After assistance has been approved, eligibility for continuing assistance shall be effective as of the first of each month. Any change affecting eligibility reported during a month shall be effective the first day of the next calendar month, subject to timely notice requirements at rule 441—7.6(217) for any adverse actions.

a. When the change creates ineligibility, eligibility under the current coverage group shall be canceled and an automatic redetermination of eligibility shall be completed in accordance with rule 441—76.11(249A).

b. Rescinded IAB 10/4/00, effective 10/1/00.

c. When an individual included in the eligible group becomes ineligible, that individual’s Medicaid shall be canceled effective the first of the next month unless the action must be delayed due to timely notice requirements at rule 441—7.6(217).

[ARC 8260B, IAB 11/4/09, effective 1/1/10; ARC 8500B, IAB 2/10/10, effective 3/1/10]

441—75.53(249A) Iowa residency policies specific to FMAP and FMAP-related coverage groups. Notwithstanding the provisions of rule 441—75.10(249A), the following rules shall apply when determining eligibility for persons under FMAP or FMAP-related coverage groups.

75.53(1) Definition of resident. A resident of Iowa is one:

a. Who is living in Iowa voluntarily with the intention of making that person’s home there and not for a temporary purpose. A child is a resident of Iowa when living there on other than a temporary basis. Residence may not depend upon the reason for which the individual entered the state, except insofar as it may bear upon whether the individual is there voluntarily or for a temporary purpose; or

b. Who, at the time of application, is living in Iowa, is not receiving assistance from another state, and entered Iowa with a job commitment or seeking employment in Iowa, whether or not currently employed. Under this definition the child is a resident of the state in which the specified relative is a resident.

75.53(2) Retention of residence. Residence is retained until abandoned. Temporary absence from Iowa, with subsequent returns to Iowa, or intent to return when the purposes of the absence have been accomplished does not interrupt continuity of residence.

75.53(3) Suitability of home. The home shall be deemed suitable until the court has ruled it unsuitable and, as a result of such action, the child has been removed from the home.

75.53(4) Absence from the home.

a. An individual who is absent from the home shall not be included in the eligible group, except as described in paragraph “b.”

(1) A parent who is a convicted offender but is permitted to live at home while serving a court-imposed sentence by performing unpaid public work or unpaid community service during the workday is considered absent from the home.

(2) A parent whose absence from the home is due solely to a pattern of employment is not considered to be absent.

(3) A parent whose absence is occasioned solely by reason of the performance of active duty in the uniformed services of the United States is considered absent from the home. “Uniformed service” means the Army, Navy, Air Force, Marine Corps, Coast Guard, National Oceanographic and Atmospheric Administration, or Public Health Service of the United States.

b. The needs of an individual who is temporarily out of the home are included in the eligible group if otherwise eligible. A temporary absence exists in the following circumstances:

(1) An individual is anticipated to be in the medical institution for less than a year, as verified by a physician’s statement. Failure to return within one year from the date of entry into the medical institution will result in the individual’s needs being removed from the eligible group.

(2) A child is out of the home to secure education or training as defined in paragraph 75.54(1) “b” as long as the child remains a dependent.

(3) A parent or specified relative is temporarily out of the home to secure education or training and was in the eligible group before leaving the home to secure education or training. For this purpose, “education or training” means any academic or vocational training program that prepares a person for a specific professional or vocational area of employment.

(4) An individual is out of the home for reasons other than reasons in subparagraphs 75.53(4) “b”(1) through (3) and intends to return to the home within three months. Failure to return within three months from the date the individual left the home will result in the individual’s needs being removed from the eligible group.

[ARC 0579C, IAB 2/6/13, effective 4/1/13]

441—75.54(249A) Eligibility factors specific to child.

75.54(1) Age. Unless otherwise specified at rule 441—75.1(249A), Medicaid shall be available to a needy child under the age of 18 years without regard to school attendance.

a. A child is eligible for the entire month in which the child’s eighteenth birthday occurs, unless the birthday falls on the first day of the month.

b. Medicaid shall also be available to a needy child aged 18 years who is a full-time student in a secondary school, or in the equivalent level of vocational or technical training, and who is reasonably expected to complete the program before reaching the age of 19 if the following criteria are met.

(1) A child shall be considered attending school full-time when enrolled or accepted in a full-time (as certified by the school or institute attended) elementary, secondary or the equivalent level of vocational or technical school or training leading to a certificate or diploma. Correspondence school is not an allowable program of study.

(2) A child shall also be considered to be in regular attendance in months when the child is not attending because of an official school or training program vacation, illness, convalescence, or family emergency. A child meets the definition of regular school attendance until the child has been officially dropped from the school rolls.

(3) When a child’s education is temporarily interrupted pending adjustment of an education or training program, exemption shall be continued for a reasonable period of time to complete the adjustment.

75.54(2) Residing with a relative. The child shall be living in the home of one of the relatives specified in subrule 75.55(1). When the mother intends to place her child for adoption shortly after birth, the child shall be considered as living with the mother until the time custody is actually relinquished.

a. Living with relatives implies primarily the existence of a relationship involving an accepted responsibility on the part of the relative for the child’s welfare, including the sharing of a common household.

b. Home is the family setting maintained or in the process of being established as evidenced by the assumption and continuation of responsibility for the child by the relative.

75.54(3) Deprivation of parental care and support. Rescinded IAB 11/1/00, effective 1/1/01.

75.54(4) Continuous eligibility for children. Rescinded IAB 11/5/08, effective 11/1/08.

441—75.55(249A) Eligibility factors specific to specified relatives.

75.55(1) Specified relationship.

a. A child may be considered as meeting the requirement of living with a specified relative if the child’s home is with one of the following or with a spouse of the relative even though the marriage is terminated by death or divorce:

Father or adoptive father.

Mother or adoptive mother.

Grandfather or grandfather-in-law, meaning the subsequent husband of the child’s natural grandmother, i.e., stepgrandfather or adoptive grandfather.

Grandmother or grandmother-in-law, meaning the subsequent wife of the child's natural grandfather, i.e., stepgrandmother or adoptive grandmother.

Great-grandfather or great-great-grandfather.

Great-grandmother or great-great-grandmother.

Stepfather, but not his parents.

Stepmother, but not her parents.

Brother, brother-of-half-blood, stepbrother, brother-in-law or adoptive brother.

Sister, sister-of-half-blood, stepsister, sister-in-law or adoptive sister.

Uncle or aunt, of whole or half blood.

Uncle-in-law or aunt-in-law.

Great uncle or great-great-uncle.

Great aunt or great-great-aunt.

First cousins, nephews, or nieces.

b. A relative of the putative father can qualify as a specified relative if the putative father has acknowledged paternity by the type of written evidence on which a prudent person would rely.

75.55(2) *Liability of relatives.* All appropriate steps shall be taken to secure support from legally liable persons on behalf of all persons in the eligible group, including the establishment of paternity as provided in rule 441—75.14(249A).

a. When necessary to establish eligibility, the department shall make the initial contact with the absent parent at the time of application. Subsequent contacts may be made by the child support recovery unit.

b. When contact with the family or other sources of information indicates that relatives other than parents and spouses of the eligible children are contributing toward the support of members of the eligible group, have contributed in the past, or are of such financial standing they might reasonably be expected to contribute, the department shall contact these persons to verify current contributions or arrange for contributions on a voluntary basis.

[ARC 8785B, IAB 6/2/10, effective 8/1/10]

441—75.56(249A) Resources.

75.56(1) *Limitation.* Unless otherwise specified, a client may have the following resources and be eligible for the family medical assistance program (FMAP) or FMAP-related programs. Any resource not specifically exempted shall be counted toward the applicable resource limit when determining eligibility for adults. All resources shall be disregarded when determining eligibility for children.

a. A homestead without regard to its value. A mobile home or similar shelter shall be considered as a homestead when it is occupied by the client. Temporary absence from the homestead with a defined purpose for the absence and with intent to return when the purpose of the absence has been accomplished shall not be considered to have altered the exempt status of the homestead. Except as described at paragraph 75.56(1) "n" or "o," the net market value of any other real property shall be considered with personal property.

b. Household goods and personal effects without regard to their value. Personal effects are personal or intimate tangible belongings of an individual, especially those that are worn or carried on the person, which are maintained in one's home, and include clothing, books, grooming aids, jewelry, hobby equipment, and similar items.

c. Life insurance which has no cash surrender value. The owner of the life insurance policy is the individual paying the premium on the policy with the right to change the policy as the individual sees fit.

d. One motor vehicle per household. If the household includes more than one adult or working teenaged child whose resources must be considered as described in subrule 75.56(2), an equity not to exceed a value of \$3,000 in one additional motor vehicle shall be disregarded for each additional adult or working teenaged child.

(1) The disregard for an additional motor vehicle shall be allowed when a working teenager is temporarily absent from work.

(2) The equity value of any additional motor vehicle in excess of \$3,000 shall be counted toward the resource limit in paragraph 75.56(1)“e.” When a motor vehicle is modified with special equipment for the handicapped, the special equipment shall not increase the value of the motor vehicle.

(3) Beginning July 1, 1994, and continuing in succeeding state fiscal years, the motor vehicle equity value to be disregarded shall be increased by the latest increase in the consumer price index for used vehicles during the previous state fiscal year.

e. A reserve of other property, real or personal, not to exceed \$2,000 for applicant assistance units and \$5,000 for member assistance units. EXCEPTION: Applicant assistance units that contain at least one person who was a Medicaid member in Iowa in the month before the month of application are subject to the \$5,000 limit. Resources of the assistance unit shall be determined in accordance with persons considered, as described at subrule 75.56(2).

f. Money which is counted as income for the month and that part of lump-sum income defined at paragraph 75.57(9)“c” reserved for the current or future month’s income.

g. Payments which are exempted for consideration as income and resources under subrule 75.57(6).

h. An equity not to exceed \$1,500 in one funeral contract or burial trust for each member of the eligible group. Any amount in excess of \$1,500 shall be counted toward resource limits unless it is established that the funeral contract or burial trust is irrevocable.

i. One burial plot for each member of the eligible group. A burial plot is defined as a conventional gravesite, crypt, mausoleum, urn, or other repository which is customarily and traditionally used for the remains of a deceased person.

j. Settlements for payment of medical expenses.

k. Life estates.

l. Federal or state earned income tax credit payments in the month of receipt and the following month, regardless of whether these payments are received with the regular paychecks or as a lump sum with the federal or state income tax refund.

m. The balance in an individual development account (IDA), including interest earned on the IDA.

n. An equity not to exceed \$10,000 for tools of the trade or capital assets of self-employed households.

When the value of any resource is exempted in part, that portion of the value which exceeds the exemption shall be considered in calculating whether the eligible group’s property is within the reserve defined in paragraph “e.”

o. Nonhomestead property that produces income consistent with the property’s fair market value.

75.56(2) Persons considered.

a. Resources of persons in the eligible group shall be considered in establishing property limits.

b. Resources of the parent who is living in the home with the eligible children but who is not eligible for Medicaid shall be considered in the same manner as if the parent were eligible for Medicaid.

c. Resources of the stepparent living in the home shall not be considered when determining eligibility of the eligible group, with one exception: The resources of a stepparent included in the eligible group shall be considered in the same manner as a parent.

d. The resources of supplemental security income (SSI) members shall not be counted in establishing property limitations. When property is owned by both the SSI beneficiary and a Medicaid member in another eligible group, each shall be considered as having a half interest in order to determine the value of the resource, unless the terms of the deed or purchase contract clearly establish ownership on a different proportional basis.

e. The resources of a nonparental specified relative who elects to be included in the eligible group shall be considered in the same manner as a parent.

75.56(3) Homestead defined. The homestead consists of the house, used as a home, and may contain one or more contiguous lots or tracts of land, including buildings and appurtenances. When within a city plat, it shall not exceed ½ acre in area. When outside a city plat it shall not contain, in the aggregate, more than 40 acres. When property used as a home exceeds these limitations, the equity value of the excess property shall be determined in accordance with subrule 75.56(5).

75.56(4) Liquidation. When proceeds from the sale of resources or conversion of a resource to cash, together with other nonexempted resources, exceed the property limitations, the member is ineligible to receive assistance until the amount in excess of the resource limitation has been expended unless immediately used to purchase a homestead, or reduce the mortgage on a homestead.

a. Property settlements. Property settlements which are part of a legal action in a dissolution of marriage or palimony suit are considered as resources upon receipt.

b. Property sold under installment contract. Property sold under an installment contract or held as security in exchange for a price consistent with its fair market value is exempt as a resource. If the price is not consistent with the contract's fair market value, the resource value of the installment contract is the gross price for which it can be sold or discounted on the open market, less any legal debts, claims, or liens against the installment contract.

Payments from property sold under an installment contract are exempt as income as specified in paragraphs 75.57(1) "d" and 75.57(7) "ag." The portion of any payment received representing principal is considered a resource upon receipt. The interest portion of the payment is considered a resource the month following the month of receipt.

75.56(5) Net market value defined. Net market value is the gross price for which property or an item can currently be sold on the open market, less any legal debts, claims, or liens against the property or item.

75.56(6) Availability.

a. A resource must be available in order for it to be counted toward resource limitations. A resource is considered available under the following circumstances:

(1) The applicant or member owns the property in part or in full and has control over it. That is, it can be occupied, rented, leased, sold, or otherwise used or disposed of at the individual's discretion.

(2) The applicant or member has a legal interest in a liquidated sum and has the legal ability to make the sum available for support and maintenance.

b. Rescinded IAB 6/30/99, effective 9/1/99.

c. When property is owned by more than one person, unless otherwise established, it is assumed that all persons hold equal shares in the property.

d. When the applicant or member owns nonhomestead property, the property shall be considered exempt for so long as the property is publicly advertised for sale at an asking price that is consistent with its fair market value.

75.56(7) Damage judgments and insurance settlements.

a. Payment resulting from damage to or destruction of an exempt resource shall be considered a resource to the applicant or member the month following the month the payment was received. When the applicant or member signs a legal binding commitment no later than the month after the month the payment was received, the funds shall be considered exempt for the duration of the commitment providing the terms of the commitment are met within eight months from the date of commitment.

b. Payment resulting from damage to or destruction of a nonexempt resource shall be considered a resource in the month following the month in which payment was received.

75.56(8) Conservatorships.

a. Conservatorships established prior to February 9, 1994. The department shall determine whether assets from a conservatorship, except one established solely for the payment of medical expenses, are available by examining the language of the order establishing the conservatorship.

(1) Funds clearly conserved and available for care, support, or maintenance shall be considered toward resource or income limitations.

(2) When the department worker questions whether the funds in a conservatorship are available, the worker shall refer the conservatorship to the central office. When assets in the conservatorship are not clearly available, central office staff may contact the conservator and request that the funds in the conservatorship be made available for current support and maintenance. When the conservator chooses not to make the funds available, the department may petition the court to have the funds released either partially or in their entirety or as periodic income payments.

(3) Funds in a conservatorship that are not clearly available shall be considered unavailable until the conservator or court actually makes the funds available.

(4) Payments received from the conservatorship for basic or special needs are considered income.

b. Conservatorships established on or after February 9, 1994. Conservatorships established on or after February 9, 1994, shall be treated according to the provisions of paragraphs 75.24(1)“*e*” and 75.24(2)“*b*.”

75.56(9) *Not considered a resource.* Inventories and supplies, exclusive of capital assets, that are required for self-employment shall not be considered a resource. Inventory is defined as all unsold items, whether raised or purchased, that are held for sale or use and shall include, but not be limited to, merchandise, grain held in storage and livestock raised for sale. Supplies are items necessary for the operation of the enterprise, such as lumber, paint, and seed. Capital assets are those assets which, if sold at a later date, could be used to claim capital gains or losses for federal income tax purposes. When self-employment is temporarily interrupted due to circumstances beyond the control of the household, such as illness, inventory or supplies retained by the household shall not be considered a resource.

441—75.57(249A) Income. When determining initial and ongoing eligibility for the family medical assistance program (FMAP) and FMAP-related Medicaid coverage groups, all unearned and earned income, unless specifically exempted, disregarded, deducted for work expenses, or diverted as defined in these rules, shall be considered.

1. Unless otherwise specified at rule 441—75.1(249A), the determination of initial eligibility is a three-step process. Initial eligibility shall be granted only when (1) the countable gross nonexempt unearned and earned income received by the eligible group and available to meet the current month’s needs is no more than 185 percent of living costs as identified in the schedule of needs at subrule 75.58(2) for the eligible group (Test 1); (2) the countable net earned and unearned income is less than the schedule of living costs as identified in the schedule of needs at subrule 75.58(2) for the eligible group (Test 2); and (3) the countable net unearned and earned income, after applying allowable disregards, is less than the schedule of basic needs as identified at subrule 75.58(2) for the eligible group (Test 3).

2. The determination of continuing eligibility is a two-step process. Continuing eligibility shall be granted only when (1) countable gross nonexempt income, as described for initial eligibility, does not exceed 185 percent of the living costs as identified in the schedule of needs at subrule 75.58(2) for the eligible group (Test 1); and (2) countable net unearned and earned income is less than the schedule of basic needs as identified in the schedule of needs at subrule 75.58(2) for the eligible group (Test 3).

3. Child support assigned to the department in accordance with 441—subrule 41.22(7) shall be considered unearned income for the purpose of determining continuing eligibility, except as specified at paragraphs 75.57(1)“*e*,” 75.57(6)“*u*,” and 75.57(7)“*o*.” Expenses for care of children or disabled adults, deductions, and diversions shall be allowed when verification is provided.

75.57(1) *Unearned income.* Unearned income is any income in cash that is not gained by labor or service. When taxes are withheld from unearned income, the amount considered will be the net income after the withholding of taxes (Federal Insurance Contribution Act, state and federal income taxes). Net unearned income shall be determined by deducting reasonable income-producing costs from the gross unearned income. Money left after this deduction shall be considered gross income available to meet the needs of the eligible group.

a. Social security income is the amount of the entitlement before withholding of a Medicare premium.

b. Financial assistance received for education or training. Rescinded IAB 2/11/98, effective 2/1/98.

c. Rescinded IAB 2/11/98, effective 2/1/98.

d. When the client sells property on contract, proceeds from the sale shall be considered exempt as income. The portion of any payment that represents principal is considered a resource upon receipt as defined in subrule 75.56(4). The interest portion of the payment is considered a resource the month following the month of receipt.

e. Support payments in cash shall be considered as unearned income in determining initial and continuing eligibility.

(1) Any nonexempt cash support payment, for a member of the eligible group, made while the application is pending shall be treated as unearned income.

(2) Support payments shall be considered as unearned income in the month in which the IV-A agency (income maintenance) is notified of the payment by the IV-D agency (child support recovery unit).

The amount of income to consider shall be the actual amount paid or the monthly entitlement, whichever is less.

(3) Support payments reported by child support recovery during a past month for which eligibility is being determined shall be used to determine eligibility for the month. Support payments anticipated to be received in future months shall be used to determine eligibility for future months. When support payments terminate in the month of decision of an FMAP-related Medicaid application, both support payments already received and support payments anticipated to be received in the month of decision shall be used to determine eligibility for that month.

(4) When the reported support payment, combined with other income, creates ineligibility under the current coverage group, an automatic redetermination of eligibility shall be conducted in accordance with the provisions of rule 441—76.11(249A). Persons receiving Medicaid under the family medical assistance program in accordance with subrule 75.1(14) may be entitled to continued coverage under the provisions of subrule 75.1(21). Eligibility may be reestablished for any month in which the countable support payment combined with other income meets the eligibility test.

f. The client shall cooperate in supplying verification of all unearned income and of any change in income, as defined at rule 441—75.50(249A).

(1) When the information is available, the department shall verify job insurance benefits by using information supplied to the department by Iowa workforce development. When the department uses this information as verification, job insurance benefits shall be considered received the second day after the date that the check was mailed by Iowa workforce development. When the second day falls on a Sunday or federal legal holiday, the time shall be extended to the next mail delivery day.

(2) When the client notifies the department that the amount of job insurance benefits used is incorrect, the client shall be allowed to verify the discrepancy. The client must report the discrepancy before the eligibility month or within ten days of the date on the Notice of Decision, Form 470-0485, 470-0485(S), 470-0486, or 470-0486(S), applicable to the eligibility month, whichever is later.

75.57(2) Earned income. Earned income is defined as income in the form of a salary, wages, tips, bonuses, commission earned as an employee, income from Job Corps, or profit from self-employment. Earned income from commissions, wages, tips, bonuses, Job Corps, or salary means the total gross amount irrespective of the expenses of employment. With respect to self-employment, earned income means the net profit from self-employment, defined as gross income less the allowable costs of producing the income. Income shall be considered earned income when it is produced as a result of the performance of services by an individual.

a. Each person in the assistance unit whose gross nonexempt earned income, earned as an employee or net profit from self-employment, considered in determining eligibility is entitled to one 20 percent earned income deduction of nonexempt monthly gross earnings. The deduction is intended to include work-related expenses other than child care. These expenses shall include, but are not limited to, all of the following: taxes, transportation, meals, uniforms, and other work-related expenses.

b. Each person in the assistance unit is entitled to a deduction for care expenses subject to the following limitations.

(1) Persons in the eligible group and excluded parents shall be allowed care expenses for a child or incapacitated adult in the eligible group.

(2) Stepparents as described at paragraph 75.57(8)“*b*” and self-supporting parents on underage parent cases as described at paragraph 75.57(8)“*c*” shall be allowed incapacitated adult care or child care expenses for the ineligible dependents of the stepparent or self-supporting parent.

(3) Unless both parents are in the home and one parent is physically and mentally able to provide the care, child care or care for an incapacitated adult shall be considered a work expense in the amount paid for care of each child or incapacitated adult, not to exceed \$175 per month, or \$200 per month for a child under the age of two, or the going rate in the community, whichever is less.

(4) If both parents are in the home, adult or child care expenses shall not be allowed when one parent is unemployed and is physically and mentally able to provide the care.

(5) The deduction is allowable only when the care covers the actual hours of the individual's employment plus a reasonable period of time for commuting; or the period of time when the individual who would normally care for the child or incapacitated adult is employed at such hours that the individual is required to sleep during the waking hours of the child or incapacitated adult, excluding any hours a child is in school.

(6) Any special needs of a physically or mentally handicapped child or adult shall be taken into consideration in determining the deduction allowed.

(7) If the amount claimed is questionable, the expense shall be verified by a receipt or a statement from the provider of care. The expense shall be allowed when paid to any person except a parent or legal guardian of the child, another member of the eligible group, or any person whose needs are met by diversion of income from any person in the eligible group.

c. Work incentive disregard. After deducting the allowable work-related expenses as defined at paragraphs 75.57(2) "a" and "b" and income diversions as defined at subrule 75.57(4), 58 percent of the total of the remaining monthly nonexempt earned income, earned as an employee or the net profit from self-employment, of each person whose income must be considered is disregarded in determining eligibility for the family medical assistance program (FMAP) and those FMAP-related coverage groups subject to the three-step process for determining initial eligibility as described at rule 441—75.57(249A).

(1) The work incentive disregard is not time-limited.

(2) Initial eligibility under the first two steps of the three-step process is determined without the application of the work incentive disregard as described at subparagraphs 75.57(9) "a"(2) and (3).

(3) A person who is not eligible for Medicaid because the person has refused to cooperate in applying for or accepting benefits from other sources, in accordance with the provisions of rule 441—75.2(249A), 441—75.3(249A), or 441—75.21(249A), is eligible for the work incentive disregard.

d. Rescinded IAB 6/30/99, effective 9/1/99.

e. A person is considered self-employed when the person:

(1) Is not required to report to the office regularly except for specific purposes such as sales training meetings, administrative meetings, or evaluation sessions.

(2) Establishes the person's own working hours, territory, and methods of work.

(3) Files quarterly reports of earnings, withholding payments, and FICA payments to the Internal Revenue Service.

f. The net profit from self-employment income in a non-home-based operation shall be determined by deducting only the following expenses that are directly related to the production of the income:

(1) The cost of inventories and supplies purchased that are required for the business, such as items for sale or consumption and raw materials.

(2) Wages, commissions, and mandated costs relating to the wages for employees of the self-employed.

(3) The cost of shelter in the form of rent, the interest on mortgage or contract payments; taxes; and utilities.

(4) The cost of machinery and equipment in the form of rent or the interest on mortgage or contract payments.

(5) Insurance on the real or personal property involved.

(6) The cost of any repairs needed.

(7) The cost of any travel required.

(8) Any other expense directly related to the production of income, except the purchase of capital equipment and payment on the principal of loans for capital assets and durable goods or any cost of depreciation.

g. When the client is renting out apartments in the client's home, the following shall be deducted from the gross rentals received to determine the profit:

(1) Shelter expense in excess of that set forth on the chart of basic needs components at subrule 75.58(2) for the eligible group.

(2) That portion of expense for utilities furnished to tenants which exceeds the amount set forth on the chart of basic needs components at subrule 75.58(2).

(3) Ten percent of gross rentals to cover the cost of upkeep.

h. In determining profit from furnishing board, room, operating a family-life home, or providing nursing care, the following amounts shall be deducted from the payments received:

(1) \$41 plus an amount equivalent to the monthly maximum food assistance program benefit for a one-member household for a boarder and roomer or an individual in the home to receive nursing care, or \$41 for a roomer, or an amount equivalent to the monthly maximum food assistance program benefit for a one-member household for a boarder.

(2) Ten percent of the total payment to cover the cost of upkeep for individuals receiving a room or nursing care.

i. Gross income from providing child care in the applicant's or member's own home shall include the total payments received for the service and any payment received due to the Child Nutrition Amendments of 1978 for the cost of providing meals to children.

(1) In determining profit from providing child care services in the applicant's or member's own home, 40 percent of the total gross income received shall be deducted to cover the costs of producing the income, unless the applicant or member requests to have actual expenses in excess of the 40 percent considered.

(2) When the applicant or member requests to have expenses in excess of the 40 percent considered, profit shall be determined in the same manner as specified at paragraph 75.57(2) "j."

j. In determining profit for a self-employed enterprise in the home other than providing room and board, renting apartments or providing child care services, the following expenses shall be deducted from the income received:

(1) The cost of inventories and supplies purchased that are required for the business, such as items for sale or consumption and raw materials.

(2) Wages, commissions, and mandated costs relating to the wages for employees.

(3) The cost of machinery and equipment in the form of rent; or the interest on mortgage or contract payment; and any insurance on such machinery equipment.

(4) Ten percent of the total gross income to cover the costs of upkeep when the work is performed in the home.

(5) Any other direct cost involved in the production of the income, except the purchase of capital equipment and payment on the principal of loans for capital equipment and payment on the principal of loans for capital assets and durable goods or any cost of depreciation.

k. Rescinded IAB 6/30/99, effective 9/1/99.

l. The applicant or member shall cooperate in supplying verification of all earned income and of any change in income, as defined at rule 441—75.50(249A). A self-employed applicant or member shall keep any records necessary to establish eligibility.

75.57(3) Shared living arrangements. When an applicant or member shares living arrangements with another family or person, funds combined to meet mutual obligations for shelter and other basic needs are not income. Funds made available to the applicant or member, exclusively for the applicant's or member's needs, are considered income.

75.57(4) Diversion of income.

a. Nonexempt earned and unearned income of the parent shall be diverted to meet the unmet needs of the ineligible children of the parent living in the family group who meet the age and school attendance requirements specified in subrule 75.54(1). Income of the parent shall be diverted to meet the unmet needs of the ineligible children of the parent and a companion in the home only when the income and resources of the companion and the children are within family medical assistance program standards. The maximum income that shall be diverted to meet the needs of the ineligible children shall be the

difference between the needs of the eligible group if the ineligible children were included and the needs of the eligible group with the ineligible children excluded, except as specified at paragraph 75.57(8) "b."

b. Nonexempt earned and unearned income of the parent shall be diverted to permit payment of court-ordered support to children not living with the parent when the payment is actually being made.

75.57(5) *Income of unmarried specified relatives under the age of 19.*

a. Income of the unmarried specified relative under the age of 19 when that specified relative lives with a parent who receives coverage under family medical assistance-related programs or lives with a nonparental relative or in an independent living arrangement.

(1) The income of the unmarried, underage specified relative who is also an eligible child in the eligible group of the specified relative's parent shall be treated in the same manner as that of any other child. The income for the unmarried, underage specified relative who is not an eligible child in the eligible group of the specified relative's parent shall be treated in the same manner as though the specified relative had attained majority.

(2) The income of the unmarried, underage specified relative living with a nonparental relative or in an independent living arrangement shall be treated in the same manner as though the specified relative had attained majority.

b. Income of the unmarried specified relative under the age of 19 who lives in the same home as a self-supporting parent. The income of the unmarried specified relative under the age of 19 living in the same home as a self-supporting parent shall be treated in accordance with subparagraphs (1), (2), and (3) below.

(1) When the unmarried specified relative is under the age of 18 and not a parent of the dependent child, the income of the specified relative shall be exempt.

(2) When the unmarried specified relative is under the age of 18 and a parent of the dependent child, the income of the specified relative shall be treated in the same manner as though the specified relative had attained majority. The income of the specified relative's self-supporting parents shall be treated in accordance with paragraph 75.57(8) "c."

(3) When the unmarried specified relative is 18 years of age, the specified relative's income shall be treated in the same manner as though the specified relative had attained majority.

75.57(6) *Exempt as income and resources.* The following shall be exempt as income and resources:

a. Food reserves from home-produced garden products, orchards, domestic animals, and the like, when used by the household for its own consumption.

b. The value of the food assistance program benefit.

c. The value of the United States Department of Agriculture donated foods (surplus commodities).

d. The value of supplemental food assistance received under the Child Nutrition Act and the special food service program for children under the National School Lunch Act.

e. Any benefits received under Title III-C, Nutrition Program for the Elderly, of the Older Americans Act.

f. Benefits paid to eligible households under the Low Income Home Energy Assistance Act of 1981.

g. Any payment received under Title II of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 and the Federal-Aid Highway Act of 1968.

h. Any judgment funds that have been or will be distributed per capita or held in trust for members of any Indian tribe. When the payment, in all or part, is converted to another type of resource, that resource is also exempt.

i. Payments to volunteers participating in the Volunteers in Service to America (VISTA) program, except that this exemption will not be applied when the director of ACTION determines that the value of all VISTA payments, adjusted to reflect the number of hours the volunteers are serving, is equivalent to or greater than the minimum wage then in effect under the Fair Labor Standards Act of 1938, or the minimum wage under the laws of the state where the volunteers are serving, whichever is greater.

j. Payments for supporting services or reimbursement of out-of-pocket expenses received by volunteers in any of the programs established under Titles II and III of the Domestic Volunteer Services Act.

- k.* Tax-exempt portions of payments made pursuant to the Alaskan Native Claims Settlement Act.
 - l.* Experimental housing allowance program payments made under annual contribution contracts entered into prior to January 1, 1975, under Section 23 of the U.S. Housing Act of 1936 as amended.
 - m.* The income of a supplemental security income recipient.
 - n.* Income of an ineligible child.
 - o.* Income in-kind.
 - p.* Family support subsidy program payments.
 - q.* Grants obtained and used under conditions that preclude their use for current living costs.
 - r.* All earned and unearned educational funds of an undergraduate or graduate student or a person in training. Any extended social security or veterans benefits received by a parent or nonparental relative as defined at subrule 75.55(1), conditional to school attendance, shall be exempt. However, any additional amount received for the person's dependents who are in the eligible group shall be counted as nonexempt income.
 - s.* Subsidized guardianship program payments.
 - t.* Any income restricted by law or regulation which is paid to a representative payee living outside the home, unless the income is actually made available to the applicant or member by the representative payee.
 - u.* The first \$50 received by the eligible group which represents a current monthly support obligation or a voluntary support payment, paid by a legally responsible individual, but in no case shall the total amount exempted exceed \$50 per month per eligible group.
 - v.* Bona fide loans. Evidence of a bona fide loan may include any of the following:
 - (1) The loan is obtained from an institution or person engaged in the business of making loans.
 - (2) There is a written agreement to repay the money within a specified time.
 - (3) If the loan is obtained from a person not normally engaged in the business of making a loan, there is borrower's acknowledgment of obligation to repay (with or without interest), or the borrower expresses intent to repay the loan when funds become available in the future, or there is a timetable and plan for repayment.
 - w.* Payments made from the Agent Orange Settlement Fund or any other fund established pursuant to the settlement in the In re Agent Orange product liability litigation, M.D.L. No. 381 (E.D.N.Y.).
 - x.* The income of a person ineligible due to receipt of state-funded foster care, IV-E foster care, or subsidized adoption assistance.
 - y.* Payments for major disaster and emergency assistance provided under the Disaster Relief Act of 1974 as amended by Public Law 100-707, the Disaster Relief and Emergency Assistance Amendments of 1988.
 - z.* Payments made to certain United States citizens of Japanese ancestry and resident Japanese aliens under Section 105 of Public Law 100-383, and payments made to certain eligible Aleuts under Section 206 of Public Law 100-383, entitled "Wartime Relocation of Civilians."
 - aa.* Payments received from the Radiation Exposure Compensation Act.
 - ab.* Deposits into an individual development account (IDA) when determining eligibility. The amount of the deposit is exempt as income and shall not be used in the 185 percent eligibility test. Deposits shall be deducted from nonexempt earned and unearned income beginning with the month following the month in which verification that deposits have begun is received. The client shall be allowed a deduction only when the deposit is made from the client's money. The earned income deductions at paragraphs 75.57(2) "a," "b," and "c" shall be applied to nonexempt earnings from employment or net profit from self-employment that remains after deducting the amount deposited into the account. Allowable deductions shall be applied to any nonexempt unearned income that remains after deducting the amount of the deposit. If the client has both nonexempt earned and unearned income, the amount deposited into the IDA account shall first be deducted from the client's nonexempt unearned income. Deposits shall not be deducted from earned or unearned income that is exempt.
- 75.57(7) Exempt as income.** The following are exempt as income.
- a.* Reimbursements from a third party.
 - b.* Reimbursement from the employer for a job-related expense.

- c.* The following nonrecurring lump sum payments:
- (1) Income tax refund.
 - (2) Retroactive supplemental security income benefits.
 - (3) Settlements for the payment of medical expenses.
 - (4) Refunds of security deposits on rental property or utilities.
 - (5) That part of a lump sum received and expended for funeral and burial expenses.
 - (6) That part of a lump sum both received and expended for the repair or replacement of resources.
- d.* Payments received by the family for providing foster care when the family is operating a licensed foster home.
- e.* A small monetary nonrecurring gift, such as a Christmas, birthday or graduation gift, not to exceed \$30 per person per calendar quarter.
- When a monetary gift from any one source is in excess of \$30, the total gift is countable as unearned income. When monetary gifts from several sources are each \$30 or less, and the total of all gifts exceeds \$30, only the amount in excess of \$30 is countable as unearned income.
- f.* Federal or state earned income tax credit.
- g.* Supplementation from county funds, providing:
- (1) The assistance does not duplicate any of the basic needs as recognized by the chart of basic needs components in accordance with subrule 75.58(2), or
 - (2) The assistance, if a duplication of any of the basic needs, is made on an emergency basis, not as ongoing supplementation.
- h.* Any payment received as a result of an urban renewal or low-cost housing project from any governmental agency.
- i.* A retroactive corrective family investment program (FIP) payment.
- j.* The training allowance issued by the division of vocational rehabilitation, department of education.
- k.* Payments from the PROMISE JOBS program.
- l.* The training allowance issued by the department for the blind.
- m.* Payments from passengers in a car pool.
- n.* Support refunded by the child support recovery unit for the first month of termination of eligibility and the family does not receive the family investment program.
- o.* Rescinded IAB 10/4/00, effective 10/1/00.
- p.* Rescinded IAB 10/4/00, effective 10/1/00.
- q.* Income of a nonparental relative as defined at subrule 75.55(1) except when the relative is included in the eligible group.
- r.* Rescinded IAB 10/4/00, effective 10/1/00.
- s.* Compensation in lieu of wages received by a child funded through an employment and training program of the U.S. Department of Labor.
- t.* Any amount for training expenses included in a payment funded through an employment and training program of the U.S. Department of Labor.
- u.* Earnings of a person aged 19 or younger who is a full-time student as defined at subparagraphs 75.54(1) "b"(1) and (2). The exemption applies through the entire month of the person's twentieth birthday.
- EXCEPTION: When the twentieth birthday falls on the first day of the month, the exemption stops on the first day of that month.
- v.* Income attributed to an unmarried, underage parent in accordance with paragraph 75.57(8) "c" effective the first day of the month following the month in which the unmarried, underage parent turns age 18 or reaches majority through marriage. When the unmarried, underage parent turns 18 on the first day of a month, the income of the self-supporting parents becomes exempt as of the first day of that month.
- w.* Incentive payments received from participation in the adolescent pregnancy prevention programs.

x. Payments received from the comprehensive child development program, funded by the Administration for Children, Youth, and Families, provided the payments are considered complimentary assistance by federal regulation.

y. Incentive allowance payments received from the work force investment project, provided the payments are considered complimentary assistance by federal regulation.

z. Interest and dividend income.

aa. Rescinded IAB 10/4/00, effective 10/1/00.

ab. Honorarium income. All moneys paid to an eligible household in connection with the welfare reform demonstration longitudinal study or focus groups shall be exempted.

ac. Income that an individual contributes to a trust as specified at paragraph 75.24(3) "b" shall not be considered for purposes of determining eligibility for the family medical assistance program (FMAP) or FMAP-related Medicaid coverage groups.

ad. Benefits paid to the eligible household under the family investment program (FIP).

ae. Moneys received through the pilot self-sufficiency grants program or through the pilot diversion program.

af. Earnings from new employment of any person whose income is considered when determining eligibility during the first four calendar months of the new employment. The date the new employment or self-employment begins shall be verified before approval of the exemption. This four-month period shall be referred to as the work transition period (WTP).

(1) The exempt period starts the first day of the month in which the client receives the first pay from the new employment and continues through the next three benefit months, regardless if the job ends during the four-month period.

(2) To qualify for this disregard, the person shall not have earned more than \$1,200 in the 12 calendar months prior to the month in which the new job begins, the income must be reported timely in accordance with rule 441—76.10(249A), and the new job must have started after the date the application is filed. For purposes of this policy, the \$1,200 earnings limit applies to the gross amount of income without any allowance for exemptions, disregards, work deductions, diversions, or the costs of doing business used in determining net profit from any income test in rule 441—75.57(249A).

(3) If another new job or self-employment enterprise starts while a WTP is in progress, the exemption shall also be applied to earnings from the new source that are received during the original 4-month period, provided that the earnings were less than \$1,200 in the 12-month period before the month the other new job or self-employment enterprise begins.

(4) An individual is allowed the 4-month exemption period only once in a 12-month period. An additional 4-month exemption shall not be granted until the month after the previous 12-month period has expired.

(5) If a person whose income is considered enters the household, the new job must start after the date the person enters the home or after the person is reported in the home, whichever is later, in order for that person to qualify for the exemption.

(6) When a person living in the home whose income is not considered subsequently becomes an assistance unit member whose income is considered, the new job must start after the date of the change that causes the person's income to be considered in order for that person to qualify for the exemption.

(7) A person who begins new employment or self-employment that is intermittent in nature may qualify for the WTP. "Intermittent" includes, but is not limited to, working for a temporary agency that places the person in different job assignments on an as-needed or on-call basis, or self-employment from providing child care for one or more families. However, a person is not considered as starting new employment or self-employment each time intermittent employment restarts or changes such as when the same temporary agency places the person in a new assignment or a child care provider acquires another child care client.

ag. Payments from property sold under an installment contract as specified in paragraphs 75.56(4) "b" and 75.57(1) "d."

ah. All census earnings received by temporary workers from the Bureau of the Census.

ai. Payments received through participation in the preparation for adult living program pursuant to 441—Chapter 187.

75.57(8) *Treatment of income in excluded parent cases, stepparent cases, and underage parent cases.*

a. *Treatment of income in excluded parent cases.* A parent who is living in the home with the eligible children but who is not eligible for Medicaid is eligible for the 20 percent earned income deduction, child care expenses for children in the eligible group, the 58 percent work incentive disregard described at paragraphs 75.57(2) “a,” “b,” and “c,” and diversions described at subrule 75.57(4). All remaining nonexempt income of the parent shall be applied against the needs of the eligible group.

b. *Treatment of income in stepparent cases.* The income of a stepparent who is not included in the eligible group but who is living with the parent in the home of an eligible child shall be given the same consideration and treatment as that of a parent subject to the limitations of subparagraphs (1) through (10) below.

(1) The stepparent’s monthly gross nonexempt earned income, earned as an employee or monthly net profit from self-employment, shall receive a 20 percent earned income deduction.

(2) The stepparent’s monthly nonexempt earned income remaining after the 20 percent earned income deduction shall be allowed child care expenses for the stepparent’s ineligible dependents in the home, subject to the restrictions described at subparagraphs 75.57(2) “b”(1) through (5).

(3) Any amounts actually paid by the stepparent to individuals not living in the home, who are claimed or could be claimed by the stepparent as dependents for federal income tax purposes, shall be deducted from nonexempt monthly earned and unearned income of the stepparent.

(4) The stepparent shall also be allowed a deduction from nonexempt monthly earned and unearned income for alimony and child support payments made to individuals not living in the home with the stepparent.

(5) Except as described at subrule 75.57(10), the nonexempt monthly earned and unearned income of the stepparent remaining after application of the deductions at subparagraphs 75.57(8) “b”(1) through (4) above shall be used to meet the needs of the stepparent and the stepparent’s dependents living in the home, when the dependents’ needs are not included in the eligible group and the stepparent claims or could claim the dependents for federal income tax purposes. These needs shall be determined in accordance with the schedule of needs for a family group of the same composition in accordance with subrule 75.58(2).

(6) The stepparent shall be allowed the 58 percent work incentive disregard from monthly earnings. The disregard shall be applied to earnings that remain after all other deductions at subparagraphs 75.57(8) “b”(1) through (5) have been subtracted from the earnings. However, the work incentive disregard is not allowed when determining initial eligibility as described at subparagraphs 75.57(9) “a”(2) and (3).

(7) The deductions described in subparagraphs (1) through (6) shall first be subtracted from earned income in the same order as they appear above.

When the stepparent has both nonexempt earned and unearned income and earnings are less than the allowable deductions, then any remaining portion of the deductions in subparagraphs (3) through (5) shall be subtracted from unearned income. Any remaining income shall be applied as unearned income to the needs of the eligible group.

If the stepparent has earned income remaining after allowable deductions, then any nonexempt unearned income shall be added to the earnings and the resulting total counted as unearned income to the needs of the eligible group.

(8) A nonexempt, nonrecurring lump sum received by a stepparent shall be considered as income and counted in computing eligibility in the same manner as it would be treated for a parent. Any portion of the nonrecurring lump sum retained by the stepparent in the month following the month of receipt shall be considered a resource to the stepparent if that portion is not exempted according to paragraph 75.56(1) “f.”

(9) When the income of the stepparent, not in the eligible group, is insufficient to meet the needs of the stepparent and the stepparent’s dependents living in the home who are not eligible for FMAP-related

Medicaid, the income of the parent may be diverted to meet the unmet needs of the children of the current marriage except as described at subrule 75.57(10).

(10) When the needs of the stepparent, living in the home, are not included in the eligible group, the eligible group and any children of the parent living in the home who are not eligible for FMAP-related Medicaid shall be considered as one unit, and the stepparent and the stepparent's dependents, other than the spouse, shall be considered a separate unit.

(11) Rescinded IAB 6/30/99, effective 9/1/99.

c. Treatment of income in underage parent cases. In the case of a dependent child whose unmarried parent is under the age of 18 and living in the same home as the unmarried, underage parent's own self-supporting parents, the income of each self-supporting parent shall be considered available to the eligible group after appropriate deductions unless the provisions of rule 441—75.59(249A) apply. The deductions to be applied are the same as are applied to the income of a stepparent pursuant to subparagraphs 75.57(8)“b”(1) through (7). Child care expenses at subparagraph 75.57(8)“b”(2) shall be allowed for the self-supporting parent's ineligible children. Nonrecurring lump sum income received by the self-supporting parent(s) shall be treated in accordance with subparagraph 75.57(8)“b”(8).

When the self-supporting spouse of a self-supporting parent is also living in the home, the income of that spouse shall be attributable to the self-supporting parent in the same manner as the income of a stepparent is determined pursuant to subparagraphs 75.57(8)“b”(1) through (7) unless the provisions of rule 441—75.59(249A) apply. Child care expenses at subparagraph 75.57(8)“b”(2) shall be allowed for the ineligible dependents of the self-supporting spouse who is a stepparent of the minor parent. Nonrecurring lump sum income received by the spouse of the self-supporting parent shall be treated in accordance with subparagraph 75.57(8)“b”(8). The self-supporting parent and any ineligible dependents of that person shall be considered as one unit. The self-supporting spouse and the spouse's ineligible dependents, other than the self-supporting parent, shall be considered a separate unit.

75.57(9) Budgeting process.

a. Initial and ongoing eligibility. Both initial and ongoing eligibility shall be based on a projection of income based on the best estimate of future income.

(1) Upon application, the department shall use all earned and unearned income received by the eligible group to project future income. Allowable work expenses shall be deducted from earned income, except in determining eligibility under the 185 percent test defined at rule 441—75.57(249A). The determination of initial eligibility is a three-step process as described at rule 441—75.57(249A).

(2) Test 1. When countable gross nonexempt earned and unearned income exceeds 185 percent of the schedule of living costs (Test 1), as identified at subrule 75.58(2) for the eligible group, eligibility does not exist under any coverage group for which these income tests apply. Countable gross income means nonexempt gross income, as defined at rule 441—75.57(249A), without application of any disregards, deductions, or diversions.

(3) Test 2. When the countable gross nonexempt earned and unearned income equals or is less than 185 percent of the schedule of living costs for the eligible group, initial eligibility under the schedule of living costs (Test 2) shall then be determined. Initial eligibility under the schedule of living costs is determined without application of the 58 percent work incentive disregard as specified at paragraph 75.57(2)“c.” All other appropriate exemptions, deductions and diversions are applied. Countable income is then compared to the schedule of living costs (Test 2) for the eligible group. When countable net earned and unearned income equals or exceeds the schedule of living costs for the eligible group, eligibility does not exist under any coverage group for which these income tests apply.

(4) Test 3. After application of Tests 1 and 2 for initial eligibility or of Test 1 for ongoing eligibility, the 58 percent work incentive disregard at paragraph 75.57(2)“c” shall be applied when there is eligibility for this disregard. When countable net earned and unearned income, after application of the work incentive disregard and all other appropriate exemptions, deductions, and diversions, equals or exceeds the schedule of basic needs (Test 3) for the eligible group, eligibility does not exist under any coverage group for which these tests apply. When the countable net income is less than the schedule of basic needs for the eligible group, the eligible group meets FMAP or CMAP income requirements.

(5) Rescinded IAB 10/4/00, effective 10/1/00.

(6) When income received weekly or biweekly (once every two weeks) is projected for future months, it shall be projected by adding all income received in the time period being used and dividing the result by the number of instances of income received in that time period. The result shall be multiplied by four if the income is received weekly, or by two if the income is received biweekly, regardless of the number of weekly or biweekly payments to be made in future months.

(7) Rescinded IAB 7/4/07, effective 8/1/07.

(8) When a change in circumstances that is required to be timely reported by the client pursuant to paragraphs 75.52(4) “d” and “e” is not reported as required, eligibility shall be redetermined beginning with the month following the month in which the change occurred. When a change in circumstances that is required to be reported by the client at annual review or upon the addition of an individual to the eligible group pursuant to paragraph 75.52(4) “c” is not reported as required, eligibility shall be redetermined beginning with the month following the month in which the change was required to be reported. All other changes shall be acted upon when they are reported or otherwise become known to the department, allowing for a ten-day notice of adverse action, if required.

b. Recurring lump-sum income. Recurring lump-sum earned and unearned income, except for the income of the self-employed, shall be prorated over the number of months for which the income was received and applied to the eligibility determination for the same number of months.

(1) Income received by an individual employed under a contract shall be prorated over the period of the contract.

(2) Income received at periodic intervals or intermittently shall be prorated over the period covered by the income and applied to the eligibility determination for the same number of months. EXCEPTION: Periodic or intermittent income from self-employment shall be treated as described at paragraph 75.57(9) “i.”

(3) When the lump-sum income is earned income, appropriate disregards, deductions and diversions shall be applied to the monthly prorated income. Income is prorated when a recurring lump sum is received at any time.

c. Nonrecurring lump-sum income. Moneys received as a nonrecurring lump sum, except as specified in subrules 75.56(4) and 75.56(7) and at paragraphs 75.57(8) “b” and “c,” shall be treated in accordance with this rule. Nonrecurring lump-sum income includes an inheritance, an insurance settlement or tort recovery, an insurance death benefit, a gift, lottery winnings, or a retroactive payment of benefits, such as social security, job insurance, or workers’ compensation.

(1) Nonrecurring lump-sum income shall be considered as income in the month of receipt and counted in computing eligibility, unless the income is exempt.

(2) When countable income exclusive of any family investment program grant but including countable lump-sum income exceeds the needs of the eligible group under their current coverage group, the countable lump-sum income shall be prorated. The number of full months for which a monthly amount of the lump sum shall be counted as income in the eligibility determination is derived by dividing the total of the lump-sum income and any other countable income received in or projected to be received in the month the lump sum was received by the schedule of living costs, as identified at subrule 75.58(2), for the eligible group. This period is referred to as the period of proration. Any income remaining after this calculation shall be applied as income to the first month following the period of proration and disregarded as income thereafter.

(3) The period of proration shall begin with the month when the nonrecurring lump sum was received, whether or not the receipt of the lump sum was timely reported. If receipt of the lump sum was reported timely and the calculation was completed timely, no recoupment shall be made. If receipt of the lump sum was not reported timely or the calculation was not completed timely, recoupment shall begin with the month of receipt of the nonrecurring lump sum.

(4) The period of proration shall be shortened when:

1. The schedule of living costs as defined at subrule 75.58(2) increases; or
2. A portion of the lump sum is no longer available to the eligible group due to loss or theft or because the person controlling the lump sum no longer resides with the eligible group and the lump sum is no longer available to the eligible group; or

3. There is an expenditure of the lump sum made for the following circumstances unless there was insurance available to meet the expense: Payments made on medical services for the former eligible group or their dependents for services listed in 441—Chapters 78, 81, 82, and 85 at the time the expense is reported to the department; the cost of necessary repairs to maintain habitability of the homestead requiring the spending of over \$25 per incident; cost of replacement of exempt resources as defined in subrule 75.56(1) due to fire, tornado, or other natural disaster; or funeral and burial expenses. The expenditure of these funds shall be verified.

(5) When countable income, including the lump-sum income, is less than the needs of the eligible group in accordance with the provisions of their current coverage group, the lump sum shall be counted as income for the month of receipt.

(6) For purposes of applying the lump-sum provision, the eligible group is defined as all eligible persons and any other individual whose lump-sum income is counted in determining the period of proration.

(7) During the period of proration, individuals not in the eligible group when the lump-sum income was received may be eligible as a separate eligible group. Income of this eligible group plus income of the parent or other legally responsible person in the home, excluding the lump-sum income already considered, shall be considered as available in determining eligibility.

d. The third digit to the right of the decimal point in any calculation of income, hours of employment and work expenses for care, as defined at paragraph 75.57(2)“*b*,” shall be dropped.

e. In any month for which an individual is determined eligible to be added to a currently active family medical assistance (FMAP) or FMAP-related Medicaid case, the individual’s needs, income, and resources shall be included. An individual who is a member of the eligible group and who is determined to be ineligible for Medicaid shall be canceled prospectively effective the first of the following month if the timely notice of adverse action requirements as provided at 441—subrule 76.4(1) can be met.

f. Rescinded IAB 10/4/00, effective 10/1/00.

g. Rescinded IAB 2/11/98, effective 2/1/98.

h. Income from self-employment received on a regular weekly, biweekly, semimonthly or monthly basis shall be budgeted in the same manner as the earnings of an employee. The countable income shall be the net income.

i. Income from self-employment not received on a regular weekly, biweekly, semimonthly or monthly basis that represents an individual’s annual income shall be averaged over a 12-month period of time, even if the income is received within a short period of time during that 12-month period. Any change in self-employment shall be handled in accordance with subparagraphs (3) through (5) below.

(1) When a self-employment enterprise which does not produce a regular weekly, biweekly, semimonthly or monthly income has been in existence for less than a year, income shall be averaged over the period of time the enterprise has been in existence and the monthly amount projected for the same period of time. If the enterprise has been in existence for such a short time that there is very little income information, the worker shall establish, with the cooperation of the client, a reasonable estimate which shall be considered accurate and projected for three months, after which the income shall be averaged and projected for the same period of time. Any changes in self-employment shall be considered in accordance with subparagraphs (3) through (5) below.

(2) These policies apply when the self-employment income is received before the month of decision and the income is expected to continue, in the month of decision, after assistance is approved.

(3) A change in the cost of producing self-employment income is defined as an established permanent ongoing change in the operating expenses of a self-employment enterprise. Change in self-employment income is defined as a change in the nature of business.

(4) When a change in operating expenses occurs, the department shall recalculate the expenses on the basis of the change.

(5) When a change occurs in the nature of the business, the income and expenses shall be computed on the basis of the change.

75.57(10) *Restriction on diversion of income.* Rescinded IAB 7/11/01, effective 9/1/01.

75.57(11) *Divesting of income.* Assistance shall not be approved when an investigation proves that income was divested and the action was deliberate and for the primary purpose of qualifying for assistance or increasing the amount of assistance paid.

[ARC 8500B, IAB 2/10/10, effective 3/1/10; ARC 8556B, IAB 3/10/10, effective 2/10/10; ARC 9043B, IAB 9/8/10, effective 11/1/10]

441—75.58(249A) Need standards.

75.58(1) *Definition of eligible group.* The eligible group consists of all eligible persons specified below and living together, except when one or more of these persons have elected to receive supplemental security income under Title XVI of the Social Security Act or are voluntarily excluded in accordance with the provisions of rule 441—75.59(249A). There shall be at least one child, which may be an unborn child, in the eligible group except when the only eligible child is receiving supplemental security income.

a. The following persons shall be included (except as otherwise provided in these rules) without regard to the person's employment status, income or resources:

- (1) All dependent children who are siblings of whole or half blood or adoptive.
- (2) Any parent of such children, if the parent is living in the same home as the dependent children.

b. The following persons may be included:

- (1) The needy specified relative who assumes the role of parent.
- (2) The needy specified relative who acts as caretaker when the parent is in the home but is unable to act as caretaker.

(3) An incapacitated stepparent, upon request, when the stepparent is the legal spouse of the parent by ceremonial or common-law marriage and the stepparent does not have a child in the eligible group.

1. A stepparent is considered incapacitated when a clearly identifiable physical or mental defect has a demonstrable effect upon earning capacity or the performance of the homemaking duties required to maintain a home for the stepchild. The incapacity shall be expected to last for a period of at least 30 days from the date of application.

2. The determination of incapacity shall be supported by medical or psychological evidence. The evidence may be submitted either by letter from the physician or on Form 470-0447, Report on Incapacity.

3. When an examination is required and other resources are not available to meet the expense of the examination, the physician shall be authorized to make the examination and submit the claim for payment on Form 470-0502, Authorization for Examination and Claim for Payment.

4. A finding of eligibility for social security benefits or supplemental security income benefits based on disability or blindness is acceptable proof of incapacity for the family medical assistance program (FMAP) and FMAP-related program purposes.

5. A stepparent who is considered incapacitated and is receiving Medicaid shall be referred to the department of education, division of vocational rehabilitation services, for evaluation and services. Acceptance of these services is optional.

(4) The stepparent who is not incapacitated when the stepparent is the legal spouse of the parent by ceremonial or common-law marriage and the stepparent is required in the home to care for the dependent children. These services must be required to the extent that if the stepparent were not available, it would be necessary to allow for care as a deduction from earned income of the parent.

75.58(2) *Schedule of needs.* The schedule of living costs represents 100 percent of the basic needs. The schedule of living costs is used to determine the needs of individuals when these needs must be determined in accordance with the schedule of needs defined at rule 441—75.50(249A). The 185 percent schedule is included for the determination of eligibility in accordance with rule 441—75.57(249A). The schedule of basic needs is used to determine the basic needs of those persons whose needs are included in the eligible group. The eligible group is considered a separate and distinct group without regard to the presence in the home of other persons, regardless of relationship to or whether they have a liability to support members of the eligible group. The schedule of basic needs is also used to determine the needs of persons not included in the eligible group. The percentage of basic needs paid to one or more persons as compared to the schedule of living costs is shown on the chart below:

SCHEDULE OF NEEDS

Number of Persons	1	2	3	4	5	6	7	8	9	10	Each Additional Person
Test 1 185% of Living Costs	675.25	1330.15	1570.65	1824.10	2020.20	2249.60	2469.75	2695.45	2915.60	3189.40	320.05
Test 2 Schedule of Living Costs	365	719	849	986	1092	1216	1335	1457	1576	1724	173
Test 3 Schedule of Basic Needs	183	361	426	495	548	610	670	731	791	865	87
Ratio of Basic Needs to Living Costs	50.18	50.18	50.18	50.18	50.18	50.18	50.18	50.18	50.18	50.18	50.18

CHART OF BASIC NEEDS COMPONENTS

(all figures are on a per person basis)

Number of Persons	1	2	3	4	5	6	7	8	9	10 or More
Shelter	77.14	65.81	47.10	35.20	31.74	26.28	25.69	22.52	20.91	20.58
Utilities	19.29	16.45	11.77	8.80	7.93	6.57	6.42	5.63	5.23	5.14
Household Supplies	4.27	5.33	4.01	3.75	3.36	3.26	3.10	3.08	2.97	2.92
Food	34.49	44.98	40.31	39.11	36.65	37.04	34.00	33.53	32.87	32.36
Clothing	11.17	11.49	8.70	8.75	6.82	6.84	6.54	6.39	6.20	6.10
Pers. Care & Supplies	3.29	3.64	2.68	2.38	2.02	1.91	1.82	1.72	1.67	1.64
Med. Chest Supplies	.99	1.40	1.34	1.13	1.15	1.11	1.08	1.06	1.09	1.08
Communications	7.23	6.17	3.85	3.25	2.50	2.07	1.82	1.66	1.51	1.49
Transportation	25.13	25.23	22.24	21.38	17.43	16.59	15.24	15.79	15.44	15.19

- a.* The definitions of the basic need components are as follows:
- (1) Shelter: Rental, taxes, upkeep, insurance, amortization.
 - (2) Utilities: Fuel, water, lights, water heating, refrigeration, garbage.
 - (3) Household supplies and replacements: Essentials associated with housekeeping and meal preparation.
 - (4) Food: Including school lunches.
 - (5) Clothing: Including layette, laundry, dry cleaning.
 - (6) Personal care and supplies: Including regular school supplies.
 - (7) Medicine chest items.
 - (8) Communications: Telephone, newspapers, magazines.
 - (9) Transportation: Including bus fares.
- b.* Special situations in determining eligible group:
- (1) The needs of a child or children in a nonparental home shall be considered a separate eligible group when the relative is receiving Medicaid for the relative's own children.

(2) When the unmarried specified relative under the age of 19 is living in the same home with a parent or parents who receive Medicaid, the needs of the specified relative, when eligible, shall be included in the same eligible group with the parents. When the specified relative is a parent, the needs of the eligible children for whom the unmarried parent is caretaker shall be included in the same eligible group. When the specified relative is a nonparental relative, the needs of the eligible children for whom the specified relative is caretaker shall be considered a separate eligible group.

When the unmarried specified relative under the age of 19 is living in the same home as a parent who receives Medicaid but the specified relative is not an eligible child, need of the specified relative shall be determined in the same manner as though the specified relative had attained majority.

When the unmarried specified relative under the age of 19 is living with a nonparental relative or in an independent living arrangement, need shall be determined in the same manner as though the specified relative had attained majority.

When the unmarried specified relative is under the age of 18 and living in the same home with a parent who does not receive Medicaid, the needs of the specified relative, when eligible, shall be included in the eligible group with the children when the specified relative is a parent. When the specified relative is a nonparental relative as defined at subrule 75.55(1), only the needs of the eligible children shall be included in the eligible group. When the unmarried specified relative is aged 18, need shall be determined in the same manner as though the specified relative had attained majority.

(3) When a person who would ordinarily be in the eligible group has elected to receive supplemental security income benefits, the person, income and resources shall not be considered in determining eligibility for the rest of the family.

(4) When two individuals, married to each other, are living in a common household and the children of each of them are recipients of Medicaid, the eligibility shall be computed on the basis of their comprising one eligible group.

(5) When a child is ineligible for Medicaid, the income and resources of that child are not used in determining eligibility of the eligible group and the ineligible child is not a part of the household size. However, the income and resources of a parent who is ineligible for Medicaid are used in determining eligibility of the eligible group and the ineligible parent is counted when determining household size.

441—75.59(249A) Persons who may be voluntarily excluded from the eligible group when determining eligibility for the family medical assistance program (FMAP) and FMAP-related coverage groups.

75.59(1) Exclusions from the eligible group. In determining eligibility under the family medical assistance program (FMAP) or any FMAP-related Medicaid coverage group in this chapter, the following persons may be excluded from the eligible group when determining Medicaid eligibility of other household members.

- a. Siblings (of whole or half blood, or adoptive) of eligible children.
- b. Self-supporting parents of minor unmarried parents.
- c. Stepparents of eligible children.
- d. Children living with a specified relative, as listed at subrule 75.55(1).

75.59(2) Needs, income, and resource exclusions. The needs, income, and resources of persons who are voluntarily excluded shall also be excluded. If a self-supporting parent of a minor unmarried parent is voluntarily excluded, then the minor unmarried parent shall not be counted in the household size when determining eligibility for the minor unmarried parent's child. However, the income and resources of the minor unmarried parent shall be used in determining eligibility for the unmarried minor parent's child. If a stepparent is voluntarily excluded, the natural or adoptive parent shall not be counted in the household size when determining eligibility for the natural or adoptive parent's children. However, the income and resources of the natural or adoptive parent shall be used in determining eligibility for the natural or adoptive parent's children.

75.59(3) Medicaid entitlement. Persons whose needs are voluntarily excluded from the eligibility determination shall not be entitled to Medicaid under this or any other coverage group.

75.59(4) *Situations where parent's needs are excluded.* In situations where the parent's needs are excluded but the parent's income and resources are considered in the eligibility determination (e.g., minor unmarried parent living with self-supporting parents), the excluded parent shall be allowed the earned income deduction, child care expenses and the work incentive disregard as provided at paragraphs 75.57(2) "a," "b," and "c."

75.59(5) *Situations where child's needs, income, and resources are excluded.* In situations where the child's needs, income, and resources are excluded from the eligibility determination pursuant to subrule 75.59(1), and the child's income is not sufficient to meet the child's needs, the parent shall be allowed to divert income to meet the unmet needs of the excluded child. The maximum amount to be diverted shall be the difference between the schedule of basic needs of the eligible group with the child included and the schedule of basic needs with the child excluded, in accordance with the provisions of subrule 75.58(2), minus any countable income of the child.

441—75.60(249A) Pending SSI approval. When a person who would ordinarily be in the eligible group has applied for supplemental security income benefits, the person's needs may be included in the eligible group pending approval of supplemental security income.

441—75.61 to 75.69 Reserved.

DIVISION III
FINANCIAL ELIGIBILITY BASED ON MODIFIED ADJUSTED GROSS INCOME (MAGI)

441—75.70(249A) Financial eligibility based on modified adjusted gross income (MAGI). Notwithstanding any other provision of this chapter, effective January 1, 2014, financial eligibility for medical assistance shall be determined using "modified adjusted gross income" (MAGI) and "household income" pursuant to 42 U.S.C. § 1396a(e)(14), to the extent required by that section as a condition of federal funding under Title XIX of the Social Security Act. For this purpose, financial eligibility for medical assistance includes any applicable purpose for which a determination of income is required, including the imposition of any premiums or cost sharing.

[**ARC 1134C**, IAB 10/30/13, effective 10/2/13; **ARC 1212C**, IAB 12/11/13, effective 1/1/14; **ARC 1356C**, IAB 3/5/14, effective 4/9/14; **ARC 3354C**, IAB 10/11/17, effective 10/1/17; **ARC 3550C**, IAB 1/3/18, effective 2/7/18]

441—75.71(249A) Income limits. Notwithstanding any other provision of this chapter, effective January 1, 2014, the following income limits apply to the following coverage groups, as identified by the legal references provided:

Coverage Group	Legal Reference	Household Size (persons)	Income Limit (per month)
Family Medical Assistance Program and Child Medical Assistance Program	441—subrule 75.1(14) and 441—subrule 75.1(15); 42 CFR Part 435.110; Title XIX of the Social Security Act, Section 1931	1	\$447
		2	\$716
		3	\$872
		4	\$1,033
		5	\$1,177
		6	\$1,330
		7	\$1,481
		8	\$1,633
		9	\$1,784
		10	\$1,950
			over 10
Mothers and Children, for pregnant women and for infants under one year of age	441—subrule 75.1(28); 42 CFR Part 435.116; Title XIX of the Social Security Act, Section 1902		375% of the federal poverty level for the household
Mothers and Children, for children aged 1 through 18 years	441—subrule 75.1(28); 42 CFR Part 435.116; Title XIX of the Social Security Act, Section 1902		167% of the federal poverty level for the household
Medicaid for Independent Young Adults	441—subrule 75.1(42); Title XIX of the Social Security Act, Section 1902(a)(10)(A)(ii)(VII)		254% of the federal poverty level for the household

[ARC 1134C, IAB 10/30/13, effective 10/2/13; ARC 1212C, IAB 12/11/13, effective 1/1/14; ARC 1356C, IAB 3/5/14, effective 4/9/14]

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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.

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.

[ARC 0485C, IAB 12/12/12, effective 2/1/13]

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.

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.

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.

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.

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.

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.

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.

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).

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
6. Iowa Administrative Code 441—Chapter 24, “Accreditation of Providers of Services to Persons with Mental Illness, Intellectual Disabilities, or Developmental Disabilities.”

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

[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]

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).

441—77.22(249A) Psychologists. 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.

This rule is intended to implement Iowa Code sections 249A.4 and 249A.15.
[ARC 2165C, IAB 9/30/15, effective 12/1/15]

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.

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.

“Guardian” means a guardian appointed in probate or juvenile court.

“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.

“*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.

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 adult 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.
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 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. The following providers may provide day habilitation:

a. 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).

b. 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 paragraph “*a*,” “*d*,” “*g*,” or “*h*.”

c. 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.

d. An agency that is accredited by the Council on Quality and Leadership in Supports for People with Disabilities.

e. 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.

f. An agency that is accredited under 441—Chapter 24 to provide day treatment or supported community living services.

g. An agency that is certified by the department to provide day habilitation services under the home- and community-based services intellectual disability waiver pursuant to rule 441—77.37(249A).

- h.* An agency that is accredited by the International Center for Clubhouse Development.
- i.* An agency that is accredited by the Joint Commission on Accreditation of Healthcare Organizations.

77.25(8) Home-based habilitation. The following agencies may provide home-based habilitation services:

- a.* 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).
- b.* An agency that is accredited under 441—Chapter 24 to provide supported community living services.
- c.* An agency that is accredited by the Commission on Accreditation of Rehabilitation Facilities as a community housing or supported living service provider.
- d.* An agency that is accredited by the Council on Quality and Leadership in Supports for People with Disabilities.
- e.* An agency that is accredited by the Council on Accreditation of Services for Families and Children.
- f.* An agency that is accredited by the Joint Commission on Accreditation of Healthcare Organizations.

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.

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]

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) 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(3) 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(4) 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(5) 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.

This rule is intended to implement Iowa Code chapter 249A as amended by 2011 Iowa Acts, Senate File 233.

[ARC 9649B, IAB 8/10/11, effective 8/1/11]

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 282—subrule 27.3(3);

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.

[ARC 3184C, IAB 7/5/17, effective 8/9/17]

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.

d. The provider of self-directed personal care 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(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.

(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 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.

d. Rescinded IAB 3/10/99, effective 5/1/99.

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 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 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.

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.

77.34(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.
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 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.

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.

77.37(3) *Contracts with consumers.* The provider shall have written procedures which provide for the establishment of an agreement between the consumer and the provider.

a. The agreement shall define the responsibilities of the provider and the consumer, the rights of the consumer, the services to be provided to the consumer by the provider, all room and board and copay fees to be charged to the consumer and the sources of payment.

b. Contracts shall be reviewed at least annually.

77.37(4) *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.

77.37(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.

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.

77.37(9) 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. 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.

b. The provider shall ensure the rights of persons applying for services.

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.

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.

77.37(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 the mentally retarded, and hospitals enrolled as providers in the Iowa Medicaid program.

(3) Residential care facilities for persons with mental retardation 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.

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.

77.37(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 mentally retarded children 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 mental retardation and developmental disabilities services and children's mental health issues. Identification and reporting of child abuse shall be covered in training at least every five 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 service 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.

4. 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:

a. Agencies accredited by the Commission on Accreditation of Rehabilitation Facilities to provide services that qualify as day habilitation under 441—subrule 78.41(14).

b. Agencies accredited by the Commission on Accreditation of Rehabilitation Facilities to provide other services that began providing services that qualify as day habilitation under 441—subrule 78.41(14) since their 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 paragraph “*a*” or “*d*.”

c. Agencies not accredited by the Commission on Accreditation of Rehabilitation Facilities that have applied to the Commission within the last 12 months for accreditation to provide services that qualify as day habilitation under 441—subrule 78.41(14). An agency that has not received accreditation within 12 months after application to the Commission is no longer a qualified provider.

d. Agencies accredited by the Council on Quality and Leadership.

e. Agencies that have applied to the Council on Quality and Leadership 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.

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]

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 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).

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).

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.

(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.

77.39(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 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 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]

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]

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]

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 designated provider may participate in the medical assistance program as a provider of health home services.

77.47(1) Qualifications. A designated provider of health home services must be a Medicaid-enrolled entity or provider that is determined through the provider enrollment process to have the systems and infrastructure in place to provide health home services.

a. Staffing. At a minimum, a qualifying provider must fill the following roles:

(1) Designated practitioner.

(2) Dedicated care coordinator.

(3) Health coach.

(4) Clinic support staff.

b. Data management. A qualifying provider shall ensure that all clinical data related to the member are maintained with the member’s medical records through the use of health information technology.

c. Collaboration with case managers. Health homes providing services to members eligible pursuant to 441—subparagraph 78.53(2)“a”(1) or (2) must collaborate, at least quarterly, with targeted case managers, other case managers, or DHS service workers for each member receiving case management services. Strategies to prevent duplication of coordination efforts by the health home and case managers or service workers must be developed by the health home and documented upon request. Documentation may include but is not limited to records of joint staffing meetings where a member’s medical needs, current activities, and waiver services needs are reviewed and appropriately updated.

d. Provision of integrated health home services. Health homes providing services to members eligible pursuant to 441—subparagraph 78.53(2)“a”(3) or (4) must be integrated health homes that:

(1) Consist of a team of health care professionals trained in providing health home services to members with a serious mental illness (SMI) and to members with a serious emotional disturbance (SED);

(2) Have a direct agreement with an Iowa Medicaid managed care organization to provide health home services for members with SMI or SED;

(3) Coordinate all community and social support services needs for members enrolled in the health home; and

(4) Follow a system of care model in providing health home services to members with SED, including collaboration with the child welfare, public health, juvenile justice, and education systems.

77.47(2) Report on quality measures. As a condition of participation in the medical assistance program as a provider of health home services and of receiving payment for health home services provided, a designated provider must report to the Iowa Medicaid enterprise on measures for determining the quality of such services. When appropriate and feasible, a designated provider shall use health information technology in providing the Iowa Medicaid enterprise with such information.

77.47(3) Selection. As a condition of payment for health home services provided to a Medicaid member eligible to receive such services pursuant to 441—subrule 78.53(2), a designated provider must be selected by the member as the member's health home, as reported by provider attestation.

This rule is intended to implement Iowa Code section 249A.4 and 2011 Iowa Acts, chapter 129, section 10.

[ARC 0198C, IAB 7/11/12, effective 7/1/12; ARC 0838C, IAB 7/24/13, effective 7/1/13; ARC 2361C, IAB 1/6/16, effective 1/1/16]

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 0360C, 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. Enrollment is for the purpose of providing professional services for Medicaid members including orders and referrals, as required under Public Law 111-148, Section 6401, otherwise known as the Patient Protection and Affordable Care Act (PPACA). Enrollment will not affect the provider's payment arrangements with 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—77.50(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.

[ARC 1698C, IAB 10/29/14, effective 1/1/15; ARC 2361C, IAB 1/6/16, effective 1/1/16]

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.

(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 or have other 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.
4. Behavioral supports and identification of antecedent triggers.
5. Health and medication management.
6. Dietary and nutritional programming.
7. Assistance with identifying and utilizing assistive technology.
8. Substance abuse and addiction issues.
9. Self-management and self-interaction skills.
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 cardiopulmonary resuscitation (CPR) training, a first-aid course, fire prevention and reaction training and universal precautions training. These training courses shall be completed no less than annually.

d. Within the first six months of commencement of direct service provision, employees shall complete training required by 441—subparagraph 78.54(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.

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 481—subrule 63.23(4), rule 481—63.33(135C), and rule 481—63.37(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. Restraint, 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.

[ARC 2341C, IAB 1/6/16, effective 2/10/16]

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.

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¹ Two ARCs

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

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

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

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

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

78.1(1) Payment will not be made for:

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

b. Routine physical examinations. Rescinded IAB 8/1/07, effective 8/1/07.

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

d. Acupuncture treatments.

e. Rescinded 9/6/78.

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

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

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

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

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

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

(1) Colostomy and ileostomy appliances.

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

(3) Disposable irrigation trays or sets.

(4) Disposable catheterization trays or sets.

(5) Indwelling Foley catheter.

(6) Disposable saline enemas.

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

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

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

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

f. Nonprescription drugs. Rescinded IAB 1/30/08, effective 4/1/08.

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

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

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

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

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

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

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

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

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

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

(1) Correction of a congenital anomaly; or

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

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

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

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

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

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

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

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

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

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

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

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

(3) Augmentation mammoplasties.

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

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

(6) Panniculectomy and body sculpture procedures.

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

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

(9) Chemical peeling for facial wrinkles.

(10) Dermabrasion of the face.

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

(12) Removal of tattoos.

(13) Hair transplants.

(14) Electrolysis.

(15) Sex reassignment.

(16) Penile implant procedures.

(17) Insertion of prosthetic testicles.

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

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

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

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

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

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

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

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

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

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

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

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

78.1(11) Rescinded, effective 8/1/87.

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

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

a. Auxiliary personnel are nurses, physician's assistants, psychologists, social workers, audiologists, occupational therapists and physical therapists.

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

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

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

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

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

A physician assistant licensed under board of physician assistants' professional licensure rules in 645—Chapter 325 is exempt from the direct personal supervision requirement but the physician must still provide general supervision and be available to provide immediate needed assistance by telephone. Physician assistants who prescribe drugs and medical devices are subject to the guidelines in effect for physicians as specified in rule 441—78.1(249A).

d. Services incident to the professional services of the physician means the service provided by the auxiliary person must be related to the physician's professional service to the member. If the physician

has not or will not perform a personal professional service to the member, the clinical records must document that the physician assigned treatment of the member to the auxiliary person.

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

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

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

a. The following definitions are pertinent to this subrule:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

f. At least 30 days and not more than 180 days shall have elapsed following the signing of the informed consent except in the case of premature delivery or emergency abdominal surgery which occurs

not less than 72 hours after the informed consent was signed. The informed consent shall have been signed at least 30 days before the expected delivery date for premature deliveries.

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

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

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

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

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

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

(1) The individual or representative has signed an acknowledgment that she has been informed orally and in writing from the person authorized to perform the hysterectomy that the hysterectomy will make the individual permanently incapable of reproducing, or

(2) The individual was already sterile before the hysterectomy, the physician has certified in writing that the individual was already sterile at the time of the hysterectomy and has stated the cause of the sterility, or

(3) The hysterectomy was performed as a result of a life-threatening emergency situation in which the physician determined that prior acknowledgment was not possible and the physician includes a description of the nature of the emergency.

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

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

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

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

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

78.1(18) Payment and procedure for obtaining eyeglasses, contact lenses, and visual aids, shall be the same as described in 441—78.6(249A). (Cross reference 78.28(3))

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

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

78.1(20) Transplants.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

78.1(23) EPSDT care coordination. Rescinded IAB 12/3/08, effective 2/1/09.

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

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

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

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

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

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]

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

78.2(1) Qualified prescriber. All drugs are covered only if prescribed by a legally qualified practitioner (physician, dentist, podiatrist, optometrist, physician assistant, or advanced registered nurse

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

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

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

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

a. Prior authorization is required as specified in the preferred drug list published by the department pursuant to Iowa Code section 249A.20A as amended by 2010 Iowa Acts, Senate File 2088, section 347.

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

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

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

1. Has on file with the department current contact information, including a current fax number, and a signed Form 470-4914, Fax Confidentiality Certificate, and
2. Does not receive a notice of approval or disapproval within 48 hours of a request for prior authorization.

b. Payment is not made for:

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

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

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

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

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

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

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

(8) Drugs prescribed for fertility purposes, except when prescribed for a medically accepted indication other than infertility, as defined in subparagraph (1).

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

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

(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 325 mg, 650 mg, 81 mg (chewable)
Aspirin tablets, enteric coated 325 mg, 650 mg, 81 mg
Aspirin tablets, buffered 325 mg
Bacitracin ointment 500 units/gm
Benzoyl peroxide 5%, gel, lotion
Benzoyl peroxide 10%, gel, lotion
Calcium carbonate chewable tablets 500 mg, 750 mg, 1000 mg, 1250 mg
Calcium carbonate suspension 1250 mg/5 ml
Calcium carbonate tablets 600 mg
Calcium carbonate-vitamin D tablets 500 mg-200 units
Calcium carbonate-vitamin D tablets 600 mg-200 units
Calcium citrate tablets 950 mg (200 mg elemental calcium)
Calcium gluconate tablets 650 mg
Calcium lactate tablets 650 mg
Cetirizine hydrochloride liquid 1 mg/ml
Cetirizine hydrochloride tablets 5 mg
Cetirizine hydrochloride tablets 10 mg
Chlorpheniramine maleate tablets 4 mg
Clotrimazole vaginal cream 1%
Diphenhydramine hydrochloride capsules 25 mg
Diphenhydramine hydrochloride elixir, liquid, and syrup 12.5 mg/5 ml
Epinephrine racemic solution 2.25%
Ferrous sulfate tablets 325 mg
Ferrous sulfate elixir 220 mg/5 ml
Ferrous sulfate drops 75 mg/0.6 ml
Ferrous gluconate tablets 325 mg
Ferrous fumarate tablets 325 mg
Guaiifenesin 100 mg/5 ml with dextromethorphan 10 mg/5 ml liquid
Ibuprofen suspension 100 mg/5 ml
Ibuprofen tablets 200 mg
Insulin
Lactic acid (ammonium lactate) lotion 12%
Loperamide hydrochloride liquid 1 mg/5 ml
Loperamide hydrochloride tablets 2 mg
Loratadine syrup 5 mg/5 ml
Loratadine tablets 10 mg
Magnesium hydroxide suspension 400 mg/5 ml

Magnesium oxide capsule 140 mg (85 mg elemental magnesium)
 Magnesium oxide tablets 400 mg
 Meclizine hydrochloride tablets 12.5 mg, 25 mg oral and chewable
 Miconazole nitrate cream 2% topical and vaginal
 Miconazole nitrate vaginal suppositories, 100 mg
 Multiple vitamin and mineral products with prior authorization
 Neomycin-bacitracin-polymyxin ointment
 Niacin (nicotinic acid) tablets 50 mg, 100 mg, 250 mg, 500 mg
 Nicotine gum 2 mg, 4 mg
 Nicotine 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
 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 and dispensed.*

a. When it is not therapeutically contraindicated, the legally qualified practitioner shall prescribe a quantity of prescription medication sufficient for up to a 31-day supply. Oral contraceptives may be prescribed in 90-day quantities.

b. Oral solid forms of covered nonprescription items shall be prescribed and dispensed in a minimum quantity of 100 units per prescription or the currently available consumer package size except when dispensed via a unit-dose system.

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

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

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

[ARC 8097B, IAB 9/9/09, effective 11/1/09; ARC 9175B, IAB 11/3/10, effective 1/1/11; ARC 9699B, IAB 9/7/11, effective 9/1/11; ARC 9834B, IAB 11/2/11, effective 11/1/11; ARC 9882B, IAB 11/30/11, effective 1/4/12; ARC 9981B, IAB 2/8/12, effective 3/14/12; ARC 0305C, IAB 9/5/12, effective 11/1/12; ARC 0580C, IAB 2/6/13, effective 4/1/13; ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 2930C, IAB 2/1/17, effective 4/1/17]

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(5)) The criteria are available from the IME Medical Services Unit, 100 Army Post Road, Des Moines, Iowa 50315, or in local hospital utilization review offices. No payment will be made for waiver days.

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

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

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

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

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

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

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

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

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

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

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

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

78.3(8) Rescinded IAB 2/6/91, effective 4/1/91.

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

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

a. Recipient selection and education.

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

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

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

b. Staffing and resource commitment.

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

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

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

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

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

The team should consist of:

A surgeon director.

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

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

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

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

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

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

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

Anesthesiology.

Blood bank services.

Cardiology.

Cardiovascular surgery.

Dialysis.

Dietary services.

Gastroenterology.

Infection control.

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

Legal counsel familiar with transplantation laws and regulations.

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

Respiratory therapy.

Pharmaceutical services.

Physical therapy.

Psychiatry.

Psycho-social.

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

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

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

c. Experience and survival rates.

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

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

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

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

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

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

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

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

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

Risk and benefit.

Morbidity and mortality.

Long-term survival.

Quality of life.

Recipient demographic information.

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

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

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

Ongoing research regarding the transplanted organs is required.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

78.3(18) Preprocedure review by the IME medical services unit is required if hospitals are to be reimbursed for certain frequently performed surgical procedures as set forth under subrule 78.1(19). Preprocedure review is also required for other types of major surgical procedures, such as organ transplants. Criteria are available from the IME medical services unit. (Cross reference 78.28(5))

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

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

[**ARC 0065C**, IAB 4/4/12, effective 6/1/12; **ARC 0194C**, IAB 7/11/12, effective 7/1/12; **ARC 0354C**, IAB 10/3/12, effective 12/1/12; **ARC 0844C**, IAB 7/24/13, effective 7/1/13; **ARC 1054C**, IAB 10/2/13, effective 11/6/13; **ARC 2361C**, IAB 1/6/16, effective 1/1/16]

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

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

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

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

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

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

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

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

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

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

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

e. Single periapical films are payable when necessary.

f. Intraoral radiograph, occlusal.

g. Extraoral radiograph.

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

i. Temporomandibular joint radiograph.

j. Cephalometric film.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

b. Periodontal scaling and root planing is payable once every 24 months when prior approval has been received. Prior approval shall be granted per quadrant when radiographs demonstrate subgingival calculus or loss of crestal bone and when the periodontal probe chart shows evidence of pocket depths of 4 mm or greater. (Cross reference 78.28(2) “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(2) “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(2) “a”(3))

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

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

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

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

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

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

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

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

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

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

a. Extractions, both surgical and nonsurgical.

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

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

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

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

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

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

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

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

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

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

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

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

c. A removable partial denture replacing posterior teeth including six months' postdelivery care when prior approval has been received. Approval shall be granted when the member has fewer than eight posterior teeth in occlusion, excluding third molars, or the member has a full denture in one arch and a partial denture replacing posterior teeth is required in the opposing arch to balance occlusion. When one removable partial denture brings eight posterior teeth in occlusion, no additional removable partial denture will be approved. Six months' postdelivery care is included in the reimbursement for the denture. (Cross reference 78.28(2) "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(2) "b"(2))

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

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

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

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

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

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

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

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

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

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

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

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

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

a. Minor treatment to control harmful habits when prior approval has been received. Approval shall be granted when it is cost-effective to lessen the severity of a malformation such that extensive treatment is not required. (Cross reference 78.28(2) "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.

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]

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

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

a. Durable plantar foot orthotic.

b. Plaster impressions for foot orthotic.

c. Molded digital orthotic.

d. Shoe padding when appliances are not practical.

e. Custom molded space shoes for rheumatoid arthritis, congenital defects and deformities, neurotropic, diabetic and ischemic intractable ulcerations and deformities due to injuries.

f. Rams horn (hypertrophic) nails.

g. Onychomycosis (mycotic) nails.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(2) Gonioscopy.

(3) Extended ophthalmoscopy. Routine ophthalmoscopy is part of the intermediate and comprehensive examination and is not payable as a separate procedure. Generally, extended

ophthalmoscopy is considered to be part of the comprehensive examination and, if performed in conjunction with that level of service, is not payable as a separate procedure.

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

(5) External photography.

(6) Fundus photography.

(7) Retinal integrity evaluation with a three-mirror lens.

d. Single vision and multifocal spectacle lens service, verification and subsequent service. When lenses are necessary, the following enumerated professional and technical optometric services are to be provided:

(1) When spectacle lenses are necessary, the following enumerated professional and technical optometric services are to be provided:

1. Ordering of corrective lenses.

2. Verification of lenses after fabrication.

3. Adjustment and alignment of completed lens order.

(2) New spectacle lenses are subject to the following limitations:

1. Up to three times for children up to one year of age.

2. Up to four times per year for children one through three years of age.

3. Once every 12 months for children four through seven years of age.

4. Once every 24 months after eight years of age when there is a change in the prescription.

(3) Spectacle lenses made from polycarbonate or equivalent material are allowed for:

1. Children through seven years of age.

2. Members with vision in only one eye.

3. Members with a diagnosis-related illness or disability where regular lenses would pose a safety risk.

e. Rescinded IAB 4/3/02, effective 6/1/02.

f. Frame service.

(1) When a new frame is necessary, the following enumerated professional and technical optometric services are to be provided:

1. Selection and styling.

2. Sizing and measurements.

3. Fitting and adjustment.

4. Readjustment and servicing.

(2) New frames are subject to the following limitations:

1. One frame every six months is allowed for children through three years of age.

2. One frame every 12 months is allowed for children four through seven years of age.

3. When there is a covered lens change and the new lenses cannot be accommodated by the current frame.

(3) Safety frames are allowed for:

1. Children through seven years of age.

2. Members with a diagnosis-related disability or illness where regular frames would pose a safety risk or result in frequent breakage.

g. Rescinded IAB 4/3/02, effective 6/1/02.

h. Repairs or replacement of frames, lenses or component parts. Payment shall be made for service in addition to materials. The service fee shall not exceed the dispensing fee for a replacement frame. Payment shall be made for replacement of glasses when the original glasses have been lost or damaged beyond repair. Replacement of lost or damaged glasses is limited to one pair of frames and two lenses once every 12 months for adults aged 21 and over, except for people with a mental or physical disability.

i. Contact lenses. Payment shall be made for documented keratoconus, aphakia, high myopia, anisometropia, trauma, severe ocular surface disease, irregular astigmatism, for treatment of acute or chronic eye disease, or when the member's vision cannot be adequately corrected with spectacle lenses. Contact lenses are subject to the following limitations:

- (1) Up to 16 gas permeable contact lenses are allowed for children up to one year of age.
- (2) Up to 8 gas permeable contact lenses are allowed every 12 months for children one through three years of age.
- (3) Up to 6 gas permeable contact lenses are allowed every 12 months for children four through seven years of age.
- (4) Two gas permeable contact lenses are allowed every 24 months for members eight years of age or older.
- (5) Soft contact lenses and replacements are allowed when medically necessary.

78.6(2) Ophthalmic materials. Ophthalmic materials which are provided in connection with any of the foregoing professional optometric services shall provide adequate vision as determined by the optometrist and meet the following standards:

- a. Corrected curve lenses, unless clinically contraindicated.
- b. Standard plastic, plastic and metal combination, or metal frames.
- c. Prescription standards according to the American National Standards Institute (ANSI) standards and tolerance.

78.6(3) Reimbursement. The reimbursement for allowed ophthalmic material is subject to a fee schedule established by the department or to actual laboratory cost as evidenced by an attached invoice. Reimbursement for rose tint is included in the fee for the lenses.

a. Materials payable by fee schedule are:

- (1) Spectacle lenses, single vision and multifocal.
- (2) Frames.
- (3) Case for glasses.

b. Materials payable at actual laboratory cost as evidenced by an attached invoice are:

- (1) Contact lenses.
- (2) Schroeder shield.
- (3) Ptosis crutch.
- (4) Safety frames.
- (5) Subnormal visual aids.
- (6) Photochromatic lenses.

78.6(4) Prior authorization. Prior authorization is required for the following:

a. A second lens correction within a 24-month period for members eight years of age and older. Approval shall be given when the member's vision has at least a five-tenths diopter of change in sphere or cylinder or ten-degree change in axis in either eye.

b. Visual therapy may be authorized when warranted by case history or diagnosis for a period of time not greater than 90 days. Should continued therapy be warranted, the prior approval process shall be reaccomplished, accompanied by a report showing satisfactory progress. Approved diagnoses are convergence insufficiency and amblyopia. Visual therapy is not covered when provided by opticians.

c. Subnormal visual aids where near visual acuity is at or better than 20/100 at 16 inches, 2M print. Prior authorization is not required if near visual acuity as described above is less than 20/100. Subnormal visual aids include, but are not limited to, hand magnifiers, loupes, telescopic spectacles, or reverse Galilean telescope systems. Payment shall be actual laboratory cost as evidenced by an attached invoice.

d. Approval for photochromatic tint shall be given when the member has a documented medical condition that causes photosensitivity and less costly alternatives are inadequate.

e. Approval for press-on prisms shall be granted for members whose vision cannot be adequately corrected with other covered prisms.

(Cross reference 78.28(3))

78.6(5) Noncovered services. Noncovered services include, but are not limited to, the following services:

- a. Glasses with cosmetic gradient tint lenses or other eyewear for cosmetic purposes.
- b. Glasses for occupational eye safety.
- c. A second pair of glasses or spare glasses.

- d. Cosmetic surgery and experimental medical and surgical procedures.
- e. Sunglasses.
- f. Progressive bifocal or trifocal lenses.

78.6(6) *Therapeutically certified optometrists.* Rescinded IAB 9/5/12, effective 11/1/12.

This rule is intended to implement Iowa Code section 249A.4.

[ARC 7548B, IAB 2/11/09, effective 4/1/09; ARC 0305C, IAB 9/5/12, effective 11/1/12]

441—78.7(249A) Opticians. Payment will be approved only for certain services and supplies provided by opticians when prescribed by a physician (MD or DO) or an optometrist. Payment and procedure for obtaining services and supplies shall be the same as described in rule 441—78.6(249A). (Cross reference 78.28(3))

78.7(1) to 78.7(3) Rescinded IAB 4/3/02, effective 6/1/02.

This rule is intended to implement Iowa Code section 249A.4.

441—78.8(249A) Chiropractors. Payment will be made for the same chiropractic procedures payable under Title XVIII of the Social Security Act (Medicare).

78.8(1) *Covered services.* Chiropractic manipulative therapy (CMT) eligible for reimbursement is specifically limited by Medicaid to the manual manipulation (i.e., by use of the hands) of the spine for the purpose of correcting a subluxation demonstrated by X-ray. Subluxation means an incomplete dislocation, off-centering, misalignment, fixation, or abnormal spacing of the vertebrae.

78.8(2) *Indications and limitations of coverage.*

a. The subluxation must have resulted in a neuromusculoskeletal condition set forth in the table below for which CMT is appropriate treatment. The symptoms must be directly related to the subluxation that has been diagnosed. The mere statement or diagnosis of “pain” is not sufficient to support the medical necessity of CMT. CMT must have a direct therapeutic relationship to the patient’s condition. No other diagnostic or therapeutic service furnished by a chiropractor is covered under the Medicaid program.

ICD	CATEGORY I	ICD	CATEGORY II	ICD	CATEGORY III
G44.1	Vascular headache NEC*	G54.0- G54.4	Nerve root and plexus disorders, brachial plexus disorders, lumbosacral plexus disorders, cervical root disorders NEC, thoracic root disorders NEC, lumbosacral root disorders NEC	M48.30- M48.33	Traumatic spondylopathy, site unspecified, occipito-atlanto-axial region, cervical region, cervicothoracic region
G44.209	Tension headache, unspecified, not intractable	G54.8	Other nerve root and plexus disorders	M48.35- M48.38	Traumatic spondylopathy, thoracolumbar region, lumbar region, lumbosacral region, sacral and sacrococcygeal region
M47.21- M47.28	Other spondylosis with radiculopathy, occipito-atlanto-axial region, cervical region, cervicothoracic region, thoracic region, thoracolumbar region, lumbar region, lumbosacral region, sacral and sacrococcygeal region	G54.9	Nerve root and plexus disorder, unspecified	M50.20- M50.23	Other cervical disc displacement
M47.811- M47.818	Spondylosis without myelopathy or radiculopathy, occipito-atlanto-axial region, cervical region, cervicothoracic region, thoracic region, thoracolumbar region, lumbar region, lumbosacral region, sacral and sacrococcygeal region	G55	Nerve root and plexus compressions in diseases classified elsewhere	M50.30- M50.33	Other cervical disc degeneration
M47.891- M47.898	Other spondylosis, occipito-atlanto-axial region, cervical region, cervicothoracic region, thoracic region, thoracolumbar region, lumbar region, lumbosacral region, sacral and sacrococcygeal region	M43.00- M43.28	Spondylolysis; spondylolisthesis; fusion of spine	M51.24- M51.27	Other thoracic, thoracolumbar and lumbosacral intervertebral disc displacement
M54.2	Cervicalgia	M43.6	Torticollis	M51.34- M51.37	Other thoracic, thoracolumbar and lumbosacral intervertebral disc degeneration
M54.5	Low back pain	M46.00- M46.09	Spinal enthesopathy	M54.30- M54.32	Sciatica
M54.6	Pain in the thoracic spine	M46.41- M46.47	Discitis, unspecified, occipito-atlanto-axial region, cervical region, cervicothoracic region, thoracic region, thoracolumbar region, lumbar region, lumbosacral region	M54.40- M54.42	Lumbago with sciatica
M54.81	Occipital neuralgia	M48.00- M48.08	Spinal stenosis	M96.1	Postlaminectomy syndrome, NEC
M54.89	Other dorsalgia	M48.34	Traumatic spondylopathy, thoracic region		

ICD	CATEGORY I	ICD	CATEGORY II	ICD	CATEGORY III
M54.9	Dorsalgia, unspecified	M50.10- M50.13	Cervical disc disorder with radiculopathy		
R51	Headache	M50.80- M50.83	Other cervical disc disorders		
		M50.90- M50.93	Cervical disc disorder, unspecified		
		M51.14- M51.17	Intervertebral disc disorders with radiculopathy, thoracic region, thoracolumbar region, lumbar region, lumbosacral region		
		M51.84- M51.87	Other thoracic, thoracolumbar and lumbosacral intervertebral disc disorders		
		M53.0	Cervicocranial syndrome		
		M53.1	Cervicobrachial syndrome		
		M53.2X1- M53.2X9	Spinal instabilities		
		M53.3	Sacrococcygeal disorders NEC		
		M53.80	Other specified dorsopathies, site unspecified		
		M53.84- M53.88	Other specified dorsopathies, thoracic region, thoracolumbar region, lumbar region, lumbosacral region, sacral and sacrococcygeal region		
		M53.9	Dorsopathy, unspecified		
		M54.10- M54.18	Radiculopathy		
		M60.80	Other myositis, unspecified site		
		M60.811, M60.812	Other myositis, shoulder, right, left		
		M60.819	Other myositis, unspecified shoulder		
		M60.821, M60.822	Other myositis, upper arm, right, left		
		M60.829	Other myositis, unspecified upper arm		
		M60.831, M60.832	Other myositis, forearm, right, left		
		M60.839	Other myositis, unspecified forearm		
		M60.841, M60.842	Other myositis, hand, right, left		
		M60.849	Other myositis, unspecified hand		
		M60.851, M60.852	Other myositis, thigh, right, left		
		M60.859	Other myositis, unspecified thigh		

ICD	CATEGORY I	ICD	CATEGORY II	ICD	CATEGORY III
		M60.861, M60.862	Other myositis, lower leg, right, left		
		M60.869	Other myositis, unspecified lower leg		
		M60.871, M60.872	Other myositis, ankle and foot, right, left		
		M60.879	Other myositis, unspecified ankle and foot		
		M60.88, M60.89	Other myositis, other site, multiple sites		
		M60.9	Myositis, unspecified		
		M62.830	Muscle spasm of back		
		M72.9	Fibroblastic disorder, unspecified		
		M79.1	Myalgia		
		M79.2	Neuralgia and neuritis, unspecified		
		M79.7	Fibromyalgia		
		M99.20- M99.23	Subluxation stenosis of neural canal, head region, cervical region, thoracic region, lumbar region		
		M99.30- M99.33	Osseous stenosis of neural canal, head region, cervical region, thoracic region, lumbar region		
		M99.40- M99.43	Connective tissue stenosis of neural canal, head region, cervical region, thoracic region, lumbar region		
		M99.50- M99.53	Intervertebral disc stenosis of neural canal, head region, cervical region, thoracic region, lumbar region		
		M99.60- M99.63	Osseous and subluxation stenosis of intervertebral foramina, head region, cervical region, thoracic region, lumbar region		
		M99.70- M99.73	Connective tissue and disc stenosis of intervertebral foramina, head region, cervical region, thoracic region, lumbar region		
		Q76.2	Congenital spondylolisthesis		
		S13.4XXA, S13.4XXD	Sprain of ligaments of cervical spine, initial encounter, subsequent encounter		

ICD	CATEGORY I	ICD	CATEGORY II	ICD	CATEGORY III
		S13.8XXA, S13.8XXD	Sprain of joints and ligaments of other parts of neck, initial encounter, subsequent encounter		
		S16.1XXA, S16.1XXD	Strain of muscle, fascia and tendon at neck level, initial encounter, subsequent encounter		
		S23.3XXA, S23.3XXD	Sprain of ligaments of thoracic spine, initial encounter, subsequent encounter		
		S23.8XXA, S23.8XXD	Sprain of other specified parts of thorax, initial encounter, subsequent encounter		
		S33.5XXA, S33.5XXD	Sprain of ligaments of lumbar spine, initial encounter, subsequent encounter		
		S33.6XXA, S33.6XXD	Sprain of sacroiliac joint, initial encounter, subsequent encounter		

* NEC means not elsewhere classified.

b. The neuromusculoskeletal conditions listed in the table in paragraph “*a*” generally require short-, moderate-, or long-term CMT. A diagnosis or combination of diagnoses within Category I generally requires short-term CMT of 12 per 12-month period. A diagnosis or combination of diagnoses within Category II generally requires moderate-term CMT of 18 per 12-month period. A diagnosis or combination of diagnoses within Category III generally requires long-term CMT of 24 per 12-month period. For diagnostic combinations between categories, 28 CMTs are generally required per 12-month period. If the CMT utilization guidelines are exceeded, documentation supporting the medical necessity of additional CMT must be submitted with the Medicaid claim form or the claim will be denied for failure to provide information.

c. CMT is not a covered benefit when:

- (1) The maximum therapeutic benefit has been achieved for a given condition.
- (2) There is not a reasonable expectation that the continuation of CMT would result in improvement of the patient’s condition.
- (3) The CMT seeks to prevent disease, promote health and prolong and enhance the quality of life.

78.8(3) Documenting X-ray. An X-ray must document the primary regions of subluxation being treated by CMT.

a. The documenting X-ray must be taken at a time reasonably proximate to the initiation of CMT. An X-ray is considered to be reasonably proximate if it was taken no more than 12 months prior to or 3 months following the initiation of CMT. X-rays need not be repeated unless there is a new condition and no payment shall be made for subsequent X-rays, absent a new condition, consistent with paragraph “*c*” of this subrule. No X-ray is required for pregnant women and for children aged 18 and under.

b. The X-ray films shall be labeled with the patient’s name and date the X-rays were taken and shall be marked right or left. The X-ray shall be made available to the department or its duly authorized representative when requested. A written and dated X-ray report, including interpretation and diagnosis, shall be present in the patient’s clinical record.

c. Chiropractors shall be reimbursed for documenting X-rays at the physician fee schedule rate. Payable X-rays shall be limited to those Current Procedural Terminology (CPT) procedure codes that are appropriate to determine the presence of a subluxation of the spine. Criteria used to determine payable X-ray CPT codes may include, but are not limited to, the X-ray CPT codes for which

major commercial payors reimburse chiropractors. The Iowa Medicaid enterprise shall publish in the Chiropractic Services Provider Manual the current list of payable X-ray CPT codes. Consistent with CPT, chiropractors may bill the professional, technical, or professional and technical components for X-rays, as appropriate. Payment for documenting X-rays shall be further limited to one per condition, consistent with the provisions of paragraph “a” of this subrule. A claim for a documenting X-ray related to the onset of a new condition is only payable if the X-ray is reasonably proximate to the initiation of CMT for the new condition, as defined in paragraph “a” of this subrule. A chiropractor is also authorized to order a documenting X-ray whether or not the chiropractor owns or possesses X-ray equipment in the chiropractor’s office. Any X-rays so ordered shall be payable to the X-ray provider, consistent with the provisions in this paragraph.

This rule is intended to implement Iowa Code section 249A.4.
[ARC 2164C, IAB 9/30/15, effective 10/1/15]

441—78.9(249A) Home health agencies. Payment shall be approved for medically necessary home health agency services prescribed by a physician in a plan of home health care provided by a Medicare-certified home health agency.

The number of hours of home health agency services shall be reasonable and appropriate to meet an established medical need of the member that cannot be met by a family member, significant other, friend, or neighbor. Services must be medically necessary in the individual case and be related to a diagnosed medical impairment or disability.

The member need not be homebound to be eligible for home health agency services; however, the services provided by a home health agency shall only be covered when provided in the member’s residence with the following exception. Private duty nursing and personal care services for persons aged 20 and under as described at 78.9(10) “a” may be provided in settings other than the member’s residence when medically necessary.

Medicaid members of home health agency services need not first require skilled nursing care to be entitled to home health aide services.

Further limitations related to specific components of home health agency services are noted in subrules 78.9(3) to 78.9(10).

Payment shall be made on an encounter basis. An encounter is defined as separately identifiable hours in which home health agency staff provide continuous service to a member.

Payment for supplies shall be approved when the supplies are incidental to the patient’s care, e.g., syringes for injections, and do not exceed \$15 per month. Dressings, durable medical equipment, and other supplies shall be obtained from a durable medical equipment dealer or pharmacy. Payment of supplies may be made to home health agencies when a durable medical equipment dealer or pharmacy is not available in the member’s community.

Payment may be made for restorative and maintenance home health agency services.

Payment may be made for teaching, training, and counseling in the provision of health care services.

Treatment plans for these services shall additionally reflect: to whom the services are to be provided (patient, family member, etc.); prior teaching training, or counseling provided; medical necessity for the rendered service; identification of specific services and goals; date of onset of the teaching, training, or counseling; frequency of services; progress of member in response to treatment; and estimated length of time these services will be needed.

The following are not covered: services provided in the home health agency office, homemaker services, well child care and supervision, and medical equipment rental or purchase.

Services shall be authorized by a physician, evidenced by the physician’s signature and date on a plan of treatment.

78.9(1) Treatment plan. A plan of treatment shall be completed prior to the start of care and at a minimum reviewed every 60 days thereafter. There must be a face-to-face encounter between a physician, a nurse practitioner, a clinical nurse specialist, a certified nurse-midwife, or a physician assistant and the Medicaid member no more than 90 days before or 30 days after the start of service. The

plan of care shall support the medical necessity and intensity of services to be provided by reflecting the following information:

- a. Place of service.
- b. Type of service to be rendered and the treatment modalities being used.
- c. Frequency of the services.
- d. Assistance devices to be used.
- e. Date home health services were initiated.
- f. Progress of member in response to treatment.
- g. Medical supplies to be furnished.
- h. Member's medical condition as reflected by the following information, if applicable:
 - (1) Dates of prior hospitalization.
 - (2) Dates of prior surgery.
 - (3) Date last seen by a physician.
 - (4) Diagnoses and dates of onset of diagnoses for which treatment is being rendered.
 - (5) Prognosis.
 - (6) Functional limitations.
 - (7) Vital signs reading.
 - (8) Date of last episode of instability.
 - (9) Date of last episode of acute recurrence of illness or symptoms.
 - (10) Medications.
- i. Discipline of the person providing the service.
- j. Certification period (no more than 60 days).
- k. Estimated date of discharge from the hospital or home health agency services, if applicable.
- l. Physician's signature and date. The plan of care must be signed and dated by the physician before the claim for service is submitted for reimbursement.

78.9(2) *Supervisory visits.* Payment shall be made for supervisory visits two times a month when a registered nurse acting in a supervisory capacity provides supervisory visits of services provided by a home health aide under a home health agency plan of treatment or when services are provided by an in-home health care provider under the department's in-home health-related care program as set forth in 441—Chapter 177.

78.9(3) *Skilled nursing services.* Skilled nursing services are services that when performed by a home health agency require a licensed registered nurse or licensed practical nurse to perform. Situations when a service can be safely performed by the member or other nonskilled person who has received the proper training or instruction or when there is no one else to perform the service are not considered a "skilled nursing service." Skilled nursing services shall be available only on an intermittent basis. Intermittent services for skilled nursing services shall be defined as a medically predictable recurring need requiring a skilled nursing service at least once every 60 days, not to exceed five days per week (except as provided below), with an attempt to have a predictable end. Daily visits (six or seven days per week) that are reasonable and necessary and show an attempt to have a predictable end shall be covered for up to three weeks. Coverage of additional daily visits beyond the initial anticipated time frame may be appropriate for a short period of time, based on the medical necessity of service. Medical documentation shall be submitted justifying the need for continued visits, including the physician's estimate of the length of time that additional visits will be necessary. Daily skilled nursing visits or multiple daily visits for wound care or insulin injections shall be covered when ordered by a physician and included in the plan of care. Other daily skilled nursing visits which are ordered for an indefinite period of time and designated as daily skilled nursing care do not meet the intermittent definition and shall be denied.

Skilled nursing services shall be evaluated based on the complexity of the service and the condition of the patient.

Private duty nursing for persons aged 21 and over is not a covered service. See subrule 78.9(10) for guidelines for private duty nursing for persons aged 20 or under.

78.9(4) *Physical therapy services.* Payment shall be made for physical therapy services when the services relate directly to an active written treatment plan, follow a treatment plan established

by the physician after any needed consultation with the qualified physical therapist, are reasonable and necessary to the treatment of the patient's illness or injury, and meet the guidelines defined for restorative, maintenance, or trial therapy as set forth in subrule 78.19(1), paragraphs "a" and "b."

For physical therapy services, the treatment plan shall additionally reflect goals, modalities of treatment, date of onset of conditions being treated, restorative potential, and progress notes.

78.9(5) Occupational therapy services. Payment shall be made for occupational therapy services when the services relate directly to an active written treatment plan, follow a treatment plan established by the physician, are reasonable and necessary to the treatment of the patient's illness or injury, and meet the guidelines defined for restorative, maintenance, or trial therapy as set forth in subrule 78.19(1), paragraphs "a" and "c."

For occupational therapy services, the treatment plan shall additionally reflect goals, modalities of treatment, date of onset of conditions being treated, restorative potential, and progress notes.

78.9(6) Speech therapy services. Payment shall be made for speech therapy services when the services relate directly to an active written treatment plan, follow a treatment plan established by the physician, are reasonable and necessary to the treatment of the patient's illness or injury, and meet the guidelines defined for restorative, maintenance, or trial therapy as set forth in subrule 78.19(1), paragraphs "a" and "d."

For speech therapy services, the treatment plan shall additionally reflect goals, modalities of treatment, date of onset of conditions being treated, restorative potential, and progress notes.

78.9(7) Home health aide services. Payment shall be made for unskilled services provided by a home health aide if the following conditions are met:

a. The service as well as the frequency and duration are stated in a written plan of treatment established by a physician. The home health agency is encouraged to collaborate with the member, or in the case of a child with the child's caregiver, in the development and implementation of the plan of treatment.

b. The member requires personal care services as determined by a registered nurse or other appropriate therapist. The services shall be given under the supervision of a registered nurse, physical, speech, or occupational therapist and the registered nurse or therapist shall assign the aide who will provide the care.

c. Services shall be provided on an intermittent basis. "Intermittent basis" for home health agency services is defined as services that are usually two to three times a week for two to three hours at a time. Services provided for four to seven days per week, not to exceed 28 hours per week, when ordered by a physician and included in a plan of care shall be allowed as intermittent services. Increased services provided when medically necessary due to unusual circumstances on a short-term basis of two to three weeks may also be allowed as intermittent services when the home health agency documents the need for the excessive time required for home health aide services.

Home health aide daily care may be provided for persons employed or attending school whose disabling conditions require the persons to be assisted with morning and evening activities of daily living in order to support their independent living.

Personal care services include the activities of daily living, e.g., helping the member to bathe, get in and out of bed, care for hair and teeth, exercise, and take medications specifically ordered by the physician, but ordinarily self-administered, and retraining the member in necessary self-help skills.

Certain household services may be performed by the aide in order to prevent or postpone the member's institutionalization when the primary need of the member for home health aide services furnished is for personal care. If household services are incidental and do not substantially increase the time spent by the aide in the home, the entire visit is considered a covered service. Domestic or housekeeping services which are not related to patient care are not a covered service if personal care is not rendered during the visit.

For home health aide services, the treatment plan shall additionally reflect the number of hours per visit and the living arrangement of the member, e.g., lives alone or with family.

78.9(8) Medical social services. Rescinded IAB 3/29/17, effective 5/3/17.

78.9(9) *Home health agency care for maternity patients and children.* The intent of home health agency services for maternity patients and children shall be to provide services when the members are unable to receive the care outside of their home and require home health care due to a high-risk factor. Routine prenatal, postpartum, or child health care is a covered service in a physician's office or clinic and, therefore, is not covered by Medicaid when provided by a home health agency.

a. Treatment plans for maternity patients and children shall identify:

- (1) The potential risk factors,
- (2) The medical factor or symptom which verifies the child is at risk,
- (3) The reason the member is unable to obtain care outside of the home,
- (4) The medically related task of the home health agency,
- (5) The member's diagnosis,
- (6) Specific services and goals, and
- (7) The medical necessity for the services to be rendered. A single high-risk factor does not provide

sufficient documentation of the need for services.

b. The following list of potential high-risk factors may indicate a need for home health services to prenatal maternity patients:

- (1) Aged 16 or under.
- (2) First pregnancy for a woman aged 35 or over.
- (3) Previous history of prenatal complications such as fetal death, eclampsia, C-section delivery, psychosis, or diabetes.
- (4) Current prenatal problems such as hypertensive disorders of pregnancy, diabetes, cardiac disease, sickle cell anemia, low hemoglobin, mental illness, or drug or alcohol abuse.
- (5) Sociocultural or ethnic problems such as language barriers, lack of family support, insufficient dietary practices, history of child abuse or neglect, or single mother.
- (6) Preexisting disabilities such as sensory deficits, or mental or physical disabilities.
- (7) Second pregnancy in 12 months.
- (8) Death of a close family member or significant other within the previous year.

c. The following list of potential high-risk factors may indicate a need for home health services to postpartum maternity patients:

- (1) Aged 16 or under.
- (2) First pregnancy for a woman aged 35 or over.
- (3) Major postpartum complications such as severe hemorrhage, eclampsia, or C-section delivery.
- (4) Preexisting mental or physical disabilities such as deaf, blind, hemiplegic, activity-limiting disease, sickle cell anemia, uncontrolled hypertension, uncontrolled diabetes, mental illness, or intellectual disability.
- (5) Drug or alcohol abuse.
- (6) Symptoms of postpartum psychosis.
- (7) Special sociocultural or ethnic problems such as lack of job, family problems, single mother, lack of support system, or history of child abuse or neglect.
- (8) Demonstrated disturbance in maternal and infant bonding.
- (9) Discharge or release from hospital against medical advice before 36 hours postpartum.
- (10) Insufficient antepartum care by history.
- (11) Multiple births.
- (12) Nonhospital delivery.

d. The following list of potential high-risk factors may indicate a need for home health services to infants:

- (1) Birth weight of five pounds or under or over ten pounds.
- (2) History of severe respiratory distress.
- (3) Major congenital anomalies such as neonatal complications which necessitate planning for long-term follow-up such as postsurgical care, poor prognosis, home stimulation activities, or periodic development evaluation.
- (4) Disabling birth injuries.

- (5) Extended hospitalization and separation from other family members.
 - (6) Genetic disorders, such as Down's syndrome, and phenylketonuria or other metabolic conditions that may lead to intellectual disability.
 - (7) Noted parental rejection or indifference toward baby such as never visiting or calling the hospital about the baby's condition during the infant's extended stay.
 - (8) Family sociocultural or ethnic problems such as low education level or lack of knowledge of child care.
 - (9) Discharge or release against medical advice before 36 hours of age.
 - (10) Nutrition or feeding problems.
- e. The following list of potential high-risk factors may indicate a need for home health services to preschool or school-age children:
- (1) Child or sibling victim of child abuse or neglect.
 - (2) Intellectual disability or other physical disabilities necessitating long-term follow-up or major readjustments in family lifestyle.
 - (3) Failure to complete the basic series of immunizations by 18 months, or boosters by 6 years.
 - (4) Chronic illness such as asthma, cardiac, respiratory or renal disease, diabetes, cystic fibrosis, or muscular dystrophy.
 - (5) Malignancies such as leukemia or carcinoma.
 - (6) Severe injuries necessitating treatment or rehabilitation.
 - (7) Disruption in family or peer relationships.
 - (8) Suspected developmental delay.
 - (9) Nutritional deficiencies.

78.9(10) Private duty nursing or personal care services for persons aged 20 and under. Payment for private duty nursing or personal care services for persons aged 20 and under shall be approved if determined to be medically necessary. Payment shall be made on an hourly unit of service.

a. Definitions.

(1) Private duty nursing services are those services which are provided by a registered nurse or a licensed practical nurse under the direction of the member's physician to a member in the member's place of residence or outside the member's residence, when normal life activities take the member outside the place of residence. Place of residence does not include nursing facilities, intermediate care facilities for the mentally retarded, or hospitals.

Services shall be provided according to a written plan of care authorized by a licensed physician. The home health agency is encouraged to collaborate with the member, or in the case of a child with the child's caregiver, in the development and implementation of the plan of treatment. These services shall exceed intermittent guidelines as defined in subrule 78.9(3). Private duty nursing and personal care services shall be inclusive of all home health agency services personally provided to the member. Enhanced payment under the interim fee schedule shall be made available for services to children who are technology dependent, i.e., ventilator dependent or whose medical condition is so unstable as to otherwise require intensive care in a hospital.

Private duty nursing or personal care services do not include:

- 1. Respite care, which is a temporary intermission or period of rest for the caregiver.
- 2. Nurse supervision services including chart review, case discussion or scheduling by a registered nurse.
- 3. Services provided to other persons in the member's household.
- 4. Services requiring prior authorization that are provided without regard to the prior authorization process.
- 5. Transportation services.
- 6. Homework assistance.

(2) Personal care services are those services provided by a home health aide or certified nurse's aide and which are delegated and supervised by a registered nurse under the direction of the member's physician to a member in the member's place of residence or outside the member's residence, when normal life activities take the member outside the place of residence. Place of residence does not include

nursing facilities, intermediate care facilities for the mentally retarded, or hospitals. Payment for personal care services for persons aged 20 and under that exceed intermittent guidelines may be approved if determined to be medically necessary as defined in subrule 78.9(7). These services shall be in accordance with the member's plan of care and authorized by a physician. The home health agency is encouraged to collaborate with the member, or in the case of a child with the child's caregiver, in the development and implementation of the plan of treatment.

Medical necessity means the service is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent the worsening of conditions that endanger life, cause pain, result in illness or infirmity, threaten to cause or aggravate a disability or chronic illness, and no other equally effective course of treatment is available or suitable for the member requesting a service.

b. Requirements.

(1) Private duty nursing or personal care services shall be ordered in writing by a physician as evidenced by the physician's signature on the plan of care.

(2) Private duty nursing or personal care services shall be authorized by the department or the department's designated review agent prior to payment.

(3) Prior authorization shall be requested at the time of initial submission of the plan of care or at any time the plan of care is substantially amended and shall be renewed with the department or the department's designated review agent. Initial request for and request for renewal of prior authorization shall be submitted to the department's designated review agent. The provider of the service is responsible for requesting prior authorization and for obtaining renewal of prior authorization.

The request for prior authorization shall include a nursing assessment, the plan of care, and supporting documentation. The request for prior authorization shall include all items previously identified as required treatment plan information and shall further include: any planned surgical interventions and projected time frame; information regarding caregiver's desire to become involved in the member's care, to adhere to program objectives, to work toward treatment plan goals, and to work toward maximum independence; and identify the types and service delivery levels of all other services to the member whether or not the services are reimbursable by Medicaid. Providers shall indicate the expected number of private duty nursing RN hours, private duty nursing LPN hours, or home health aide hours per day, the number of days per week, and the number of weeks or months of service per discipline. If the member is currently hospitalized, the projected date of discharge shall be included.

Prior authorization approvals shall not be granted for treatment plans that exceed 16 hours of home health agency services per day. (Cross reference 78.28(9))

78.9(11) Vaccines. In order to be paid for the administration of a vaccine covered under the Vaccines for Children (VFC) Program, a home health agency must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

This rule is intended to implement Iowa Code section 249A.4.

[ARC 7548B, IAB 2/11/09, effective 4/1/09; ARC 9315B, IAB 12/29/10, effective 2/2/11; ARC 0065C, IAB 4/4/12, effective 6/1/12; ARC 3005C, IAB 3/29/17, effective 5/3/17]

441—78.10(249A) Durable medical equipment (DME), prosthetic devices and medical supplies.

78.10(1) General payment requirements. Payment will be made for items of DME, prosthetic devices and medical supplies, subject to the following general requirements and the requirements of subrule 78.10(2), 78.10(3), or 78.10(4), as applicable:

a. DME, prosthetic devices, and medical supplies must be required by the member because of the member's medical condition.

b. The item shall be necessary and reasonable either for the treatment of an illness or injury, or to improve the functioning of a malformed body part. Determination will be made by the Iowa Medicaid enterprise medical services unit.

(1) An item is necessary when it can be expected to make a meaningful contribution to the treatment of a specific illness or injury or to the improvement in function of a malformed body part.

(2) Although an item may be necessary, it must also be a reasonable expenditure for the Medicaid program. The following considerations enter into the determination of reasonableness: Whether the

expense of the item to the program would be clearly disproportionate to the therapeutic benefits which could ordinarily be derived from use of the item; whether the item would be substantially more costly than a medically appropriate and realistically feasible alternative pattern of care; and whether the item serves essentially the same purpose as an item already available to the beneficiary.

c. A physician's (doctor of medicine, osteopathy, or podiatry), physician assistant's, or advanced registered nurse practitioner's prescription is required to establish medical necessity. The prescription shall state the member's name, diagnosis, prognosis, item(s) to be dispensed, quantity, and length of time the item is to be required and shall include the signature of the prescriber and the date of signature.

For items requiring prior authorization, a request shall include a physician's, physician assistant's, or advanced registered nurse practitioner's written order or prescription and sufficient medical documentation to permit an independent conclusion that the requirements for the equipment or device are met and the item is medically necessary and reasonable. A request for prior authorization is made on Form 470-0829, Request for Prior Authorization. See rule 441—78.28(249A) for prior authorization requirements.

d. Nonmedical items will not be covered. These include but are not limited to:

- (1) Physical fitness equipment, e.g., an exercycle, weights.
- (2) First-aid or precautionary-type equipment, e.g., preset portable oxygen units.
- (3) Self-help devices, e.g., safety grab bars, raised toilet seats.
- (4) Training equipment, e.g., speech teaching machines, braille training texts.
- (5) Equipment used for environmental control or to enhance the environmental setting, e.g., room heaters, air conditioners, humidifiers, dehumidifiers, and electric air cleaners.
- (6) Equipment which basically serves comfort or convenience functions or is primarily for the convenience of a person caring for the member, e.g., elevators, stairway elevators and posture chairs.

e. The amount payable is based on the least expensive item which meets the member's medical needs. Payment will not be approved for items that serve duplicate functions. EXCEPTION: A second ventilator for which prior authorization has been granted. See 78.10(5) "k" for prior authorization requirements.

f. Consideration will be given to rental or purchase based on the price of the item and the length of time it would be required. The decision on rental or purchase shall be made by the Iowa Medicaid enterprise and be based on the most reasonable method to provide the equipment.

(1) The provider shall monitor rental payments up to 100 percent of the purchase price. At the point that total rent paid equals 100 percent of the purchase allowance, the member will be considered to own the item and no further rental payments will be made to the provider.

(2) Payment may be made for the purchase of an item even though rental payments may have been made for prior months. The rental of the equipment may be necessary for a period of time to establish that it will meet the identified need before the purchase of the equipment. When a decision is made to purchase after renting an item, all of the rental payments will be applied to the purchase allowance.

(3) EXCEPTION: Ventilators and oxygen systems shall be maintained on a rental basis for the duration of use.

(4) A deposit shall not be charged by a provider to a Medicaid member or any other person on behalf of a Medicaid member for rental of medical equipment.

g. Payment may be made for necessary repair, maintenance, and supplies for member-owned equipment. No payment may be made for repairs, maintenance, or supplies when the member is renting the item.

h. Replacement of member-owned equipment is covered in cases of loss or irreparable damage or when required because of a change in the member's condition.

i. No allowance will be made for delivery, freight, postage, or other provider operating expenses for DME, prosthetic devices or medical supplies.

j. Reimbursement over the established fee schedule amount is allowed when prior authorization has been obtained. See 78.10(5) "n" for prior authorization requirements.

78.10(2) Durable medical equipment. DME is equipment that can withstand repeated use, is primarily and customarily used to serve a medical purpose, is generally not useful to a person in the absence of an illness or injury, and is appropriate for use in the home.

a. Durable medical equipment provided in a hospital, nursing facility, or intermediate care facility for persons with an intellectual disability is not separately payable.

EXCEPTIONS:

(1) Oxygen services in a nursing facility or an intermediate care facility for persons with an intellectual disability when all of the following requirements and conditions have been met:

1. A Certificate of Medical Necessity for Oxygen, Form CMS-484, or a reasonable facsimile is completed by a physician, physician assistant, or advanced registered nurse practitioner and qualifies the member in accordance with Medicare criteria.

2. Additional documentation shows that the member requires oxygen for 12 hours or more per day for at least 30 days.

3. Oxygen logs must be maintained by the provider. The time between any reading shall not exceed more than 45 days. The documentation maintained in the provider record must contain the following:

- The initial, periodic and ending reading on the time meter clock on each oxygen system, and
- The dates of each initial, periodic and ending reading, and
- Evidence of ongoing need for oxygen services.

4. The maximum Medicaid payment shall be based on the least costly method of oxygen delivery.

5. Oxygen prescribed “PRN” or “as necessary” is not payable.

6. Medicaid payment shall be made for the rental of equipment only. All accessories and disposable supplies related to the oxygen delivery system and costs for servicing and repair of equipment are included in the Medicaid payment and shall not be separately payable.

7. Payment is not allowed for oxygen services that are not documented according to the department of inspections and appeals requirements at 481—subrule 58.21(8).

(2) Speech generating devices for which prior authorization has been obtained. See 78.10(5) “*f*” for prior authorization requirements.

(3) Wheelchairs for members in an intermediate care facility for persons with an intellectual disability.

(4) Medicaid will provide separate payment for customized wheelchairs for members who are residents of nursing facilities, subject to the following:

1. The member’s condition must necessitate regular use of a wheelchair on a long-term basis to enable independent mobility within the facility.

2. The member must require a wheelchair that is designed, assembled, modified, or constructed for the specific individual, in whole or in part, based on the individual’s condition, measurements, and needs.

3. Prior authorization pursuant to rule 441—79.8(249A) is required.

b. The types of durable medical equipment covered through the Medicaid program include, but are not limited to:

Automated medication dispenser. See 78.10(5) “*d*” for prior authorization requirements.

Bathtub/shower chair, bench. See 78.10(5) “*g*” and “*j*” for prior authorization requirements.

Commode, shower commode chair. See 78.10(5) “*j*” for prior authorization requirements.

Decubitus equipment.

Dialysis equipment.

Diaphragm (contraceptive device).

Enclosed bed. See 78.10(5) “*a*” for prior authorization requirements.

Enuresis alarm system (bed-wetting alarm device) for members five years of age or older.

Heat/cold application device.

Hospital bed and accessories.

Inhalation equipment. See 78.10(5) “*c*” for prior authorization requirements.

Insulin infusion pump. See 78.10(5) “*b*” and 78.10(5) “*e*” for prior authorization requirements.

Lymphedema pump.

Mobility device and accessories. See 78.10(5) "i" for prior authorization requirements.

Neuromuscular stimulator.

Oximeter.

Oxygen, subject to the limitations in 78.10(2) "a" and 78.10(2) "c."

Patient lift. See 78.10(5) "h" for prior authorization requirements.

Phototherapy bilirubin light.

Protective helmet.

Seat lift chair.

Speech generating device. See 78.10(5) "f" for prior authorization requirements.

Traction equipment.

Ventilator.

c. Coverage of home oxygen equipment and oxygen will be considered reasonable and necessary for members in accordance with Medicare criteria and as shown by supporting medical documentation. The physician, physician assistant, or advanced registered nurse practitioner shall document that other forms of treatment are contraindicated or have been tried and have not been successful and that oxygen therapy is required. EXCEPTION: Home oxygen equipment and oxygen are covered for children through three years of age when prescribed by a physician, physician assistant or advanced registered nurse practitioner. A pulse oximeter reading must be obtained yearly and documented in the provider and physician record.

(1) To identify the medical necessity for oxygen therapy, a Certificate of Medical Necessity for Oxygen, Form CMS-484, or a reasonable facsimile completed by a physician, physician assistant, or advanced registered nurse practitioner, shall qualify the member in accordance with Medicare criteria.

(2) If the member's condition or need for oxygen services changes, the attending physician, physician assistant, or advanced registered nurse practitioner must adjust the documentation accordingly.

(3) A second oxygen system is not covered by Medicaid when used as a backup for oxygen concentrators or as a standby in case of emergency. Members may be provided with a portable oxygen system to complement a stationary oxygen system, or to be used by itself, with documentation from the physician, physician assistant, or advanced registered nurse practitioner of the specific activities for which portable oxygen is medically necessary.

(4) Payment for oxygen systems shall be made only on a rental basis for the duration of use.

(5) All accessories, disposable supplies, servicing, and repairing of oxygen systems are included in the monthly Medicaid payment for oxygen systems.

(6) Oxygen prescribed "PRN" or "as necessary" is not allowed.

78.10(3) Prosthetic devices. Prosthetic devices mean replacement, corrective, or supportive devices prescribed by a physician (doctor of medicine, osteopathy or podiatry), physician assistant, or advanced registered nurse practitioner within the scope of practice as defined by state law to artificially replace a missing portion of the body, prevent or correct a physical deformity or malfunction, or support a weak or deformed portion of the body. This does not require a determination that there is no possibility that the member's condition may improve sometime in the future.

a. Prosthetic devices are not covered when dispensed to a member prior to the time the member undergoes a procedure which will make necessary the use of the device.

b. The types of prosthetic devices covered through the Medicaid program include, but are not limited to:

(1) Artificial eyes.

(2) Artificial limbs.

(3) Enteral delivery supplies and products. See 78.10(5) "l" for prior authorization requirements.

(4) Hearing aids. See rule 441—78.14(249A).

(5) Orthotic devices. See 78.10(3) "c" for limitations on coverage of cranial orthotic devices.

(6) Ostomy appliances.

(7) Parenteral delivery supplies and products. Daily parenteral nutrition therapy is considered necessary and reasonable for a member with severe pathology of the alimentary tract that does not

allow absorption of sufficient nutrients to maintain weight and strength commensurate with the member's general condition.

(8) Prosthetic shoes, orthopedic shoes. See rule 441—78.15(249A).

(9) Tracheotomy tubes.

(10) Vibrotactile aids. Vibrotactile aids are payable only once in a four-year period unless the original aid is broken beyond repair or lost. (Cross reference 78.28(4))

c. Cranial orthotic device. Payment shall be approved for cranial orthotic devices when the device is medically necessary for the postsurgical treatment of synostotic plagiocephaly. Payment shall also be approved when there is documentation supporting moderate to severe nonsynostotic positional plagiocephaly and either:

(1) The member is 12 weeks of age but younger than 36 weeks of age and has failed to respond to a two-month trial of repositioning therapy; or

(2) The member is 36 weeks of age but younger than 108 weeks of age and there is documentation of either of the following conditions:

1. Cephalic index at least two standard deviations above the mean for the member's gender and age; or

2. Asymmetry of 12 millimeters or more in the cranial vault, skull base, or orbitotragial depth.

78.10(4) Medical supplies. Medical supplies are nondurable items consumed in the process of giving medical care, for example, nebulizers, gauze, bandages, sterile pads, adhesive tape, and sterile absorbent cotton. Medical supplies are payable for a specific medicinal purpose. This does not include food or drugs. However, active pharmaceutical ingredients and excipients that are identified as preferred on the preferred drug list published by the department pursuant to Iowa Code section 249A.20A are covered. Medical supplies shall not be dispensed at any one time in quantities exceeding a 31-day supply for active pharmaceutical ingredients and excipients or a three-month supply for all other items. After the initial dispensing of medical supplies, the provider must document a refill request from the Medicaid member or the member's caregiver for each refill.

a. The types of medical supplies and supplies necessary for the effective use of a payable item covered through the Medicaid program include, but are not limited to:

Active pharmaceutical ingredients and excipients identified as preferred on the preferred drug list published pursuant to Iowa Code section 249A.20A.

Catheter (indwelling Foley).

Colostomy and ileostomy appliances.

Colostomy and ileostomy care dressings, liquid adhesive, and adhesive tape.

Diabetic supplies (including but not limited to blood glucose test strips, lancing devices, lancets, needles, syringes, and diabetic urine test supplies). See 78.10(5) "e" for prior authorization requirements.

Dialysis supplies.

Disposable catheterization trays or sets (sterile).

Disposable irrigation trays or sets (sterile).

Disposable saline enemas (e.g., sodium phosphate type).

Dressings.

Elastic antiembolism support stocking.

Enema.

Hearing aid batteries.

Incontinence products (for members three years of age and older).

Oral nutritional products. See 78.10(5) "m" for prior authorization requirements.

Ostomy appliances and supplies.

Respirator supplies.

Shoes, diabetic.

Surgical supplies.

Urinary collection supplies.

b. Only the following types of medical supplies will be approved for payment for members receiving care in a nursing facility or an intermediate care facility for persons with an intellectual

disability when prescribed by the physician, physician assistant, or advanced registered nurse practitioner:

Catheter (indwelling Foley).

Diabetic supplies (including but not limited to lancing devices, lancets, needles and syringes, blood glucose test strips, and diabetic urine test supplies).

Disposable catheterization trays or sets (sterile).

Disposable irrigation trays or sets (sterile).

Disposable saline enemas (e.g., sodium phosphate type).

Ostomy appliances and supplies.

Shoes, diabetic.

78.10(5) Prior authorization requirements. Prior authorization pursuant to rule 441—79.8(249A) is required for the following medical equipment and supplies (Cross reference 78.28(1)):

a. Enclosed beds. Payment for an enclosed bed shall be approved when prescribed for a member who meets all of the following conditions:

(1) The member has a diagnosis-related cognitive or communication impairment that results in risk to safety.

(2) The member's mobility puts the member at risk for injury.

b. External insulin infusion pumps. Payment will be approved according to Medicare coverage criteria.

c. Vest airway clearance systems. Payment will be approved for a vest airway clearance system when prescribed by a pulmonologist for a member with a diagnosis of a lung disorder if all of the following conditions are met:

(1) Pulmonary function tests for the 12 months before the initiation of the vest demonstrate an overall significant decrease in lung function.

(2) The member resides in an independent living situation or has a medical condition that precludes the caregiver from administering traditional chest physiotherapy.

(3) Treatment by flutter device failed or is contraindicated.

(4) Treatment by intrapulmonary percussive ventilation failed or is contraindicated.

(5) All other less costly alternatives have been tried.

d. Automated medication dispenser. Payment will be approved for an automated medication dispenser when prescribed for a member who meets all of the following conditions:

(1) The member has a diagnosis indicative of cognitive impairment or age-related factors that affect the member's ability to remember to take medications.

(2) The member is on two or more medications prescribed to be administered more than one time per day.

(3) The availability of a caregiver to administer the medications or perform setup is limited or nonexistent.

(4) Less costly alternatives, such as medisets or telephone reminders, have failed.

e. Diabetic equipment and supplies. If the department has a current agreement for a rebate with at least one manufacturer of a particular category of diabetic equipment or supplies (by healthcare common procedure coding system (HCPCS) code), prior authorization is required for any equipment or supplies in that category produced by a manufacturer that does not have a current agreement to provide a rebate to the department (other than supplies for members receiving care in a nursing facility or an intermediate care facility for persons with an intellectual disability). Prior approval shall be granted when the member's medical condition necessitates use of equipment or supplies produced by a manufacturer that does not have a current rebate agreement with the department.

f. Speech generating device. Payment shall be approved according to Medicare coverage criteria. Form 470-2145, Speech Generating Device System Selection, completed by a speech-language pathologist and a physician's, physician assistant's, or advanced registered nurse practitioner's prescription for a particular device shall be submitted with the request for prior authorization. In addition, documentation from a speech-language pathologist must include information on the member's educational ability and needs, vocational potential, anticipated duration of need, prognosis regarding

oral communication skills, prognosis with a particular device, and recommendations. A minimum one-month trial period is required for all devices. The Iowa Medicaid enterprise consultant with expertise in speech-language pathology will evaluate each prior authorization request and make recommendations to the department.

g. Bathtub/shower chair, bench. Payment shall be approved for specialized bath equipment for members whose medical condition necessitates additional body support while bathing.

h. Patient lift, nonstandard. Payment shall be approved for a nonstandard lift, such as a portable, ceiling or electric lifter, when the member meets the Medicare criteria for a patient lift and a standard lifter (Hoyer type) will not work.

i. Power wheelchair attendant control. Payment shall be approved when the member has a power wheelchair and:

- (1) Has a sip 'n puff attachment, or
- (2) The medical documentation demonstrates the member's difficulty operating the wheelchair in tight space, or
- (3) The medical documentation demonstrates the member becomes fatigued.

j. Shower commode chairs. Prior authorization shall be granted when documentation from a physician, physician assistant, advanced registered nurse practitioner, physical therapist or occupational therapist indicates that the member:

- (1) Is unable to stand for the duration of a shower or is unable to get in or out of a bathtub, and
- (2) Needs upper body support while sitting, and
- (3) Needs to be tilted back for safety or pressure relief, if a tilt-in-space chair is requested.

k. Ventilator, secondary. Payment shall be approved according to the Medicare coverage criteria.

l. Enteral products and enteral delivery pumps and supplies. Payment shall be approved according to Medicare coverage criteria. EXCEPTION: The Medicare criteria for permanence is not required.

m. Oral nutritional products. Payment shall be approved when the member is not able to ingest or absorb sufficient nutrients from regular food due to a metabolic, digestive, or psychological disorder or pathology, to the extent that supplementation is necessary to provide 51 percent or more of the daily caloric intake, or when the use of oral nutritional products is otherwise determined medically necessary in accordance with evidence-based guidelines for treatment of the member's condition. Nutritional products consumed orally are not covered for members in nursing facilities or intermediate care facilities for persons with an intellectual disability.

n. Reimbursement over the established Medicaid fee schedule amount. Payment shall be approved for bariatric equipment, pediatric equipment or other specialized medical equipment, supply, prosthetic or orthotic which:

- (1) Meets the definition of a code in the current healthcare common procedure coding system (HCPCS), and
- (2) Has an established Medicaid fee schedule amount that is inadequate to cover the provider's cost to obtain the equipment or supply.

o. Customized wheelchairs for members who are residents of nursing facilities, subject to the requirements of 78.10(2)“a”(4).

This rule is intended to implement Iowa Code sections 249A.3, 249A.4 and 249A.12.

[ARC 7548B, IAB 2/11/09, effective 4/1/09; ARC 8344B, IAB 12/2/09, effective 12/1/09; ARC 8643B, IAB 4/7/10, effective 3/11/10; ARC 8714B, IAB 5/5/10, effective 5/1/10; ARC 8993B, IAB 8/11/10, effective 10/1/10; ARC 9256B, IAB 12/1/10, effective 1/1/11; ARC 0632C, IAB 3/6/13, effective 5/1/13; ARC 0823C, IAB 7/10/13, effective 9/1/13; ARC 1151C, IAB 10/30/13, effective 1/1/14]

441—78.11(249A) Ambulance service. Payment will be approved for ambulance service if it is required by the recipient's condition and the recipient is transported to the nearest hospital with appropriate facilities or to one in the same locality, from one hospital to another, to the patient's home or to a nursing facility. Payment for ambulance service to the nearest hospital for outpatient service will be approved only for emergency treatment. Ambulance service must be medically necessary and not merely for the convenience of the patient.

78.11(1) Partial payment may be made when an individual is transported beyond the destinations specified, and is limited to the amount that would have been paid had the individual been transported to

the nearest institution with appropriate facilities. When transportation is to the patient's home, partial payment is limited to the amount that would have been paid from the nearest institution with appropriate facilities. When a recipient who is a resident of a nursing care facility is hospitalized and later discharged from the hospital, payment will be made for the trip to the nursing care facility where the recipient resides even though it may not in fact be the nearest nursing care facility.

78.11(2) The Iowa Medicaid enterprise medical services unit shall determine that the ambulance transportation was medically necessary and that the condition of the patient precluded any other method of transportation. Payment can be made without the physician's confirmation when:

- a. The individual is admitted as a hospital inpatient or in an emergency situation.
- b. Previous information on file relating to the patient's condition clearly indicates ambulance service was necessary.

78.11(3) When a patient is transferred from one nursing home to another because of the closing of a facility or from a nursing home to a custodial home because the recipient no longer requires nursing care, the conditions of medical necessity and the distance requirements shall not be applicable. Approval for transfer shall be made by the local office of the department of human services prior to the transfer. When such a transfer is made, the following rate schedule shall apply:

- One patient - normal allowance
- Two patients - 3/4 normal allowance per patient
- Three patients - 2/3 normal allowance per patient
- Four patients - 5/8 normal allowance per patient

78.11(4) Transportation of hospital inpatients. When an ambulance service provides transport of a hospital inpatient to a provider and returns the recipient to the same hospital (the recipient continuing to be an inpatient of the hospital), the ambulance service shall bill the hospital for reimbursement as the hospital's DRG reimbursement system includes all costs associated with providing inpatient services as stated in 441—paragraph 79.1(5) "j."

78.11(5) In the event that more than one ambulance service is called to provide ground ambulance transport, payment shall be made only to one ambulance company. When a paramedic from one ambulance service joins a ground ambulance company already in transport, coverage is not available for the services and supplies provided by the paramedic.

This rule is intended to implement Iowa Code section 249A.4.

441—78.12(249A) Behavioral health intervention. Payment will be made for behavioral health intervention services not otherwise covered under this chapter that are designed to minimize or, if possible, eliminate the symptoms or causes of a mental disorder, subject to the limitations in this rule.

78.12(1) Definitions.

"Behavioral health intervention" means skill-building services that focus on:

1. Addressing the mental and functional disabilities that negatively affect a member's integration and stability in the community and quality of life;
2. Improving a member's health and well-being related to the member's mental disorder by reducing or managing the symptoms or behaviors that prevent the member from functioning at the member's best possible functional level; and
3. Promoting a member's mental health recovery and resilience through increasing the member's ability to manage symptoms.

"Licensed practitioner of the healing arts" or *"LPHA,"* as used in this rule, means a practitioner such as a physician (M.D. or D.O.), a physician assistant (PA), an advanced registered nurse practitioner (ARNP), a psychologist, a social worker (LMSW or LISW), a marital and family therapist (LMFT), or a mental health counselor (LMHC) who is licensed by the applicable state authority for that profession.

"Managed care organization" means an entity that (1) is under contract with the department to provide services to Medicaid recipients and (2) meets the definition of "health maintenance organization" as defined in Iowa Code section 514B.1.

"Mental disorder" means a disorder, dysfunction, or dysphoria diagnosed pursuant to the current version of the Diagnostic and Statistical Manual of Mental Disorders published by the American

Psychiatric Association, excluding intellectual disabilities, personality disorders, medication-induced movement disorders and other adverse effects of medication, and other conditions that may be a focus of clinical attention.

78.12(2) Covered services.

a. Service setting.

(1) Community-based behavioral health intervention is available to a member living in a community-based environment. Services have a primary goal of assisting the member and the member's family to learn age-appropriate skills to manage behavior and regain or retain self-control. Depending on the member's age and diagnosis, specific services offered may include:

1. Behavior intervention,
2. Crisis intervention,
3. Skill training and development, and
4. Family training.

(2) Residential behavioral health intervention is available to members eligible for foster group care payment pursuant to 441—subrule 156.20(1). Services have the primary goal of assisting the member to prepare to transition to the community through learning age-appropriate skills to manage behavior and regain or retain self-control. Specific services offered include:

1. Behavior intervention,
2. Crisis intervention, and
3. Family training.

(3) Behavioral health intervention is not covered for members who are in an acute care or psychiatric hospital, a long-term care facility, or a psychiatric medical institution for children.

b. Crisis intervention. Crisis intervention services shall provide a focused intervention and rapid stabilization of acute symptoms of mental illness or emotional distress. The intervention shall be designed to de-escalate situations in which a risk to self, others, or property exists.

(1) Services shall assist a member to regain self-control and reestablish effective management of behavioral symptoms associated with a psychological disorder in an age-appropriate manner.

(2) Crisis intervention is covered only for Medicaid members who are aged 20 or under and shall be provided as outlined in a written treatment plan.

(3) Crisis intervention services do not include control room or other restraint activities.

c. Behavior intervention. Behavior intervention includes services designed to modify the psychological, behavioral, emotional, cognitive, and social factors affecting a member's functioning.

(1) Interventions may address the following skills for effective functioning with family, peers, and community in an age-appropriate manner:

1. Cognitive flexibility skills,
2. Communication skills,
3. Conflict resolution skills,
4. Emotional regulation skills,
5. Executive skills,
6. Interpersonal relationship skills,
7. Problem-solving skills, and
8. Social skills.

(2) Behavior intervention shall be provided in a location appropriate for skill identification, teaching and development. Intervention may be provided in an individual, family, or group format as appropriate to meet the member's needs.

(3) Behavior intervention is covered only for Medicaid members aged 20 or under.

(4) Covered services include only direct teaching or development of skills and not general recreation, non-skill-based activities, mentoring, or interruption of school.

d. Family training. Family training is covered only for Medicaid members aged 20 or under.

(1) Family training services shall:

1. Enhance the family's ability to effectively interact with the child and support the child's functioning in the home and community, and

2. Teach parents to identify and implement strategies to reduce target behaviors and reinforce the appropriate skills.

(2) Training provided must:

1. Be for the direct benefit of the member, and
2. Be based on a curriculum with a training manual.

e. Skill training and development. Skill training and development services are covered for Medicaid members aged 18 or over.

(1) Skill training and development shall consist of interventions to:

1. Enhance a member's independent living, social, and communication skills;
2. Minimize or eliminate psychological barriers to a member's ability to effectively manage symptoms associated with a psychological disorder; and
3. Maximize a member's ability to live and participate in the community.

(2) Interventions may include training in the following skills for effective functioning with family, peers, and community:

1. Communication skills,
2. Conflict resolution skills,
3. Daily living skills,
4. Employment-related skills,
5. Interpersonal relationship skills,
6. Problem-solving skills, and
7. Social skills.

78.12(3) Excluded services.

a. Services that are habilitative in nature are not covered under behavioral health intervention. For purposes of this subrule, "habilitative services" means services that are designed to assist individuals in acquiring skills that they never had, as well as associated training to acquire self-help, socialization, and adaptive skills necessary to reside successfully in a home or community setting.

b. Respite, day care, education, and recreation services are not covered under behavioral health intervention.

78.12(4) Coverage requirements. Medicaid covers behavioral health intervention only when the following conditions are met:

a. A licensed practitioner of the healing arts acting within the practitioner's scope of practice under state law has diagnosed the member with a psychological disorder.

b. The licensed practitioner of the healing arts has recommended the behavioral health intervention as part of a plan of treatment designed to treat the member's psychological disorder. The plan of treatment shall be comprehensive in nature and shall detail all behavioral health services that the member may require, not only services included under behavioral health intervention.

(1) The member's need for services must meet specific individual goals that are focused to address:

1. Risk of harm to self or others,
2. Behavioral support in the community,
3. Specific skills impaired due to the member's mental illness, and
4. Needs of children at risk of out-of-home placement due to mental health needs or the transition back to the community or home following an out-of-home placement.

(2) Diagnosis and treatment plan development are covered services.

c. For a member under the age of 21, the licensed practitioner of the healing arts:

(1) Has, in cooperation with the managed care contractor, selected a standardized assessment instrument appropriate for baseline measurement of the member's current skill level in managing mental health needs;

(2) Has completed an initial formal assessment of the member using the instrument selected; and

(3) Completes a formal assessment every six months thereafter if continued services are ordered.

d. The behavioral health intervention provider has prepared a written services implementation plan that meets the requirements of subrule 78.12(5).

78.12(5) Approval of plan. The behavioral health intervention provider shall contact the Iowa Plan provider for authorization of the services.

a. Initial plan. The initial services implementation plan must meet all of the following criteria:

- (1) The plan conforms to the medical necessity requirements in subrule 78.12(6);
- (2) The plan is consistent with the written diagnosis and treatment recommendations made by the licensed practitioner of the healing arts;
- (3) The plan is sufficient in amount, duration, and scope to reasonably achieve its purpose;
- (4) The provider meets the requirements of rule 441—77.12(249A); and
- (5) The plan does not exceed six months' duration.

b. Subsequent plans. The Iowa Plan contractor may approve a subsequent services implementation plan according to the conditions in paragraph 78.12(5)“a” if the services are recommended by a licensed practitioner of the healing arts who has:

- (1) Reexamined the member;
- (2) Reviewed the original diagnosis and treatment plan; and
- (3) Evaluated the member's progress, including a formal assessment as required by 78.12(4)“c”(3).

78.12(6) Medical necessity. Nothing in this rule shall be deemed to exempt coverage of behavioral health intervention from the requirement that services be medically necessary. For purposes of behavioral health intervention, “medically necessary” means that the service is:

a. Consistent with the diagnosis and treatment of the member's condition and specific to a daily impairment caused by a mental disorder;

b. Required to meet the medical needs of the member and is needed for reasons other than the convenience of the member or the member's caregiver;

c. The least costly type of service that can reasonably meet the medical needs of the member; and

d. In accordance with the standards of evidence-based medical practice. The standards of practice for each field of medical and remedial care covered by the Iowa Medicaid program are those standards of practice identified by:

- (1) Knowledgeable Iowa clinicians practicing or teaching in the field; and
- (2) The professional literature regarding evidence-based practices in the field.

This rule is intended to implement Iowa Code section 249A.4 and 2010 Iowa Acts, chapter 1192, section 31.

[**ARC 8504B**, IAB 2/10/10, effective 3/22/10; **ARC 9487B**, IAB 5/4/11, effective 7/1/11; **ARC 1850C**, IAB 2/4/15, effective 4/1/15; **ARC 2164C**, IAB 9/30/15, effective 10/1/15; **ARC 2361C**, IAB 1/6/16, effective 1/1/16]

441—78.13(249A) Nonemergency medical transportation. The department makes available nonemergency medical transportation through a transportation brokerage. Medicaid members who are eligible for full Medicaid benefits and need transportation services so that they can receive Medicaid-covered services from providers enrolled with the Iowa Medicaid program may obtain transportation services consistent with this rule.

78.13(1) Covered services. Nonemergency medical transportation services available are limited to:

a. The most economical transportation appropriate to the needs of the member, provided to members eligible for nonemergency transportation when those members need transportation to providers enrolled in the Iowa Medicaid program for the receipt of goods or services covered by the Iowa Medicaid program. Consistent with the member's needs and subject to the limitations and restrictions set forth in this rule, subject to the advance approval of the broker, such transportation may include:

- (1) Mileage reimbursement to the member, if the member is the driver.
- (2) Mileage reimbursement to a volunteer or other responsible person, if the volunteer or other responsible person is the driver.
- (3) Taxi service.
- (4) Public transportation when public transportation is reasonably available and the member's condition does not preclude its use.
- (5) Wheelchair and stretcher vans.

(6) Airfare costs when the most appropriate mode of transport is by air, based on the member's medical condition.

b. Reimbursement for costs of the member's meals necessary during periods of transportation and medical treatment.

c. Reimbursement of lodging expenses incurred by the member during periods of transportation and medical treatment.

d. Reimbursement of car rental costs incurred by the member during periods of transportation and medical treatment.

e. Reimbursement of a medically necessary escort's travel expenses when an escort is required because of the member's needs.

78.13(2) Exclusions. Nonemergency medical transportation is not available through the Iowa Medicaid program for:

a. Transportation to obtain services not covered by Iowa Medicaid;

b. Transportation to providers that are not enrolled in Iowa Medicaid;

c. Transportation for members residing in nursing facilities or ICF/ID facilities when such facilities provide the transportation (i.e., within 30 miles, one way, of the facility);

d. Transportation of family members to visit or participate in therapy when the member is hospitalized or institutionalized;

e. Transportation to durable medical equipment providers when such providers offer a delivery service that can be accessed at no cost to the member, unless the equipment requires a fitting that cannot be provided without transporting the member;

f. Reimbursement to HCBS and Medicaid providers for transportation provided as part of other covered services, such as personal care, home health, and supported community living services;

g. Transportation to a pharmacy that provides a free delivery service, with the exception of new prescription fills that are otherwise not available to the patient in the absence of nonemergency medical transportation services; and

h. Emergency transportation.

78.13(3) Conditions and limitations on covered services. Nonemergency medical transportation services are subject to the following limitations and conditions:

a. *Member request.* When a member needs nonemergency transportation to receive medical care provided by the Iowa Medicaid program, the member must contact the broker with as much advance notice as possible, but not more than 30 days' advance notice.

(1) Generally, members who require a ride from a transportation provider scheduled by the broker must contact the broker at least two business days in advance of the member's appointment to schedule the transportation. For purposes of calculating the two-business-day notice obligation, the advance notice includes the day of the medical appointment but not the day of the telephone call.

(2) If the member's nonemergency transportation need for a ride from a transportation provider scheduled by the broker makes the provision of two business days' notice impossible because of the member's urgent transportation need, the member must provide as much advance notice as is possible before the transportation need so that the broker can appropriately schedule the most economical form of transportation for the member. Urgent transportation needs for a ride from a transportation provider scheduled by the broker are limited to unscheduled episodic situations in which there is no immediate threat to life or limb but which require that the broker schedule transportation with less than two business days' notice. Examples of urgent trips include, but are not limited to:

1. Postsurgical or medical follow-up care specified by a health care provider;

2. Unexpected preoperative appointments;

3. Hospital discharges;

4. Appointments for new medical conditions or tests; and

5. Dialysis.

(3) The two-business-day advance notice obligation does not apply when the member requests only mileage reimbursement. To be eligible for mileage reimbursement:

1. The member must notify the broker no later than the day of the trip;

2. The transportation must be provided by a driver with a valid driver's license and insurance coverage on the vehicle at the time of the transport; and

3. The other requirements of rule 441—78.13(249A) must be met.

b. No free transportation alternatives available. Member transportation through the nonemergency medical transportation broker is not available to the member when the member is capable of securing the member's own transportation at no cost to the member (e.g., free-gas voucher programs).

c. No member transportation alternatives available. Members who have their own transportation available to them are required to use their own vehicle and seek mileage reimbursement. For purposes of determining whether or not the member has the member's own transportation that is available to the member, the broker shall take into consideration:

- (1) Whether the member owns a vehicle;
- (2) Whether a member-owned vehicle is in working mechanical order and is licensed;
- (3) Whether the member has a valid driver's license and auto insurance;
- (4) Whether the member is unable to drive because of age, physical condition, cognitive impairment, or developmental limitations; and
- (5) Whether friends or family are available to transport the member to the member's medical appointment and receive mileage reimbursement.

d. Limitations on reimbursement for meals. Reimbursement for costs of members' meals necessary during periods of transportation and medical treatment is limited to situations in which:

- (1) The transportation being provided spans the entire meal period;
- (2) The one-way distance to or from the medical appointment is more than 50 miles;
- (3) The meal is necessary to satisfy the needs of the member or medically necessary escort; and
- (4) The meal reimbursement is limited to the subsistence allowance amounts applicable to state officers and state employees pursuant to Iowa Administrative Code rule 11—41.6(8A) and is supported by detailed receipts.

e. Limitations on reimbursement for lodging expenses. Reimbursement of lodging expenses incurred by members during periods of transportation and medical treatment is limited to reasonable reimbursement for expenses incurred by the member or the medically necessary escort, or both, during a nonemergency trip provided by the broker when the one-way distance to or from the medical appointment is more than 50 miles, supported by detailed receipts, and required for treatment.

f. Closest medical provider. Nonemergency medical transportation will only be provided to members to the closest qualified and enrolled Medicaid provider unless:

- (1) The difference between the closest qualified and enrolled Medicaid provider and the enrolled provider requested by the member is less than 10 miles one way; or
- (2) The additional cost of transportation to the enrolled provider requested by the member is medically justified based on:

1. The member's previous relationship with the requested provider; or
2. The member's prior experience with the requested provider; or
3. The requested provider's special expertise or experience; or
4. A referral requiring the member to be seen by the requested provider.

g. Member scheduling obligations. Members who require a ride will need to schedule medical appointments on days the transportation provider sends a shuttle to facilitate the provision of the most economical nonemergency medical transportation available, subject to reasonable medical exceptions.

h. Abusive behavior. Members who are abusive or inappropriate may be restricted by the department to only receiving mileage reimbursement. Such restricted members will be responsible for finding their own way to their medical appointments.

i. Member claim submission. Members must submit claims and supporting documentation to the broker within 120 days of the date of service. The broker shall deny member claims submitted more than 120 days from the date of service.

78.13(4) Grievance procedure. The broker shall establish an internal grievance procedure for members and transportation providers.

- a. Members may appeal to the department pursuant to 441—Chapter 7 as an “aggrieved person.”
- b. Transportation providers.
 - (1) Consent for state fair hearing.
 - 1. Transportation providers that are contracted with the broker and are in good standing with the broker may request a state fair hearing only for disputes regarding payment of claims, specifically, disputes concerning the denial of a claim or reduction in payment, and only when acting on behalf of the member.
 - 2. The transportation provider requesting such a state fair hearing must have the prior, express, signed written consent of the member or the member’s lawfully appointed guardian in order to request such a hearing. Notwithstanding any contrary provision in 441—Chapter 7, no state fair hearing will be granted unless the transportation provider submits a document providing such member approval with the request for a state fair hearing.
 - 3. The document must specifically inform the member that protected health information (PHI) may be discussed at the hearing and may be made public in the course of the hearing and subsequent administrative and judicial proceedings. The document must contain language that indicates the knowledge of the potential for PHI to become public and that the member knowingly, voluntarily and intelligently consents to the network provider’s bringing the state fair hearing on the member’s behalf.
 - (2) For all transportation provider grievances not addressed by paragraph 78.13(4)“b,” the grievance process shall end with binding arbitration, with a designee of the Iowa Medicaid enterprise as arbitrator.

[ARC 8344B, IAB 12/2/09, effective 12/1/09; ARC 8643B, IAB 4/7/10, effective 3/11/10; ARC 8994B, IAB 8/11/10, effective 10/1/10; ARC 1264C, IAB 1/8/14, effective 3/1/14; ARC 1976C, IAB 4/29/15, effective 7/1/15]

441—78.14(249A) Hearing aids. Payment shall be approved for a hearing aid and examinations subject to the following conditions:

78.14(1) Physician examination. The member shall have an examination by a physician to determine that the member has no condition which would contraindicate the use of a hearing aid. This report shall be documented in the patient record. The requirement for a physician evaluation shall be waived for members 18 years of age or older when the member has signed an informed consent statement acknowledging that the member:

- a. Has been advised that it may be in the member’s best health interest to receive a medical evaluation from a licensed physician before purchase of a hearing aid.

- b. Does not wish to receive a medical evaluation prior to purchase of a hearing aid.

78.14(2) Audiological testings. A physician or an audiologist shall perform audiological testing as a part of making a determination that a member could benefit from the use of a hearing aid. The department shall cover vestibular testing performed by an audiologist only when prescribed by a physician.

78.14(3) Hearing aid evaluation. A physician or an audiologist shall perform a hearing aid evaluation to establish if a member could benefit from a hearing aid. When a hearing aid is recommended for a member, the physician or audiologist recommending the hearing aid shall see the member at least one time within 30 days after purchase of the hearing aid to determine that the aid is adequate.

78.14(4) Hearing aid selection. A physician or audiologist may recommend a specific brand or model appropriate to the member’s condition. When a physician or an audiologist makes a general hearing aid recommendation, a hearing aid dispenser may perform the tests to determine the specific brand or model appropriate to the member’s condition.

78.14(5) Travel. When a member is unable to travel to the physician or audiologist because of health reasons, the department shall make payment for travel to the member’s place of residence or other suitable location. The department shall make payment to physicians as specified in 78.1(8) and payment to audiologists at the same rate it reimburses state employees for travel.

78.14(6) Purchase of hearing aid. The department shall pay for the type of hearing aid recommended when purchased from an eligible licensed hearing aid dispenser pursuant to rule 441—77.13(249A). The department shall pay for binaural amplification when:

- a. A child needs the aid for speech development,

- b. The aid is needed for educational or vocational purposes,
- c. The aid is for a blind member,
- d. The member's hearing loss has caused marked restriction of daily activities and constriction of interests resulting in seriously impaired ability to relate to other people, or
- e. Lack of binaural amplification poses a hazard to a member's safety.

78.14(7) Payment for hearing aids.

a. Payment for hearing aids shall be acquisition cost plus a dispensing fee covering the fitting and service for six months. The department shall make payment for routine service after the first six months. Dispensing fees and payment for routine service shall not exceed the fee schedule appropriate to the place of service. Shipping and handling charges are not allowed.

b. Payment for ear mold and batteries shall be at the current audiologist's fee schedule.

c. Payment for repairs shall be made to the dealer for repairs made by the dealer. Payment for in-house repairs shall be made at the current fee schedule. Payment shall also be made to the dealer for repairs when the hearing aid is repaired by the manufacturer or manufacturer's depot. Payment for out-of-house repairs shall be at the amount shown on the manufacturer's invoice. Payment shall be allowed for a service or handling charge when it is necessary for repairs to be performed by the manufacturer or manufacturer's depot and this charge is made to the general public.

d. Prior approval. When prior approval is required, Form 470-4767, Examiner Report of Need for a Hearing Aid, shall be submitted along with the forms required by 441—paragraph 79.8(1) "a."

(1) Payment for the replacement of a hearing aid less than four years old shall require prior approval except when the member is under 21 years of age. The department shall approve payment when the original hearing aid is lost or broken beyond repair or there is a significant change in the member's hearing that would require a different hearing aid. (Cross reference 78.28(4) "a")

(2) Payment for a hearing aid costing more than \$650 shall require prior approval. The department shall approve payment for either of the following purposes (Cross reference 78.28(4) "b"):

1. Educational purposes when the member is participating in primary or secondary education or in a postsecondary academic program leading to a degree and an in-office comparison of an analog aid and a digital aid matched (+/- 5dB) for gain and output shows a significant improvement in either speech recognition in quiet or speech recognition in noise or an in-office comparison of two aids, one of which is single channel, shows significantly improved audibility.

2. Vocational purposes when documentation submitted indicates the necessity, such as varying amounts of background noise in the work environment and a need to converse in order to do the job, and an in-office comparison of an analog aid and a digital aid matched (+/- 5dB) for gain and output shows a significant improvement in either speech recognition in quiet or speech recognition in noise or an in-office comparison of two aids, one of which is single channel, shows significantly improved audibility.

This rule is intended to implement Iowa Code section 249A.4.

[ARC 8008B, IAB 7/29/09, effective 8/1/09]

441—78.15(249A) Orthopedic shoes. Payment shall be approved only for depth or custom-molded orthopedic shoes, inserts, and modifications, subject to the following definitions and conditions.

78.15(1) Definitions.

"Custom-molded shoe" means a shoe that:

- 1. Has been constructed over a cast or model of the recipient's foot;
- 2. Is made of leather or another suitable material of equal quality;
- 3. Has inserts that can be removed, altered, or replaced according to the recipient's conditions and needs; and
- 4. Has some form of closure.

"Depth shoe" means a shoe that:

- 1. Has a full length, heel-to-toe filler that when removed provides a minimum of 3/16 inch of additional depth used to accommodate custom-molded or customized inserts;
- 2. Is made from leather or another suitable material of equal quality;

3. Has some form of closure; and
4. Is available in full and half sizes with a minimum of three widths, so that the sole is graded to the size and width of the upper portions of the shoe according to the American Standard last sizing schedule or its equivalent.

“Insert” means a foot mold or orthosis constructed of more than one layer of a material that:

1. Is soft enough and firm enough to take and hold an impression during use, and
2. Is molded to the recipient’s foot or is made over a model of the foot.

78.15(2) Prescription. The recipient shall present to the provider a written prescription by a physician, a podiatrist, a physician assistant, or an advanced registered nurse practitioner that includes all of the following:

1. The date.
2. The patient’s diagnosis.
3. The reason orthopedic shoes are needed.
4. The probable duration of need.
5. A specific description of any required modification of the shoes.

78.15(3) Diagnosis. The recipient shall have a diagnosis of an orthopedic, neuromuscular, vascular, or insensate foot condition, supported by applicable codes from the current version of the International Classification of Diseases (ICD). A diagnosis of flat feet is not covered.

a. A recipient with diabetes must meet the Medicare criteria for therapeutic depth and custom-molded shoes.

b. Custom-molded shoes are covered only when the recipient has a foot deformity and the provider has documentation of all of the following:

- (1) The reasons the recipient cannot be fitted with a depth shoe.
- (2) Pain.
- (3) Tissue breakdown or a high probability of tissue breakdown.
- (4) Any limitation on walking.

78.15(4) Frequency. Only two pairs of orthopedic shoes are allowed per recipient in a 12-month period unless documentation of change in size or evidence of excessive wear is submitted. EXCEPTION: School-aged children under the age of 21 may obtain athletic shoes in addition to the two pairs of shoes in a 12-month period.

This rule is intended to implement Iowa Code section 249A.4.

441—78.16(249A) Community mental health centers. Payment will be approved for all reasonable and necessary services provided by a psychiatrist on the staff of a community mental health center. Payment will be approved for services provided by a clinical psychologist, social worker or psychiatric nurse on the staff of the center, subject to the following conditions:

78.16(1) Payment to a community mental health center will be approved for reasonable and necessary services provided to members by a psychiatrist, psychologist, social worker or psychiatric nurse on the staff of the center under the following conditions:

a. Services must be rendered under the supervision of a board-eligible or board-certified psychiatrist. All services must be performed under the supervision of a board-eligible or board-certified psychiatrist subject to the conditions set forth in 78.16(1) “*b*” with the following exceptions:

- (1) Services by staff psychiatrists, or
- (2) Services rendered by psychologists meeting the requirements of the National Register of Health Service Providers in Psychology, or
- (3) Services provided by a staff member listed in this subrule performing the preliminary diagnostic evaluation of a member for voluntary admission to one of the state mental health institutes.

b. Supervisory process.

(1) Each patient shall have an initial evaluation completed which shall include at least one personal evaluation interview with a mental health professional, as defined under Iowa Code section 228.1. If the evaluation interview results indicate a need for an interview with a board-eligible or board-certified

psychiatrist, then such referral shall be made. This must be accomplished before submission of the first claim for services rendered to that patient.

(2) Ongoing review and assessment of patients' treatment needs, treatment plans, and the appropriateness of services rendered shall be assured through the peer review process in effect for community mental health centers, as directed by 2002 Iowa Acts, chapter 1120, section 13.

(3) and (4) Rescinded IAB 2/5/03, effective 2/1/03.

78.16(2) The treatment plans for and services rendered to patients of the center shall be evaluated and revised as necessary and appropriate, consistent with the standards of the peer review process described in subparagraph 78.16(1)“b”(1).

78.16(3) The peer review process and related activities, as described under subparagraph 78.16(1)“b”(1), are not payable as separate services under the Medicaid program. The center shall maintain the results of and information related to the peer review process, and these records shall be subject to audit by the department of human services or department designees, as necessary and appropriate.

78.16(4) Clinical records of medical assistance patients shall be available to the carrier on request. All these records shall be held confidential.

78.16(5) At the time of application for participation in the program the center will be provided with a form on which to list its professional staff. The center shall report acquisitions or losses of professional staff to the carrier within ten days.

78.16(6) Payment to a community mental health center will be approved for day treatment services for persons aged 21 or over if the center is certified by the department for day treatment services, the services are provided on the premises of the community mental health center or satellite office of the community mental health center, and the services meet the standards outlined herein.

a. Community mental health centers providing day treatment services for persons aged 21 or over shall have available a written narrative providing the following day treatment information:

(1) Documented need for day treatment services for persons aged 21 and over in the area served by the program, including studies, needs assessments, and consultations with other health care professionals.

(2) Goals and objectives of the day treatment program for persons aged 21 and over that meet the day treatment program guidelines noted in 78.16(6)“b.”

(3) Organization and staffing including how the day treatment program for persons aged 21 and over fits with the rest of the community mental health center, the number of staff, staff credentials, and the staff's relationship to the program, e.g., employee, contractual, or consultant.

(4) Policies and procedures for the program including admission criteria, patient assessment, treatment plan, discharge plan, postdischarge services, and the scope of services provided.

(5) Any accreditations or other types of approvals from national or state organizations.

(6) The physical facility and any equipment to be utilized.

b. Day treatment services for persons aged 21 and over shall be structured, long-term services designed to assist in restoring, maintaining or increasing levels of functioning, minimizing regression, and preventing hospitalization.

(1) Service components include training in independent functioning skills necessary for self-care, emotional stability and psychosocial interactions and training in medication management.

(2) Services are structured with an emphasis on program variation according to individual need.

(3) Services are provided for a period of three to five hours per day, three or four times per week.

c. Payment will be approved for day treatment services provided by or under the general supervision of a mental health professional as defined in rule 441—33.1(225C,230A). When services are provided by an employee or consultant of the community mental health center who is not a mental health professional, the employee or consultant shall be supervised by a mental health professional who gives professional direction and active guidance to the employee or consultant and who retains responsibility for consumer care. The supervision shall be timely, regular, and documented. The employee or consultant shall meet the following minimum requirements:

(1) Have a bachelor's degree in a human services related field from an accredited college or university; or

(2) Have an Iowa license to practice as a registered nurse with two years of experience in the delivery of nursing or human services.

d. Persons aged 18 through 20 with chronic mental illness as defined by rule 441—24.1(225C) can receive day treatment services under this subrule or subrule 78.16(7).

78.16(7) Payment to a community mental health center will be approved for day treatment services for persons aged 20 or under if the center is certified by the department for day treatment services and the services are provided on the premises of the community mental health center or satellite office of the community mental health center. Exception: Field trips away from the premises are a covered service when the trip is therapeutic and integrated into the day treatment program's description and milieu plan.

Day treatment coverage will be limited to a maximum of 15 hours per week. Day treatment services for persons aged 20 or under shall be outpatient services provided to persons who are not inpatients in a medical institution or residents of a group care facility licensed under 441—Chapter 114.

a. Program documentation. Community mental health centers providing day treatment services for persons aged 20 or under shall have available a written narrative which provides the following day treatment program information:

(1) Documented need for day treatment services for persons aged 20 or under in the area served by the program, including studies, needs assessments, and consultations with other health care professionals.

(2) Goals and objectives of the day treatment program for persons aged 20 or under that meet the guidelines noted in paragraphs "c" to "h" below.

(3) Organization and staffing including how the day treatment program for persons aged 20 or under fits with the rest of the community mental health center, the number of staff, staff credentials, and the staff's relationship to the program, e.g., employee, contractual, or consultant.

(4) Policies and procedures for the program including admission criteria, patient assessment, treatment plan, discharge plan, postdischarge services, and the scope of services provided.

(5) Any accreditations or other types of approvals from national or state organizations.

(6) The physical facility and any equipment to be utilized.

b. Program standards. Medicaid day treatment program services for persons aged 20 and under shall meet the following standards:

(1) Staffing shall:

1. Be sufficient to deliver program services and provide stable, consistent, and cohesive milieu with a staff-to-patient ratio of no less than one staff for each eight participants. Clinical, professional, and paraprofessional staff may be counted in determining the staff-to-patient ratio. Professional or clinical staff are those staff who are either mental health professionals as defined in rule 441—33.1(225C,230A) or persons employed for the purpose of providing offered services under the supervision of a mental health professional. All other staff (administrative, adjunctive, support, nonclinical, clerical, and consulting staff or professional clinical staff) when engaged in administrative or clerical activities shall not be counted in determining the staff-to-patient ratio or in defining program staffing patterns. Educational staff may be counted in the staff-to-patient ratio.

2. Reflect how program continuity will be provided.

3. Reflect an interdisciplinary team of professionals and paraprofessionals.

4. Include a designated director who is a mental health professional as defined in rule 441—33.1(225C,230A). The director shall be responsible for direct supervision of the individual treatment plans for participants and the ongoing assessment of program effectiveness.

5. Be provided by or under the general supervision of a mental health professional as defined in rule 441—33.1(225C,230A). When services are provided by an employee or consultant of the community mental health center who is not a mental health professional, the employee or consultant shall be supervised by a mental health professional who gives direct professional direction and active guidance to the employee or consultant and who retains responsibility for consumer care. The supervision shall be timely, regular and documented. The employee or consultant shall have a bachelor's degree in a human services related field from an accredited college or university or have an Iowa license to practice as a registered nurse with two years of experience in the delivery of nursing or human services. Exception: Other certified or licensed staff, such as certified addiction counselors or certified

occupational and recreational therapy assistants, are eligible to provide direct services under the general supervision of a mental health professional, but they shall not be included in the staff-to-patient ratio.

(2) There shall be written policies and procedures addressing the following: admission criteria; patient assessment; patient evaluation; treatment plan; discharge plan; community linkage with other psychiatric, mental health, and human service providers; a process to review the quality of care being provided with a quarterly review of the effectiveness of the clinical program; postdischarge services; and the scope of services provided.

(3) The program shall have hours of operation available for a minimum of three consecutive hours per day, three days or evenings per week.

(4) The length of stay in a day treatment program for persons aged 20 or under shall not exceed 180 treatment days per episode of care, unless the rationale for a longer stay is documented in the patient's case record and treatment plan every 30 calendar days after the first 180 treatment days.

(5) Programming shall meet the individual needs of the patient. A description of services provided for patients shall be documented along with a schedule of when service activities are available including the days and hours of program availability.

(6) There shall be a written plan for accessing emergency services 24 hours a day, seven days a week.

(7) The program shall maintain a community liaison with other psychiatric, mental health, and human service providers. Formal relationships shall exist with hospitals providing inpatient programs to facilitate referral, communication, and discharge planning. Relationships shall also exist with appropriate school districts and educational cooperatives. Relationships with other entities such as physicians, hospitals, private practitioners, halfway houses, the department, juvenile justice system, community support groups, and child advocacy groups are encouraged. The provider's program description will describe how community links will be established and maintained.

(8) Psychotherapeutic treatment services and psychosocial rehabilitation services shall be available. A description of the services shall accompany the application for certification.

(9) The program shall maintain a distinct clinical record for each patient admitted. Documentation, at a minimum, shall include: the specific services rendered, the date and actual time services were rendered, who rendered the services, the setting in which the services were rendered, the amount of time it took to deliver the services, the relationship of the services to the treatment regimen described in the plan of care, and updates describing the patient's progress.

c. Program services. Day treatment services for persons aged 20 or under shall be a time-limited, goal-oriented active treatment program that offers therapeutically intensive, coordinated, structured clinical services within a stable therapeutic milieu. Time-limited means that the patient is not expected to need services indefinitely or lifelong, and that the primary goal of the program is to improve the behavioral functioning or emotional adjustment of the patient in order that the service is no longer necessary. Day treatment services shall be provided within the least restrictive therapeutically appropriate context and shall be community-based and family focused. The overall expected outcome is clinically adaptive behavior on the part of the patient and the family.

At a minimum, day treatment services will be expected to improve the patient's condition, restore the condition to the level of functioning prior to onset of illness, control symptoms, or establish and maintain a functional level to avoid further deterioration or hospitalization. Services are expected to be age-appropriate forms of psychosocial rehabilitation activities, psychotherapeutic services, social skills training, or training in basic care activities to establish, retain or encourage age-appropriate or developmentally appropriate psychosocial, educational, and emotional adjustment.

Day treatment programs shall use an integrated, comprehensive and complementary schedule of therapeutic activities and shall have the capacity to treat a wide array of clinical conditions.

The following services shall be available as components of the day treatment program. These services are not separately billable to Medicaid, as day treatment reimbursement includes reimbursement for all day treatment components.

(1) Psychotherapeutic treatment services (examples would include individual, group, and family therapy).

(2) Psychosocial rehabilitation services. Active treatment examples include, but are not limited to, individual and group therapy, medication evaluation and management, expressive therapies, and theme groups such as communication skills, assertiveness training, other forms of community skills training, stress management, chemical dependency counseling, education, and prevention, symptom recognition and reduction, problem solving, relaxation techniques, and victimization (sexual, emotional, or physical abuse issues).

Other program components may be provided, such as personal hygiene, recreation, community awareness, arts and crafts, and social activities designed to improve interpersonal skills and family mental health. Although these other services may be provided, they are not the primary focus of treatment.

(3) Evaluation services to determine need for day treatment prior to program admission. For persons for whom clarification is needed to determine whether day treatment is an appropriate therapy approach, or for persons who do not clearly meet admission criteria, an evaluation service may be performed. Evaluation services shall be individual and family evaluation activities made available to courts, schools, other agencies, and individuals upon request, who assess, plan, and link individuals with appropriate services. This service must be completed by a mental health professional. An evaluation from another source performed within the previous 12 months or sooner if there has not been a change may be substituted. Medicaid will not make separate payment for these services under the day treatment program.

(4) Assessment services. All day treatment patients will receive a formal, comprehensive biopsychosocial assessment of day treatment needs including, if applicable, a diagnostic impression based on the current Diagnostic and Statistical Manual of Mental Disorders. An assessment from another source performed within the previous 12 months may be used if the symptomatology is the same as 12 months ago. If not, parts of the assessment which reflect current functioning may be used as an update. Using the assessment, a comprehensive summation will be produced, including the findings of all assessments performed. The summary will be used in forming a treatment plan including treatment goals. Indicators for discharge planning, including recommended follow-up goals and provision for future services, should also be considered, and consistently monitored.

(5) The day treatment program may include an educational component as an additional service. The patient's educational needs shall be served without conflict from the day treatment program. Hours in which the patient is involved in the educational component of the day treatment program are not included in the day treatment hours billable to Medicaid.

d. Admission criteria. Admission criteria for day treatment services for persons aged 20 or under shall reflect the following clinical indicators:

(1) The patient is at risk for exclusion from normative community activities or residence.

(2) The patient exhibits psychiatric symptoms, disturbances of conduct, decompensating conditions affecting mental health, severe developmental delays, psychological symptoms, or chemical dependency issues sufficiently severe to bring about significant or profound impairment in day-to-day educational, social, vocational, or interpersonal functioning.

(3) Documentation is provided that the traditional outpatient setting has been considered and has been determined not to be appropriate.

(4) The patient's principal caretaker (family, guardian, foster family or custodian) must be able and willing to provide the support and monitoring of the patient, to enable adequate control of the patient's behavior, and must be involved in the patient's treatment. Persons aged 20 or under who have reached the age of majority, either by age or emancipation, are exempt from family therapy involvement.

(5) The patient has the capacity to benefit from the interventions provided.

e. Individual treatment plan. Each patient receiving day treatment services shall have a treatment plan prepared. A preliminary treatment plan should be formulated within 3 days of participation after admission, and replaced within 30 calendar days by a comprehensive, formalized plan utilizing the comprehensive assessment. This individual treatment plan should reflect the patient's strengths and weaknesses and identify areas of therapeutic focus. The treatment goals which are general statements of consumer outcomes shall be related to identified strengths, weaknesses, and clinical needs

with time-limited, measurable objectives. Objectives shall be related to the goal and have specific anticipated outcomes. Methods that will be used to pursue the objectives shall be stated. The plan should be reviewed and revised as needed, but shall be reviewed at least every 30 calendar days. The treatment plan shall be developed or approved by a board-eligible or board-certified psychiatrist, a staff psychiatrist, physician, or a psychologist registered either on the “National Register of Health Service Providers in Psychology” or the “Iowa Register of Health Service Providers for Psychology.” Approval will be evidenced by a signature of the physician or health service provider.

f. Discharge criteria. Discharge criteria for the day treatment program for persons aged 20 or under shall incorporate at least the following indicators:

(1) In the case of patient improvement:

1. The patient’s clinical condition has improved as shown by symptom relief, behavioral control, or indication of mastery of skills at the patient’s developmental level. Reduced interference with and increased responsibility with social, vocational, interpersonal, or educational goals occurs sufficient to warrant a treatment program of less supervision, support, and therapeutic intervention.

2. Treatment goals in the individualized treatment plan have been achieved.

3. An aftercare plan has been developed that is appropriate to the patient’s needs and agreed to by the patient and family, custodian, or guardian.

(2) If the patient does not improve:

1. The patient’s clinical condition has deteriorated to the extent that the safety and security of inpatient or residential care is necessary.

2. Patient, family, or custodian noncompliance with treatment or with program rules exists.

g. Coordination of services. Programming services shall be provided in accordance with the individual treatment plan developed by appropriate day treatment staff, in collaboration with the patient and appropriate caretaker figure (parent, guardian, or principal caretaker), and under the supervision of the program director, coordinator, or supervisor.

The program for each patient will be coordinated by primary care staff of the community mental health center. A coordinated, consistent array of scheduled therapeutic services and activities shall comprise the day treatment program. These may include counseling or psychotherapy, theme groups, social skills development, behavior management, and other adjunctive therapies. At least 50 percent of scheduled therapeutic program hours exclusive of educational hours for each patient shall consist of active treatment that specifically addresses the targeted problems of the population served. Active treatment shall be defined as treatment in which the program staff assume significant responsibility and often intervene.

Family, guardian, or principal caretaker shall be involved with the program through family therapy sessions or scheduled family components of the program. They will be encouraged to adopt an active role in treatment. Medicaid will not make separate payment for family therapy services. Persons aged 20 or under who have reached the age of majority, either by age or emancipation, are exempt from family therapy involvement.

Therapeutic activities will be scheduled according to the needs of the patients, both individually and as a group.

Scheduled therapeutic activities, which may include other program components as described above, shall be provided at least 3 hours per week up to a maximum of 15 hours per week.

h. Stable milieu. The program shall formally seek to provide a stable, consistent, and cohesive therapeutic milieu. In part this will be encouraged by scheduling attendance such that a stable core of patients exists as much as possible. The milieu will consider the developmental and social stage of the participants such that no patient will be significantly involved with other patients who are likely to contribute to retardation or deterioration of the patient’s social and emotional functioning. To help establish a sense of program identity, the array of therapeutic interventions shall be specifically identified as the day treatment program. Program planning meetings shall be held at least quarterly to evaluate the effectiveness of the clinical program. In the program description, the provider shall state how milieu stability will be provided.

i. Chronic mental illness. Persons aged 18 through 20 with chronic mental illness as defined by rule 441—24.1(225C) can receive day treatment services under this subrule or subrule 78.16(6).

This rule is intended to implement Iowa Code section 249A.4.

441—78.17(249A) Physical therapists. Payment will be approved for the same services payable under Title XVIII of the Social Security Act (Medicare).

This rule is intended to implement Iowa Code section 249A.4.

441—78.18(249A) Screening centers. Payment will be approved for health screening as defined in 441—subrule 84.1(1) for Medicaid members under 21 years of age.

78.18(1) In order to be paid for the administration of a vaccine covered under the Vaccines for Children (VFC) Program, a screening center must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

78.18(2) Payment will be approved for necessary laboratory service related to an element of screening when performed by the screening center and billed as a separate item.

78.18(3) Periodicity schedules for health, hearing, vision, and dental screenings.

a. Payment will be approved for health, vision, and hearing screenings as follows:

- (1) Six screenings in the first year of life.
- (2) Four screenings between the ages of 1 and 2.
- (3) One screening a year at ages 3, 4, 5, and 6.
- (4) One screening a year at ages 8, 10, 12, 14, 16, 18, and 20.

b. Payment for dental screenings will be approved in conjunction with the health screenings up to age 12 months. Screenings will be approved at ages 12 months and 24 months and thereafter at six-month intervals up to age 21.

c. Interperiodic screenings will be approved as medically necessary.

78.18(4) When it is established by the periodicity schedule in 78.18(3) that an individual is in need of screening the individual will receive a notice that screening is due.

78.18(5) When an individual is screened, a member of the screening center shall complete a medical history. The medical history shall become part of the individual's medical record.

78.18(6) Rescinded IAB 12/3/08, effective 2/1/09.

78.18(7) Payment will be made for persons aged 20 and under for nutritional counseling provided by a licensed dietitian employed by or under contract with a screening center for a nutritional problem or condition of a degree of severity that nutritional counseling beyond that normally expected as part of the standard medical management is warranted. For persons eligible for the WIC program, a WIC referral is required. Medical necessity for nutritional counseling services exceeding those available through WIC shall be documented.

78.18(8) Payment shall be made for dental services provided by a dental hygienist employed by or under contract with a screening center.

This rule is intended to implement Iowa Code section 249A.4.

[ARC 0065C, IAB 4/4/12, effective 6/1/12]

441—78.19(249A) Rehabilitation agencies.

78.19(1) Coverage of services.

a. General provisions regarding coverage of services.

(1) Services are provided in the member's home or in a care facility (other than a hospital) by a speech therapist, physical therapist, or occupational therapist employed by or contracted by the agency. Services provided to a member residing in a residential care facility are payable when the facility submits a signed statement that the facility does not have these services available. The statement need only be submitted at the start of care unless the situation changes. Payment will not be made to a rehabilitation agency for therapy provided to a member residing in a nursing facility or an intermediate care facility for persons with an intellectual disability since these facilities are responsible for providing or paying for services required by members.

(2) All services must be determined to be medically necessary, reasonable, and meet a significant need of the recipient that cannot be met by a family member, friend, medical staff personnel, or other caregiver; must meet accepted standards of medical practice; and must be a specific and effective treatment for a patient's medical or disabling condition.

(3) In order for a service to be payable, a licensed therapist must complete a plan of treatment every 30 days and indicate the type of service required. The plan of treatment must contain the information noted in subrule 78.19(2).

(4) There is no specific limitation on the number of visits for which payment through the program will be made so long as that amount of service is medically necessary in the individual case, is related to a diagnosed medical impairment or disabling condition, and meets the current standards of practice in each related field. Documentation must be submitted with each claim to support the need for the number of services being provided.

(5) Payments will be made both for restorative service and also for maintenance types of service. Essentially, maintenance services means services to a patient whose condition is stabilized and who requires observation by a therapist of conditions defined by the physician as indicating a possible deterioration of health status. This would include persons with long-term illnesses or a disabling condition whose status is stable rather than posthospital. Refer to 78.19(1) "b"(7) and (8) for guidelines under restorative and maintenance therapy.

(6) Restorative or maintenance therapy sessions must meet the following criteria:

1. There must be face-to-face patient contact interaction.

2. Services must be provided primarily on an individual basis. Group therapy is covered, but total units of service in a month shall not exceed total units of individual therapy. Family members receiving therapy may be included as part of a group.

3. Treatment sessions may be no less than 15 minutes of service and no more than 60 minutes of service per date unless more than 60 minutes of service is required for a treatment session due to the patient's specific condition. If more than 60 minutes of service is required for a treatment session, additional documentation of the specific condition and the need for the longer treatment session shall be submitted with the claim. A unit of treatment shall be considered to be 15 minutes in length.

4. Progress must be documented in measurable statistics in the progress notes in order for services to be reimbursed. Refer to 78.19(1) "b"(7) and (8) for guidelines under restorative and maintenance therapy.

(7) Payment will be made for an appropriate period of diagnostic therapy or trial therapy (up to two months) to determine a patient's rehabilitation potential and establish appropriate short-term and long-term goals. Documentation must be submitted with each plan to support the need for diagnostic or trial therapy. Refer to 78.19(1) "b"(16) for guidelines under diagnostic or trial therapy.

b. Physical therapy services.

(1) To be covered under rehabilitation agency services, physical therapy services must relate directly and specifically to an active written treatment plan, follow a treatment plan established by the licensed therapist after consultation with the physician, be reasonable and necessary to the treatment of the person's illness, injury, or disabling condition, be specific and effective treatment for the patient's medical or disabling condition, and be of such a level of complexity and sophistication, or the condition of the patient must be such that the services required can be safely and effectively performed only by a qualified physical therapist or under the supervision of the therapist.

(2) A qualified physical therapist assistant may provide any restorative services performed by a licensed physical therapist under supervision of the therapist as set forth in the department of public health, professional licensure division, 645—subrule 200.20(7).

(3) The initial physical therapy evaluation must be provided by a licensed physical therapist.

(4) There must be an expectation that there will be a significant, practical improvement in the patient's condition in a reasonable amount of time based on the patient's restorative potential assessed by the physician.

(5) It must be demonstrated there is a need to establish a safe and effective maintenance program related to a specific disease state, illness, injury, or disabling condition.

(6) The amount, frequency, and duration of the services must be reasonable.

(7) Restorative therapy must be reasonable and necessary to the treatment of the patient's injury or disabling condition. The expected restorative potential must be practical and in relation to the extent and duration of the treatment. There must be an expectation that the patient's medical or disabling condition will show functional improvement in a reasonable period of time. Functional improvement means that demonstrable measurable increases have occurred in the patient's level of independence outside the therapeutic environment.

(8) Generally, maintenance therapy means services to a patient whose condition is stabilized and who requires observation by a therapist of conditions defined by the physician as indicating a possible deterioration of health status. This includes persons with long-term illnesses or disabling conditions whose status is stable rather than posthospital. Maintenance therapy is also appropriate for individuals whose condition is such that a professionally established program of activities, exercises, or stimulation is medically necessary to prevent deterioration or maintain present functioning levels.

Where a maintenance program is appropriate, the initial evaluation and the instruction of the patient, family members, home health aides, facility personnel, or other caregivers to carry out the program are considered a covered physical therapy service. Payment shall be made for a maximum of three visits to establish a maintenance program and instruct the caregivers. Payment for supervisory visits to monitor the program is limited to two per month for a maximum period of 12 months. The plan of treatment must specify the anticipated monitoring activity of the supervisor.

Beyond evaluation, instruction, and monitoring, maintenance therapy is not reimbursable.

After 12 months of maintenance therapy, a reevaluation is a covered service, if medically necessary. A reevaluation will be considered medically necessary only if there is a significant change in residential or employment situation or the patient exhibits an increase or decrease in functional ability or motivation, clearing of confusion, or the remission of some other medical condition which previously contraindicated restorative therapy. A statement by the interdisciplinary team of a person with developmental disabilities recommending a reevaluation and stating the basis for medical necessity will be considered as supporting the necessity of a reevaluation and may expedite approval.

(Restorative and maintenance therapy definitions also apply to speech and occupational therapy.)

When a patient is under a restorative physical therapy program, the patient's condition is regularly reevaluated and the program adjusted by the physical therapist. It is expected that prior to discharge, a maintenance program has been designed by the physical therapist. Consequently, where a maintenance program is not established until after the restorative program has been completed, it would not be considered reasonable and necessary to the treatment of the patient's condition and would be excluded from coverage.

(9) Hot packs, hydrocollator, infrared treatments, paraffin baths, and whirlpool baths do not ordinarily require the skills of a qualified physical therapist. These are covered when the patient's condition is complicated by other conditions such as a circulatory deficiency or open wounds or if the service is an integral part of a skilled physical therapy procedure.

(10) Gait training and gait evaluation and training constitute a covered service if the patient's ability to walk has been impaired by a neurological, muscular or skeletal condition or illness. The gait training must be expected to significantly improve the patient's ability to walk or level of independence.

Repetitious exercise to increase endurance of weak or unstable patients can be safely provided by supportive personnel, e.g., aides, nursing personnel. Therefore, it is not a covered physical therapy service.

(11) Ultrasound, shortwave, and microwave diathermy treatments are considered covered services.

(12) Range of motion tests must be performed by a qualified physical therapist. Range of motion exercises require the skills of a qualified physical therapist only when they are part of the active treatment of a specific disease or disabling condition which has resulted in a loss or restriction of mobility.

Documentation must reflect the degree of motion lost, the normal range of motion, and the degree to be restored.

Range of motion to unaffected joints only does not constitute a covered physical therapy service.

(13) Reconditioning programs after surgery or prolonged hospitalization are not covered as physical therapy.

(14) Therapeutic exercises would constitute a physical therapy service due either to the type of exercise employed or to the condition of the patient.

(15) Use of isokinetic or isotonic type equipment in physical therapy is covered when normal range of motion of a joint is affected due to bone, joint, ligament or tendon injury or postsurgical trauma. Billing can only be made for the time actually spent by the therapist in instructing the patient and assessing the patient's progress.

(16) When recipients do not meet restorative or maintenance therapy criteria, diagnostic or trial therapy may be utilized. When the initial evaluation is not sufficient to determine whether there are rehabilitative goals that should be addressed, diagnostic or trial therapy to establish goals shall be considered appropriate. Diagnostic or trial therapy may be appropriate for recipients who need evaluation in multiple environments in order to adequately determine their rehabilitative potential. Diagnostic or trial therapy consideration may be appropriate when there is a need to assess the patient's response to treatment in the recipient's environment.

When during diagnostic or trial therapy a recipient has been sufficiently evaluated to determine potential for restorative or maintenance therapy, or lack of therapy potential, diagnostic or trial therapy ends. When as a result of diagnostic or trial therapy, restorative or maintenance therapy is found appropriate, claims shall be submitted noting restorative or maintenance therapy (instead of diagnostic or trial therapy).

At the end of diagnostic or trial therapy, the rehabilitation provider shall recommend continuance of services under restorative therapy, recommend continuance of services under maintenance therapy, or recommend discontinuance of services. Continuance of services under restorative or maintenance therapy will be reviewed based on the criteria in place for restorative or maintenance therapy.

Trial therapy shall not be granted more often than once per year for the same issue. If the recipient has a previous history of rehabilitative services, trial therapy for the same type of services generally would be payable only when a significant change has occurred since the last therapy. Requests for subsequent diagnostic or trial therapy for the same issue would require documentation reflecting a significant change. See number 4 below for guidelines under a significant change. Further diagnostic or trial therapy for the same issue would not be considered appropriate when progress was not achieved, unless the reasons which blocked change previously are listed and the reasons the new diagnostic or trial therapy would not have these blocks are provided.

The number of diagnostic or trial therapy hours authorized in the initial treatment period shall not exceed 12 hours per month. Documentation of the medical necessity and the plan for services under diagnostic trial therapy are required as they will be reviewed in the determination of the medical necessity of the number of hours of service provided.

Diagnostic or trial therapy standards also apply to speech and occupational therapy.

The following criteria additionally must be met:

1. There must be face-to-face interaction with a licensed therapist. (An aide's services will not be payable.)

2. Services must be provided on an individual basis. (Group diagnostic or trial therapy will not be payable.)

3. Documentation of the diagnostic therapy or trial therapy must reflect the provider's plan for therapy and the recipient's response.

4. If the recipient has a previous history of rehabilitative services, trial therapy for the same type of services generally would be payable only when a significant change has occurred since the last therapy. A significant change would be considered as having occurred when any of the following exist: new onset, new problem, new need, new growth issue, a change in vocational or residential setting that requires a reevaluation of potential, or surgical intervention that may have caused new rehabilitative potentials.

5. For persons who received previous rehabilitative treatment, consideration of trial therapy generally should occur only if the person has incorporated any regimen recommended during prior treatment into the person's daily life to the extent of the person's abilities.

6. Documentation should include any previous attempts to resolve problems using nontherapy personnel (i.e., residential group home staff, family members, etc.) and whether follow-up programs from previous therapy have been carried out.

7. Referrals from residential, vocational or other rehabilitation personnel that do not meet present evaluation, restorative or maintenance criteria shall be considered for trial therapy. Documentation of the proposed service, the medical necessity and the current medical or disabling condition, including any secondary rehabilitative diagnosis, will need to be submitted with the claim.

8. Claims for diagnostic or trial therapy shall reflect the progress being made toward the initial diagnostic or trial therapy plan.

c. Occupational therapy services.

(1) To be covered under rehabilitation agency services, occupational therapy services must be included in a plan of treatment, improve or restore practical functions which have been impaired by illness, injury, or disabling condition, or enhance the person's ability to perform those tasks required for independent functioning, be prescribed by a physician under a plan of treatment, be performed by a qualified licensed occupational therapist or a qualified licensed occupational therapist assistant under the general supervision of a qualified licensed occupational therapist as set forth in the department of public health, professional licensure division, rule 645—201.9(148B), and be reasonable and necessary for the treatment of the person's illness, injury, or disabling condition.

(2) Restorative therapy is covered when an expectation exists that the therapy will result in a significant practical improvement in the person's condition.

However, in these cases where there is a valid expectation of improvement met at the time the occupational therapy program is instituted, but the expectation goal is not realized, services would only be covered up to the time one would reasonably conclude the patient would not improve.

The guidelines under restorative therapy, maintenance therapy, and diagnostic or trial therapy for physical therapy in 78.19(1) "b"(7), (8), and (16) apply to occupational therapy.

(3) Maintenance therapy, or any activity or exercise program required to maintain a function at the restored level, is not a covered service. However, designing a maintenance program in accordance with the requirements of 78.19(1) "b"(8) and monitoring the progress would be covered.

(4) The selection and teaching of tasks designed to restore physical function are covered.

(5) Planning and implementing therapeutic tasks, such as activities to restore sensory-integrative functions are covered. Other examples include providing motor and tactile activities to increase input and improve responses for a stroke patient.

(6) The teaching of activities of daily living and energy conservation to improve the level of independence of a patient which require the skill of a licensed therapist and meet the definition of restorative therapy is covered.

(7) The designing, fabricating, and fitting of orthotic and self-help devices are considered covered services if they relate to the patient's condition and require occupational therapy. A maximum of 13 visits is reimbursable.

(8) Vocational and prevocational assessment and training are not payable by Medicaid. These include services which are related solely to specific employment opportunities, work skills, or work settings.

d. Speech therapy services.

(1) To be covered by Medicaid as rehabilitation agency services, speech therapy services must be included in a plan of treatment established by the licensed, skilled therapist after consultation with the physician, relate to a specific medical diagnosis which will significantly improve a patient's practical, functional level in a reasonable and predictable time period, and require the skilled services of a speech therapist. Services provided by a speech aide are not reimbursable.

(2) Speech therapy activities which are considered covered services include: restorative therapy services to restore functions affected by illness, injury, or disabling condition resulting in a communication impairment or to develop functions where deficiencies currently exist. Communication impairments fall into the general categories of disorders of voice, fluency, articulation, language, and

swallowing disorders resulting from any condition other than mental impairment. Treatment of these conditions is payable if restorative criteria are met.

(3) Aural rehabilitation, the instruction given by a qualified speech pathologist in speech reading or lip reading to patients who have suffered a hearing loss (input impairment), constitutes a covered service if reasonable and necessary to the patient's illness or injury. Group treatment is not covered. Audiological services related to the use of a hearing aid are not reimbursable.

(4) Teaching a patient to use sign language and to use an augmentative communication device is reimbursable. The patient must show significant progress outside the therapy sessions in order for these services to be reimbursable.

(5) Where a maintenance program is appropriate, the initial evaluation, the instruction of the patient and caregivers to carry out the program, and supervisory visits to monitor progress are covered services. Beyond evaluation, instruction, and monitoring, maintenance therapy is not reimbursable. However, designing a maintenance program in accordance with the requirements of maintenance therapy and monitoring the progress are covered.

(6) The guidelines and limits on restorative therapy, maintenance therapy, and diagnostic or trial therapy for physical therapy in 78.19(1) "b"(7), (8), and (16) apply to speech therapy. If the only goal of prior rehabilitative speech therapy was to learn the prerequisite speech components, then number "5" under 78.19(1) "b"(16) will not apply to trial therapy.

78.19(2) General guidelines for plans of treatment.

a. The minimum information to be included on medical information forms and treatment plans includes:

(1) The patient's current medical condition and functional abilities, including any disabling condition.

(2) The physician's signature and date (within the certification period).

(3) Certification period.

(4) Patient's progress in measurable statistics. (Refer to 78.19(1) "b"(16).)

(5) The place services are rendered.

(6) Dates of prior hospitalization (if applicable or known).

(7) Dates of prior surgery (if applicable or known).

(8) The date the patient was last seen by the physician (if available).

(9) A diagnosis relevant to the medical necessity for treatment.

(10) Dates of onset of any diagnoses for which treatment is being rendered (if applicable).

(11) A brief summary of the initial evaluation or baseline.

(12) The patient's prognosis.

(13) The services to be rendered.

(14) The frequency of the services and discipline of the person providing the service.

(15) The anticipated duration of the services and the estimated date of discharge (if applicable).

(16) Assistive devices to be used.

(17) Functional limitations.

(18) The patient's rehabilitative potential and the extent to which the patient has been able to apply the skills learned in the rehabilitation setting to everyday living outside the therapy sessions.

(19) The date of the last episode of instability or the date of the last episode of acute recurrence of illness or symptoms (if applicable).

(20) Quantitative, measurable, short-term and long-term functional goals.

(21) The period of time of a session.

(22) Prior treatment (history related to current diagnosis) if available or known.

b. The information to be included when developing plans for teaching, training, and counseling include:

(1) To whom the services were provided (patient, family member, etc.).

(2) Prior teaching, training, or counseling provided.

(3) The medical necessity of the rendered services.

(4) The identification of specific services and goals.

- (5) The date of the start of the services.
- (6) The frequency of the services.
- (7) Progress in response to the services.
- (8) The estimated length of time the services are needed.

This rule is intended to implement Iowa Code section 249A.4.
[ARC 0994C, IAB 9/4/13, effective 11/1/13]

441—78.20(249A) Independent laboratories. Payment will be made for medically necessary laboratory services provided by laboratories that are independent of attending and consulting physicians' offices, hospitals, and critical access hospitals and that are certified to participate in the Medicare program.

This rule is intended to implement Iowa Code section 249A.4.

441—78.21(249A) Rural health clinics. Payment will be made to rural health clinics for the same services payable under the Medicare program (Title XVIII of the Social Security Act). Payment will be made for sterilization in accordance with 78.1(16).

78.21(1) Utilization review. Utilization review shall be conducted of Medicaid members who access more than 24 outpatient visits in any 12-month period from physicians, advanced registered nurse practitioners, federally qualified health centers, other clinics, and emergency rooms. Refer to rule 441—76.9(249A) for further information concerning the member lock-in program.

78.21(2) Risk assessment. Risk assessment, using Form 470-2942, Medicaid Prenatal Risk Assessment, shall be completed at the initial visit during a Medicaid member's pregnancy.

a. If the risk assessment reflects a low-risk pregnancy, the assessment shall be completed again at approximately the twenty-eighth week of pregnancy.

b. If the risk assessment reflects a high-risk pregnancy, referral shall be made for enhanced services. (See description of enhanced services at subrule 78.25(3).)

78.21(3) Vaccines. In order to be paid for the administration of a vaccine covered under the Vaccines for Children (VFC) Program, a rural health center must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

This rule is intended to implement Iowa Code section 249A.4.
[ARC 0065C, IAB 4/4/12, effective 6/1/12]

441—78.22(249A) Family planning clinics. Payments will be made on a fee schedule basis for services provided by family planning clinics.

78.22(1) Payment will be made for sterilization in accordance with 78.1(16).

78.22(2) In order to be paid for the administration of a vaccine covered under the Vaccines for Children (VFC) Program, a family planning clinic must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

This rule is intended to implement Iowa Code section 249A.4.
[ARC 0065C, IAB 4/4/12, effective 6/1/12]

441—78.23(249A) Other clinic services. Payment will be made on a fee schedule basis to facilities not part of a hospital, funded publicly or by private contributions, which provide medically necessary treatment by or under the direct supervision of a physician or dentist to outpatients.

78.23(1) Sterilization. Payment will be made for sterilization in accordance with 78.1(16).

78.23(2) Utilization review. Utilization review shall be conducted of Medicaid members who access more than 24 outpatient visits in any 12-month period from physicians, advanced registered nurse practitioners, federally qualified health centers, other clinics, and emergency rooms. Refer to rule 441—76.9(249A) for further information concerning the member lock-in program.

78.23(3) Risk assessment. Risk assessment, using Form 470-2942, Medicaid Prenatal Risk Assessment, shall be completed at the initial visit during a Medicaid member's pregnancy.

a. If the risk assessment reflects a low-risk pregnancy, the assessment shall be completed again at approximately the twenty-eighth week of pregnancy.

b. If the risk assessment reflects a high-risk pregnancy, referral shall be made for enhanced services. (See description of enhanced services at subrule 78.25(3).)

78.23(4) Vaccines. In order to be paid for the administration of a vaccine covered under the Vaccines for Children (VFC) Program, a clinic must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

This rule is intended to implement Iowa Code section 249A.4.
[ARC 0065C, IAB 4/4/12, effective 6/1/12]

441—78.24(249A) Psychologists. Payment will be approved for services authorized by state law when they are provided by the psychologist in the psychologist's office, a hospital, nursing facility, or residential care facility.

78.24(1) Payment for covered services provided by the psychologist shall be made on a fee for service basis.

a. Payment shall be made only for time spent in face-to-face consultation with the client.

b. Time spent with clients shall be rounded to the quarter hour.

78.24(2) Payment will be approved for the following psychological procedures:

a. Individual outpatient psychotherapy or other psychological procedures not to exceed one hour per week or 40 hours in any 12-month period, or

b. Couple, marital, family, or group outpatient therapy not to exceed one and one-half hours per week or 60 hours in any 12-month period, or

c. A combination of individual and group therapy not to exceed the cost of 40 individual therapy hours in any 12-month period.

d. Psychological examinations and testing for purposes of evaluation, placement, psychotherapy, or assessment of therapeutic progress, not to exceed eight hours in any 12-month period.

e. Mileage at the same rate as in 78.1(8) when the following conditions are met:

(1) It is necessary for the psychologist to travel outside of the home community, and

(2) There is no qualified mental health professional more immediately available in the community, and

(3) The member has a medical condition which prohibits travel.

f. Covered procedures necessary to maintain continuity of psychological treatment during periods of hospitalization or convalescence for physical illness.

g. Procedures provided within a licensed hospital, residential treatment facility, day hospital, or nursing home as part of an approved treatment plan and a psychologist is not employed by the facility.

78.24(3) Payment will not be approved for the following services:

a. Psychological examinations performed without relationship to evaluations or psychotherapy for a specific condition, symptom, or complaint.

b. Psychological examinations covered under Part B of Medicare, except for the Part B Medicare deductible and coinsurance.

c. Psychological examinations employing unusual or experimental instrumentation.

d. Individual and group psychotherapy without specification of condition, symptom, or complaint.

e. Sensitivity training, marriage enrichment, assertiveness training, growth groups or marathons, or psychotherapy for nonspecific conditions of distress such as job dissatisfaction or general unhappiness.

78.24(4) Rescinded IAB 10/12/94, effective 12/1/94.

78.24(5) The following services shall require review by a consultant to the department.

a. Protracted therapy beyond 16 visits. These cases shall be reviewed following the sixteenth therapy session and periodically thereafter.

b. Any service which does not appear necessary or appears to fall outside the scope of what is professionally appropriate or necessary for a particular condition.

This rule is intended to implement Iowa Code sections 249A.4 and 249A.15.

441—78.25(249A) Maternal health centers. Payment will be made for prenatal and postpartum medical care, health education, and transportation to receive prenatal and postpartum services. Payment

will be made for enhanced perinatal services for persons determined high risk. These services include additional health education services, nutrition counseling, social services, and one postpartum home visit. Maternal health centers shall provide trimester and postpartum reports to the referring physician. Risk assessment using Form 470-2942, Medicaid Prenatal Risk Assessment, shall be completed at the initial visit during a Medicaid member's pregnancy. If the risk assessment reflects a low-risk pregnancy, the assessment shall be completed again at approximately the twenty-eighth week of pregnancy. If the risk assessment reflects a high-risk pregnancy, referral shall be made for enhanced services. (See description of enhanced services at subrule 78.25(3).)

78.25(1) Provider qualifications.

a. Prenatal and postpartum medical services shall be provided by a physician, a physician assistant, or a nurse practitioner employed by or on contract with the center. Medical services performed by maternal health centers shall be performed under the supervision of a physician. Nurse practitioners and physician assistants performing under the supervision of a physician must do so within the scope of practice of that profession, as defined by Iowa Code chapters 152 and 148C, respectively.

b. Rescinded IAB 12/3/08, effective 2/1/09.

c. Education services and postpartum home visits shall be provided by a registered nurse.

d. Nutrition services shall be provided by a licensed dietitian.

e. Psychosocial services shall be provided by a person with at least a bachelor's degree in social work, counseling, sociology, psychology, family and community services, health or human development, health education, or individual and family studies.

78.25(2) Services covered for all pregnant women. Services provided may include:

a. Prenatal and postpartum medical care.

b. Health education, which shall include:

(1) Importance of continued prenatal care.

(2) Normal changes of pregnancy including both maternal changes and fetal changes.

(3) Self-care during pregnancy.

(4) Comfort measures during pregnancy.

(5) Danger signs during pregnancy.

(6) Labor and delivery including the normal process of labor, signs of labor, coping skills, danger signs, and management of labor.

(7) Preparation for baby including feeding, equipment, and clothing.

(8) Education on the use of over-the-counter drugs.

(9) Education about HIV protection.

c. Home visit.

d. Transportation to receive prenatal and postpartum services that is not payable under rule 441—78.11(249A) or 441—78.13(249A).

e. Dental hygiene services within the scope of practice as defined by the dental board at 650—paragraph 10.5(3)“b.”

78.25(3) Enhanced services covered for women with high-risk pregnancies. Enhanced perinatal services may be provided to a patient who has been determined to have a high-risk pregnancy as documented by Form 470-2942, Medicaid Prenatal Risk Assessment. An appropriately trained physician or advanced registered nurse practitioner must be involved in staffing the patients receiving enhanced services.

Enhanced services are as follows:

a. Rescinded IAB 12/3/08, effective 2/1/09.

b. Education, which shall include as appropriate education about the following:

(1) High-risk medical conditions.

(2) High-risk sexual behavior.

(3) Smoking cessation.

(4) Alcohol usage education.

(5) Drug usage education.

(6) Environmental and occupational hazards.

- c. Nutrition assessment and counseling, which shall include:
 - (1) Initial assessment of nutritional risk based on height, current and prepregnancy weight status, laboratory data, clinical data, and self-reported dietary information.
 - (2) Ongoing nutritional assessment.
 - (3) Development of an individualized nutritional care plan.
 - (4) Referral to food assistance programs if indicated.
 - (5) Nutritional intervention.
- d. Psychosocial assessment and counseling, which shall include:
 - (1) A psychosocial assessment including: needs assessment, profile of client demographic factors, mental and physical health history and concerns, adjustment to pregnancy and future parenting, and environmental needs.
 - (2) A profile of the client's family composition, patterns of functioning and support systems.
 - (3) An assessment-based plan of care, risk tracking, counseling and anticipatory guidance as appropriate, and referral and follow-up services.
- e. A postpartum home visit within two weeks of the child's discharge from the hospital, which shall include:
 - (1) Assessment of mother's health status.
 - (2) Physical and emotional changes postpartum.
 - (3) Family planning.
 - (4) Parenting skills.
 - (5) Assessment of infant health.
 - (6) Infant care.
 - (7) Grief support for unhealthy outcome.
 - (8) Parenting of a preterm infant.
 - (9) Identification of and referral to community resources as needed.

78.25(4) Vaccines. In order to be paid for the administration of a vaccine covered under the Vaccines for Children (VFC) Program, a maternal health center must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

This rule is intended to implement Iowa Code section 249A.4.
 [ARC 0065C, IAB 4/4/12, effective 6/1/12]

441—78.26(249A) Ambulatory surgical center services. Ambulatory surgical center services are those services furnished by an ambulatory surgical center in connection with a covered surgical procedure or a covered dental procedure. Covered procedures are listed in the fee schedule published on the department's website.

78.26(1) Covered surgical procedures shall be those medically necessary procedures that are eligible for payment as physicians' services, under the circumstances specified in rule 441—78.1(249A) and performed on a Medicaid member, that can safely be performed in an outpatient setting as determined by the department upon advice from the Iowa Medicaid enterprise medical services unit.

78.26(2) Covered dental procedures are those medically necessary procedures that are eligible for payment as dentists' services, under the circumstances specified in rule 441—78.4(249A) and performed on a Medicaid member, that can safely be performed in an outpatient setting for Medicaid members whose mental, physical, or emotional condition necessitates deep sedation or general anesthesia.

78.26(3) The covered services provided by the ambulatory surgical center in connection with a Medicaid-covered surgical or dental procedure shall be those nonsurgical and nondental services that:

- a. Are medically necessary in connection with a Medicaid-covered surgical or dental procedure;
- b. Are eligible for payment as physicians' services under the circumstances specified in rule 441—78.1(249A) or as dentists' services under the circumstances specified in rule 441—78.4(249A); and
- c. Can safely and economically be performed in an outpatient setting, as determined by the department upon advice from the Iowa Medicaid enterprise medical services unit.

78.26(4) Limits on covered services.

- a. Abortion procedures are covered only when criteria in subrule 78.1(17) are met.
- b. Sterilization procedures are covered only when criteria in subrule 78.1(16) are met.
- c. Preprocedure review by the IME medical services unit is required if ambulatory surgical centers are to be reimbursed for certain frequently performed surgical procedures as set forth under subrule 78.1(19). Criteria are available from the IME medical services unit. (Cross reference 78.28(6))

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]

441—78.27(249A) Home- and community-based habilitation services. Payment for habilitation services will only be made to providers enrolled to provide habilitation through the Iowa Medicaid enterprise. Effective March 17, 2022, payment shall only be made for services provided to members in integrated, community-based settings that support full access of members receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.

78.27(1) Definitions.

“*Adult*” means a person who is 18 years of age or older.

“*Assessment*” means the review of the current functioning of the member using the service in regard to the member’s situation, needs, strengths, abilities, desires, and goals.

“*Benefits education*” means providing basic information to understand and access appropriate resources to pursue employment, and knowledge of work incentives and the Medicaid for employed persons with disabilities (MEPD) program. Benefits education may include gathering information needed to pursue work incentives and offering basic financial management information to members, families, guardians and legal representatives.

“*Care coordinator*” means the professional who assists members in care coordination as described in paragraph 78.53(1)“b.”

“*Career exploration*,” also referred to as “career planning,” means a person-centered, comprehensive employment planning and support service that provides assistance for waiver program participants to obtain, maintain or advance in competitive employment or self-employment. Career exploration is a focused, time-limited service engaging a participant in identifying a career direction and developing a plan for achieving competitive, integrated employment at or above the state’s minimum wage. The outcome of this service is documentation of the participant’s stated career objective and a career plan used to guide individual employment support.

“*Career plan*” means a written plan documenting the member’s stated career objective and used to guide individual employment support services for achieving competitive, integrated employment at or above the state’s minimum wage.

“*Case management*” means case management services accredited under 441—Chapter 24 and provided according to 441—Chapter 90.

“*Comprehensive service plan*” means an individualized, person-centered, and goal-oriented plan of services written in language understandable by the member using the service and developed collaboratively by the member and the case manager.

“*Customized employment*” means an approach to supported employment which individualizes the employment relationship between employees and employers in ways that meet the needs of both. Customized employment is based on an individualized determination of the strengths, needs, and interests of the person with a disability and is also designed to meet the specific needs of the employer. Customized employment may include employment developed through job carving, self-employment or entrepreneurial initiatives, or other job development or restructuring strategies that result in job responsibilities being customized and individually negotiated to fit the needs of the individual with a disability. Customized employment assumes the provision of reasonable accommodations and supports necessary for the individual to perform the functions of a job that is individually negotiated and developed.

“*Department*” means the Iowa department of human services.

“*Emergency*” means a situation for which no approved individual program plan exists that, if not addressed, may result in injury or harm to the member or to other persons or in significant amounts of property damage.

“*HCBS*” means home- and community-based services.

“*Individual employment*” means employment in the general workforce where the member interacts with the general public to the same degree as nondisabled persons in the same job, and for which the member is paid at or above minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by persons without disabilities.

“*Individual placement and support*” means an evidence-based supported employment model that helps people with mental illness to seek and obtain employment.

“*Integrated community employment*” means work (including self-employment) for which an individual with a disability is paid at or above minimum wage and not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by employees who are not disabled, where the individual interacts with other persons who are not disabled to the same extent as others who are in comparable positions, and which presents opportunities for advancement that are similar to those for employees who are not disabled. In the case of an individual who is self-employed, the business results in an income that is comparable to the income received by others who are not disabled and are self-employed in similar occupations.

“*Integrated health home*” means the provision of services to enrolled members as described in subrule 78.53(1).

“*Interdisciplinary team*” means a group of persons with varied professional backgrounds who meet with the member to develop a comprehensive service plan to address the member’s need for services.

“*ISIS*” means the department’s individualized services information system.

“*Managed care organization*” means an entity that (1) is under contract with the department to provide services to Medicaid recipients and (2) meets the definition of “health maintenance organization” as defined in Iowa Code section 514B.1.

“*Member*” means a person who has been determined to be eligible for Medicaid under 441—Chapter 75.

“*Program*” means a set of related resources and services directed to the accomplishment of a fixed set of goals for qualifying members.

“*Supported employment*” means the ongoing supports to participants who, because of their disabilities, need intensive ongoing support to obtain and maintain an individual job in competitive or customized employment, or self-employment, in an integrated work setting in the general workforce at or above the state’s minimum wage or at or above the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. The outcome of this service is sustained paid employment at or above the minimum wage in an integrated setting in the general workforce in a job that meets personal and career goals. Supported employment services can be provided through many different service models.

“*Supported self-employment*” includes services and supports that assist the participant in achieving self-employment through the operation of a business; however, Medicaid funds may not be used to defray the expenses associated with starting up or operating a business. Assistance for self-employment may include aid to the individual in identifying potential business opportunities; assistance in the development of a business plan, including potential sources of business financing and other assistance in developing and launching a business; identification of the supports necessary for the individual to operate the business; and ongoing assistance, counseling and guidance once the business has been launched.

“*Sustained employment*” means an individual employment situation that the member maintains over time but not for less than 90 calendar days following the receipt of employment services and supports.

78.27(2) Member eligibility. To be eligible to receive home- and community-based habilitation services, a member shall meet the following criteria:

- a. *Risk factors.* The member has at least one of the following risk factors:

(1) The member has undergone or is currently undergoing psychiatric treatment more intensive than outpatient care (e.g., emergency services, alternative home care, partial hospitalization, or inpatient hospitalization) more than once in the member's life; or

(2) The member has a history of psychiatric illness resulting in at least one episode of continuous, professional supportive care other than hospitalization.

b. Need for assistance. The member has a need for assistance demonstrated by meeting at least two of the following criteria on a continuing or intermittent basis for at least two years:

(1) The member is unemployed, is employed in a sheltered setting, or has markedly limited skills and a poor work history.

(2) The member requires financial assistance for out-of-hospital maintenance and is unable to procure this assistance without help.

(3) The member shows severe inability to establish or maintain a personal social support system.

(4) The member requires help in basic living skills such as self-care, money management, housekeeping, cooking, and medication management.

(5) The member exhibits inappropriate social behavior that results in a demand for intervention.

c. Income. The countable income used in determining the member's Medicaid eligibility does not exceed 150 percent of the federal poverty level.

d. Needs assessment. The interRAI - Child and Youth Mental Health (ChYMH) for youth aged 16 to 18 or the interRAI - Community Mental Health (CMH) for those aged 19 and older has been completed, and based on information submitted on the information submission tool and other supporting documentation as relevant, the IME medical services unit has determined that the member is in need of home- and community-based habilitation services. The interRAI - Child and Youth Mental Health (ChYMH) and the interRAI - Community Mental Health (CMH) information submission tools are available on request from the IME medical services unit. Copies of the information submission tool for an individual are available to that individual from the individual's case manager, integrated health home care coordinator, or managed care organization. The designated case manager or integrated health home care coordinator shall:

(1) Arrange for the completion of the interRAI, before services begin and annually thereafter.

(2) Use the information submission tool and other supporting documentation as relevant to develop a comprehensive service plan as specified in subrule 78.27(4), before services begin and annually thereafter.

e. Plan for service. The department has approved the member's comprehensive service plan for home- and community-based habilitation services. Home- and community-based habilitation services included in a comprehensive service plan or treatment plan that has been validated through ISIS shall be considered approved by the department. Home- and community-based habilitation services provided before approval of a member's eligibility for the program cannot be reimbursed.

(1) The member's comprehensive service plan shall be completed annually according to the requirements of subrule 78.27(4). A service plan may change at any time due to a significant change in the member's needs.

(2) The member's habilitation services shall not exceed the maximum number of units established for each service in 441—subrule 79.1(2).

(3) The cost of the habilitation services shall not exceed unit expense maximums established in 441—subrule 79.1(2).

78.27(3) Application for services. The member, case manager or integrated health home care coordinator shall apply for habilitation services on behalf of a member by contacting the IME medical services unit. The department shall issue a notice of decision to the applicant when financial eligibility and needs-based eligibility determinations have been completed.

78.27(4) Comprehensive service plan. Individualized, planned, and appropriate services shall be guided by a member-specific comprehensive service plan or treatment plan developed with the member in collaboration with an interdisciplinary team, as appropriate. Medically necessary services shall be planned for and provided at the locations where the member lives, learns, works, and socializes.

a. Development. A comprehensive service plan or treatment plan shall be developed for each member receiving home- and community-based habilitation services based on the member's current assessment and shall be reviewed on an annual basis.

(1) The case manager or the integrated health home care coordinator shall establish an interdisciplinary team as selected by the member or the member's legal representative. The team shall include the case manager or integrated health home care coordinator and the member and, if applicable, the member's legal representative, the member's family, the member's service providers, and others directly involved with the member.

(2) With assistance from the member and the interdisciplinary team, the case manager or integrated health home care coordinator shall identify the member's services based on the member's needs, the availability of services, and the member's choice of services and providers.

(3) The comprehensive service plan development shall be completed at the member's home or at another location chosen by the member.

(4) The interdisciplinary team meeting shall be conducted before the current comprehensive service plan expires.

(5) The comprehensive service plan shall reflect desired individual outcomes.

(6) Services defined in the comprehensive service plan shall be appropriate to the severity of the member's problems and to the member's specific needs or disabilities.

(7) Activities identified in the comprehensive service plan shall encourage the ability and right of the member to make choices, to experience a sense of achievement, and to modify or continue participation in the treatment process.

(8) For members receiving home-based habilitation in a licensed residential care facility of 16 or fewer beds, the service plan shall address the member's opportunities for independence and community integration.

(9) The initial comprehensive service plan or treatment plan and annual updates to the comprehensive service plan or treatment plan must be approved by the IME medical services unit in ISIS before services are implemented. Services provided before the approval date are not payable. The written comprehensive service plan or treatment plan must be completed, signed and dated by the case manager or integrated health home care coordinator within 30 calendar days after plan approval.

(10) Any changes to the comprehensive service plan or treatment plan must be approved by the IME medical services unit for members not eligible to enroll in a managed care organization in ISIS before the implementation of services. Services provided before the approval date are not payable.

b. Service goals and activities. The comprehensive service plan shall:

(1) Identify observable or measurable individual goals.

(2) Identify interventions and supports needed to meet those goals with incremental action steps, as appropriate.

(3) Identify the staff persons, businesses, or organizations responsible for carrying out the interventions or supports.

(4) List all Medicaid and non-Medicaid services received by the member and identify:

1. The name of the provider responsible for delivering the service;

2. The funding source for the service; and

3. The number of units of service to be received by the member.

(5) Identify for a member receiving home-based habilitation:

1. The member's living environment at the time of enrollment;

2. The number of hours per day of on-site staff supervision needed by the member; and

3. The number of other members who will live with the member in the living unit.

(6) Include a separate, individualized, anticipated discharge plan that is specific to each service the member receives.

c. Rights restrictions. Any rights restrictions must be implemented in accordance with 441—subrule 77.25(4). The comprehensive service plan or treatment plan shall include documentation of:

- (1) Any restrictions on the member's rights, including maintenance of personal funds and self-administration of medications;
- (2) The need for the restriction; and
- (3) Either a plan to restore those rights or written documentation that a plan is not necessary or appropriate.

d. Emergency plan. The comprehensive service plan or treatment plan shall include a plan for emergencies and identification of the supports available to the member in an emergency. Emergency plans shall be developed as follows:

- (1) The member's interdisciplinary team shall identify in the comprehensive service plan or treatment plan any health and safety issues applicable to the individual member based on information gathered before the team meeting, including a risk assessment.

- (2) The interdisciplinary team shall identify an emergency backup support and crisis response system to address problems or issues arising when support services are interrupted or delayed or the member's needs change.

- (3) Providers of applicable services shall provide for emergency backup staff.

e. Plan approval. Services shall be entered into ISIS based on the comprehensive service plan. A comprehensive service plan or treatment plan that has been validated and authorized through ISIS shall be considered approved by the department. Services must be authorized in ISIS as specified in paragraph 78.27(2)“e.”

78.27(5) Requirements for services. Home- and community-based habilitation services shall be provided in accordance with the following requirements:

- a.* The services shall be based on the member's needs as identified in the member's comprehensive service plan.

- b.* The services shall be delivered in the least restrictive environment appropriate to the needs of the member.

- c.* The services shall include the applicable and necessary instruction, supervision, assistance, and support required by the member to achieve the member's life goals.

- d.* Service components that are the same or similar shall not be provided simultaneously.

- e.* Service costs are not reimbursable while the member is in a medical institution, including but not limited to a hospital or nursing facility.

- f.* Reimbursement is not available for room and board.

- g.* Services shall be billed in whole units.

- h.* Services shall be documented. Each unit billed must have corresponding financial and medical records as set forth in rule 441—79.3(249A).

78.27(6) Case management. Case management assists members in gaining access to needed medical, social, educational, housing, transportation, vocational, and other appropriate services in order to ensure the health, safety, and welfare of the member.

- a. Scope.* Case management services shall be provided as set forth in rules 441—90.5(249A) and 441—90.8(249A).

- b. Exclusions.*

- (1) Payment shall not be made for case management provided to a member who is enrolled for integrated health home services under rule 441—78.53(249A) except during the transition to the integrated health homes.

- (2) Payment shall not be made for case management provided to a member who is eligible for case management services under 441—Chapter 90.

78.27(7) Home-based habilitation. “Home-based habilitation” means individually tailored supports that assist with the acquisition, retention, or improvement of skills related to living in the community.

- a. Scope.* Home-based habilitation services are individualized supportive services provided in the member's home and community that assist the member to reside in the most integrated setting appropriate to the member's needs. Services are intended to provide for the daily living needs of the member and shall be available as needed during any 24-hour period. The specific support needs for each member

shall be determined necessary by the interdisciplinary team and shall be identified in the member's comprehensive service plan. Covered supports include:

- (1) Adaptive skill development;
- (2) Assistance with activities of daily living;
- (3) Community inclusion;
- (4) Transportation;
- (5) Adult educational supports;
- (6) Social and leisure skill development;
- (7) Personal care; and
- (8) Protective oversight and supervision.

b. Exclusions. Home-based habilitation payment shall not be made for the following:

- (1) Room and board and maintenance costs, including the cost of rent or mortgage, utilities, telephone, food, household supplies, and building maintenance, upkeep, or improvement.
- (2) Service activities associated with vocational services, day care, medical services, or case management.
- (3) Transportation to and from a day program.
- (4) Services provided to a member who lives in a licensed residential care facility of more than 16 persons.
- (5) Services provided to a member who lives in a facility that provides the same service as part of an inclusive or "bundled" service rate, such as a nursing facility or an intermediate care facility for persons with mental retardation.

(6) Personal care and protective oversight and supervision may be a component part of home-based habilitation services but may not comprise the entirety of the service.

78.27(8) Day habilitation. "Day habilitation" means assistance with acquisition, retention, or improvement of self-help, socialization, and adaptive skills.

a. Scope. Day habilitation activities and environments are designed to foster the acquisition of skills, appropriate behavior, greater independence, and personal choice. Services focus on enabling the member to attain or maintain the member's maximum functional level and shall be coordinated with any physical, occupational, or speech therapies in the comprehensive service plan. Services may serve to reinforce skills or lessons taught in other settings. Services must enhance or support the member's:

- (1) Intellectual functioning;
- (2) Physical and emotional health and development;
- (3) Language and communication development;
- (4) Cognitive functioning;
- (5) Socialization and community integration;
- (6) Functional skill development;
- (7) Behavior management;
- (8) Responsibility and self-direction;
- (9) Daily living activities;
- (10) Self-advocacy skills; or
- (11) Mobility.

b. Setting. Day habilitation shall take place in community-based, nonresidential settings separate from the member's residence.

c. Duration. Day habilitation services shall be furnished for four or more hours per day on a regularly scheduled basis for one or more days per week or as specified in the member's comprehensive service plan. Meals provided as part of day habilitation shall not constitute a full nutritional regimen (three meals per day).

d. Exclusions. Day habilitation payment shall not be made for the following:

- (1) Vocational or prevocational services.
- (2) Services that duplicate or replace education or related services defined in Public Law 94-142, the Education of the Handicapped Act.
- (3) Compensation to members for participating in day habilitation services.

78.27(9) Prevocational service habilitation. “Prevocational services” means services that provide career exploration, learning and work experiences, including volunteer opportunities, where the member can develop non-job-task-specific strengths and skills that lead to paid employment in individual community settings.

a. Scope. Prevocational services are provided to persons who are expected to be able to join the general workforce with the assistance of supported employment. Prevocational services are intended to develop and teach general employability skills relevant to successful participation in individual employment. These skills include but are not limited to the ability to communicate effectively with supervisors, coworkers and customers; an understanding of generally accepted community workplace conduct and dress; the ability to follow directions; the ability to attend to tasks; workplace problem-solving skills and strategies; general workplace safety and mobility training; the ability to navigate local transportation options; financial literacy skills; and skills related to obtaining employment.

Prevocational services include career exploration activities to facilitate successful transition to individual employment in the community. Participation in prevocational services is not a prerequisite for individual or small-group supported employment services.

(1) Career exploration. Career exploration activities are designed to develop an individual career plan and facilitate the member’s experientially based informed choice regarding the goal of individual employment. Career exploration may be provided in small groups of no more than four members to participate in career exploration activities that include business tours, attending industry education events, benefit information, financial literacy classes, and attending career fairs. Career exploration may be authorized for up to 34 hours, to be completed over 90 days in the member’s local community or nearby communities and may include but is not limited to the following activities:

1. Meeting with the member and the member’s family, guardian or legal representative to introduce them to supported employment and explore the member’s employment goals and experiences,
2. Business tours,
3. Informational interviews,
4. Job shadows,
5. Benefits education and financial literacy,
6. Assistive technology assessment, and
7. Job exploration events.

(2) Expected outcome of service.

1. The expected outcome of prevocational services is individual employment in the general workforce, or self-employment, in a setting typically found in the community, where the member interacts with individuals without disabilities, other than those providing services to the member or other individuals with disabilities, to the same extent that individuals without disabilities in comparable positions interact with other persons; and for which the member is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities.

2. The expected outcome of the career exploration activity is a written career plan that will guide employment services which lead to community employment or self-employment for the member.

b. Setting. Prevocational services shall take place in community-based nonresidential settings.

c. Concurrent services. A member’s individual service plan may include two or more types of nonresidential habilitation services (e.g., individual supported employment, long-term job coaching, small-group supported employment, prevocational services, and day habilitation); however, more than one service may not be billed during the same period of time (e.g., the same hour).

d. Exclusions. Prevocational services payment shall not be made for the following:

(1) Services that are available to the individual under a program funded under Section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.). Documentation that funding is not available to the individual for the service under these programs shall be maintained in the service plan of each member receiving prevocational services.

(2) Services available to the individual that duplicate or replace education or related services defined in the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.).

(3) Compensation to members for participating in prevocational services.

(4) Support for members volunteering in for-profit organizations and businesses other than for-profit organizations, or businesses that have formal volunteer programs in place (e.g., hospitals, nursing homes), and support for members volunteering to benefit the service provider.

(5) The provision of vocational services delivered in facility-based settings where individuals are supervised for the primary purpose of producing goods or performing services or where services are aimed at teaching skills for specific types of jobs rather than general skills.

(6) A prevocational service plan with the goal or purpose of the service documented as maintaining or supporting the individual in continuing prevocational services or any employment situation similar to sheltered employment.

e. Limitations.

(1) Time limitation for members starting prevocational services. For members starting prevocational services after May 4, 2016, participation in these services is limited to 24 calendar months. This time limit can be extended to continue beyond 24 months if one or more of the following conditions apply:

1. The member who is in prevocational services is also working in either individual or small-group community employment for at least the number of hours per week desired by the member, as identified in the member's current service plan; or

2. The member who is in prevocational services is also working in either individual or small-group community employment for less than the number of hours per week the member desires, as identified in the member's current service plan, but the member has services documented in the member's current service plan, or through another identifiable funding source (e.g., Iowa vocational rehabilitation services (IVRS)), to increase the number of hours the member is working in either individual or small-group community employment; or

3. The member is actively engaged in seeking individual or small-group community employment or individual self-employment, and services for this are included in the member's current service plan or services funded through another identifiable funding source (e.g., IVRS) are documented in the member's service plan; or

4. The member has requested supported employment services from Medicaid and IVRS in the past 24 months, and the member's request has been denied or the member has been placed on a waiting list by both Medicaid and IVRS; or

5. The member has been receiving individual supported employment services (or comparable services available through IVRS) for at least 18 months without obtaining individual or small-group community employment or individual self-employment; or

6. The member is participating in career exploration activities as described in subparagraph 78.27(9) "a"(1).

(2) Time limitation for members enrolled in prevocational services. For members enrolled in prevocational services on or before May 4, 2016, participation in these services is limited to 90 business days beyond the completion of the career exploration activity including the development of the career plan described in subparagraph 78.27(9) "a"(1). This time limit can be extended as stated in paragraphs 78.27(9) "e"(1) "1" through "6." If the criteria in paragraphs 78.27(9) "e"(1) "1" through "6" do not apply, the member will not be reauthorized to continue prevocational services.

78.27(10) Supported employment services.

a. Individual supported employment. Individual supported employment involves supports provided to, or on behalf of, the member that enable the member to obtain and maintain individual employment. Services are provided to members who need support because of their disabilities.

(1) Scope. Individual supported employment services are services provided to, or on behalf of, the member that enable the member to obtain and maintain an individual job in competitive employment, customized employment or self-employment in an integrated work setting in the general workforce.

(2) Expected outcome of service. The expected outcome of this service is sustained employment, or self-employment, paid at or above the minimum wage or the customary wage and level of benefits paid by an employer, in an integrated setting in the general workforce, in a job that meets personal and career goals. Successful transition to long-term job coaching, if needed, is also an expected outcome of this service. An expected outcome of supported self-employment is that the member earns income that is equal to or exceeds the average income for the chosen business within a reasonable period of time.

(3) Setting. Individual supported employment services shall take place in integrated work settings. For self-employment, the member's home can be considered an integrated work setting. Employment in the service provider's organization (not including a sheltered workshop or similar type of work setting where members are paid for the production of goods or services) can be considered employment in an integrated work setting in the general workforce if the employment occurs in a work setting where interactions are predominantly with coworkers or business associates who do not have disabilities or with the general public.

(4) Individual employment strategies include but are not limited to: customized employment, individual placement and support, and supported self-employment. Service activities are individualized and may include any combination of the following:

1. Benefits education.
2. Career exploration (e.g., tours, informational interviews, job shadows).
3. Employment assessment.
4. Assistive technology assessment.
5. Trial work experience.
6. Person-centered employment planning.
7. Development of visual/traditional résumés.
8. Job-seeking skills training and support.
9. Outreach to prospective employers on behalf of the member (e.g., job development; negotiation with prospective employers to customize, create or carve out a position for the member; employer needs analysis).
10. Job analysis (e.g., work site assessment or job accommodations evaluation).
11. Identifying and arranging transportation.
12. Career advancement services (e.g., assisting a member in making an upward career move or seeking promotion from an existing employer).
13. Reemployment services (if necessary due to job loss).
14. Financial literacy and asset development.
15. Other employment support services deemed necessary to enable the member to obtain employment.
16. Systematic instruction and support during initial on-the-job training including initial on-the-job training to stabilization.
17. Engagement of natural supports during initial period of employment.
18. Implementation of assistive technology solutions during initial period of employment.
19. Transportation of the member during service hours.
20. Initial on-the-job training to stabilization activity.

(5) Self-employment. Individual employment may also include support to establish a viable self-employment opportunity, including home-based self-employment. An expected outcome of supported self-employment is that the member earns income that is equal to or exceeds the average income for the chosen business within a reasonable period of time. In addition to the activities listed under subparagraph 78.27(10) "a"(4), assistance to establish self-employment may include:

1. Aid to the member in identifying potential business opportunities.
2. Assistance in the development of a business plan, including identifying potential sources of business financing and other assistance in developing and launching a business.
3. Identification of the long-term supports necessary for the individual to operate the business.

b. Long-term job coaching. Long-term job coaching is support provided to, or on behalf of, the member that enables the member to maintain an individual job in competitive employment, customized employment or self-employment in an integrated work setting in the general workforce.

(1) *Scope.* Long-term job coaching services are provided to or on behalf of members who need support because of their disabilities and who are unlikely to maintain and advance in individual employment absent the provision of supports. Long-term job coaching services shall provide individualized and ongoing support contacts at intervals necessary to promote successful job retention and advancement.

(2) *Expected outcome of service.* The expected outcome of this service is sustained employment paid at or above the minimum wage in an integrated setting in the general workforce, in a job that meets the member's personal and career goals. An expected outcome of supported self-employment is that the member earns income that is equal to or exceeds the average income for the chosen business within a reasonable period of time.

(3) *Setting.* Long-term job coaching services shall take place in integrated work settings. For self-employment, the member's home can be considered an integrated work setting. Employment in the service provider's organization (not including a sheltered workshop or similar type of work setting) can be considered employment in an integrated work setting in the general workforce if the employment occurs in a work setting where interactions are predominantly with coworkers or business associates who do not have disabilities, or with the general public, and if the position would exist within the provider's organization were the provider not being paid to provide the job coaching to the member.

(4) *Service activities.* Long-term job coaching services are designed to assist the member with learning and retaining individual employment, resulting in workplace integration, and which allows for the reduction of long-term job coaching over time. Services are individualized, and service plans are adjusted as support needs change and may include any combination of the following activities with or on behalf of the member:

1. Job analysis.
2. Job training and systematic instruction.
3. Training and support for use of assistive technology/adaptive aids.
4. Engagement of natural supports.
5. Transportation coordination.
6. Job retention training and support.
7. Benefits education and ongoing support.
8. Supports for career advancement.
9. Financial literacy and asset development.
10. Employer consultation and support.
11. Negotiation with employer on behalf of the member (e.g., accommodations; employment conditions; access to natural supports; and wage and benefits).
12. Other workplace support services may include services not specifically related to job skill training that enable the waiver member to be successful in integrating into the job setting.
13. Transportation of the member during service hours.
14. Career exploration services leading to increased hours or career advancement.

(5) *Self-employment long-term job coaching.* Self-employment long-term job coaching may include support to maintain a self-employment opportunity, including home-based self-employment. In addition to the activities listed under subparagraph 78.27(10) "b"(4), assistance to maintain self-employment may include:

1. Ongoing identification of the supports necessary for the individual to operate the business;
2. Ongoing assistance, counseling and guidance to maintain and grow the business; and
3. Ongoing benefits education and support.

(6) The hours of support for long-term job coaching are based on the identified needs of the member as documented in the member's comprehensive service plan.

c. Small-group supported employment. Small-group supported employment services are training and support activities provided in regular business or industry settings for groups of two to eight

workers with disabilities. The outcome of this service is sustained paid employment experience, skill development, career exploration and planning leading to referral for services to obtain individual integrated employment or self-employment for which an individual is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities.

(1) Scope. Small-group supported employment services must be provided in a manner that promotes integration into the workplace and interaction between members and people without disabilities (e.g., customers, coworkers, natural supports) in those workplaces. Examples include but are not limited to mobile crews and other business-based workgroups employing small groups of workers with disabilities in employment in integrated business settings; and small-group activities focused on career exploration and development of strengths and skills that contribute to successful participation in individual community employment.

(2) Expected outcome of service. Small-group supported employment services are expected to enable the member to make reasonable and continued progress toward individual employment. Participation in small-group supported employment services is not a prerequisite for individual supported employment services. The expected outcome of the service is sustained paid employment and skill development which leads to individual employment in the community.

(3) Setting. Small-group supported employment services shall take place in integrated, community-based nonresidential settings separate from the member's residence.

(4) Service activities. Small-group supported employment services may include any combination of the following activities:

1. Employment assessment.
2. Person-centered employment planning.
3. Job placement (limited to service necessary to facilitate hire into individual employment paid at minimum wage or higher for a member in small-group supported employment who receives an otherwise unsolicited offer of a job from a business where the member has been working in a mobile crew or enclave).
4. Job analysis.
5. On-the-job training and systematic instruction.
6. Job coaching.
7. Transportation planning and training.
8. Benefits education.
9. Career exploration services leading to career advancement outcomes.
10. Other workplace support services may include services not specifically related to job skill training that enable the waiver member to be successful in integrating into the individual or community setting.

11. Transportation of the member during service hours.

d. Service requirements for all supported employment services.

(1) Community transportation options (e.g., transportation provided by family, coworkers, carpools, volunteers, self or public transportation) shall be identified by the member's interdisciplinary team and utilized before the service provider provides the transportation to and from work for the member. If none of these options are available to a member, transportation between the member's place of residence and the employment or service location may be included as a component part of supported employment services.

(2) Personal care or personal assistance and protective oversight may be a component part of supported employment services, but may not comprise the entirety of the service.

(3) Activities performed on behalf of a member receiving long-term job coaching or individual or small-group supported employment shall not comprise the entirety of the service.

(4) Concurrent services. A member's individual service plan may include two or more types of nonresidential services (e.g., individual supported employment, long-term job coaching, small-group supported employment, prevocational services, and day habilitation); however, more than one service may not be billed during the same period of time (e.g., the same hour).

(5) Integration requirements. In the performance of job duties, the member shall have regular contact with other employees or members of the general public who do not have disabilities, unless the absence of regular contact with other employees or the general public is typical for the job as performed by persons without disabilities.

(6) Compensation. Members receiving these services are compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. For supported self-employment, the member earns income that is equal to or exceeds the average income for the chosen business within a reasonable period of time. For small-group supported employment, if the member is not compensated at or above minimum wage, the compensation to the member shall be in accordance with all applicable state and federal labor laws and regulations.

e. Limitations. Supported employment services are limited as follows:

(1) Total monthly costs of supported employment may not exceed the monthly cap on the cost of waiver services set for the individual waiver program.

(2) In absence of a monthly cap on the cost of waiver services, the total monthly cost of all supported employment services may not exceed \$3,059.29 per month.

(3) Individual supported employment is limited to 240 units per calendar year.

(4) Long-term job coaching is limited in accordance with 441—subrule 79.1(2).

(5) Small-group supported employment is limited to 160 units per week.

f. Exclusions. Supported employment services payments shall not be made for the following:

(1) Services that are available to the individual under a program funded under Section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.). Documentation that the service is not available to the individual under these programs shall be maintained in the service plan of each member receiving individual supported employment or long-term job coaching services.

(2) Incentive payments, not including payments for coworker supports, made to an employer to encourage or subsidize the employer's participation in a supported employment program.

(3) Subsidies or payments that are passed through to users of supported employment programs.

(4) Training that is not directly related to a member's supported employment program.

(5) Services involved in placing and stabilizing members in day activity programs, work activity programs, sheltered workshop programs or other similar types of vocational or prevocational services furnished in specialized facilities that are not a part of the general workplace.

(6) Supports for placement and stabilization in volunteer positions or unpaid internships. Such volunteer learning and unpaid training activities that prepare a person for entry into the general workforce are addressed through prevocational services and career exploration activities.

(7) Tuition for education or vocational training.

(8) Individual advocacy that is not related to integrated individual employment participation or is not member-specific.

(9) Medicaid funds may not be used to defray the expenses associated with starting up or operating a business.

78.27(11) *Adverse service actions.*

a. Denial. Services shall be denied when the department determines that:

(1) The member is not eligible for or in need of home- and community-based habilitation services.

(2) The service is not identified in the member's comprehensive service plan or treatment plan.

(3) Needed services are not available or received from qualifying providers, or no qualifying providers are available.

(4) The member's service needs exceed the unit or reimbursement maximums for a service as set forth in 441—subrule 79.1(2).

(5) Completion or receipt of required documents for the program has not occurred.

b. Reduction. A particular home- and community-based habilitation service may be reduced when the department determines that continued provision of service at its current level is not necessary.

c. Termination. A particular home- and community-based habilitation service may be terminated when the department determines that:

(1) The member's income exceeds the allowable limit, or the member no longer meets other eligibility criteria for the program established by the department.

(2) The service is not identified in the member's comprehensive service plan.

(3) Needed services are not available or received from qualifying providers, or no qualifying providers are available.

(4) The member's service needs are not being met by the services provided.

(5) The member has received care in a medical institution for 30 consecutive days in any one stay. When a member has been an inpatient in a medical institution for 30 consecutive days, the department will issue a notice of decision to inform the member of the service termination. If the member returns home before the effective date of the notice of decision and the member's condition has not substantially changed, the decision shall be rescinded, and eligibility for home- and community-based habilitation services shall continue.

(6) The member's service needs exceed the unit or reimbursement maximums for a service as established by the department.

(7) Duplication of services provided during the same period has occurred.

(8) The member or the member's legal representative, through the interdisciplinary process, requests termination of the service.

(9) Completion or receipt of required documents for the program has not occurred, or the member refuses to allow documentation of eligibility as to need and income.

d. Appeal rights. The department shall give notice of any adverse action and the right to appeal in accordance with 441—Chapter 7. The member is entitled to have a review of the determination of needs-based eligibility by the Iowa Medicaid enterprise medical services unit by sending a letter requesting a review to the medical services unit. If dissatisfied with that decision, the member may file an appeal with the department.

78.27(12) County reimbursement. Rescinded IAB 7/11/12, effective 7/1/12.

This rule is intended to implement Iowa Code section 249A.4.

[ARC 7957B, IAB 7/15/09, effective 7/1/09 (See Delay note at end of chapter); ARC 9311B, IAB 12/29/10, effective 1/1/11; ARC 9403B, IAB 3/9/11, effective 5/1/11; ARC 0191C, IAB 7/11/12, effective 7/1/12; ARC 0359C, IAB 10/3/12, effective 12/1/12; ARC 0709C, IAB 5/1/13, effective 7/1/13; ARC 0848C, IAB 7/24/13, effective 7/1/13; ARC 1051C, IAB 10/2/13, effective 11/6/13; ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 2471C, IAB 3/30/16, effective 5/4/16; ARC 2848C, IAB 12/7/16, effective 11/15/16; ARC 2936C, IAB 2/1/17, effective 3/8/17; ARC 3184C, IAB 7/5/17, effective 8/9/17; ARC 3874C, IAB 7/4/18, effective 8/8/18]

441—78.28(249A) List of medical services and equipment requiring prior authorization, preprocedure review or preadmission review.

78.28(1) Services, procedures, and medications prescribed by a physician, physician assistant, or advanced registered nurse practitioner which are subject to prior authorization or preprocedure review are as follows or as specified in the preferred drug list published by the department pursuant to Iowa Code section 249A.20A:

a. Drugs require prior authorization as specified in the preferred drug list published by the department pursuant to Iowa Code section 249A.20A. For drugs requiring prior authorization, reimbursement will be made for a 72-hour supply dispensed in an emergency when a prior authorization request cannot be submitted.

b. Automated medication dispenser. Payment shall be approved pursuant to the criteria at 78.10(5)“d.”

c. Enteral products and enteral delivery pumps and supplies. Payment shall be approved pursuant to the criteria at 78.10(5)“l.”

d. Rescinded IAB 5/11/05, effective 5/1/05.

e. Speech generating device. Payment shall be approved pursuant to the criteria at 78.10(5)“f.”

f. Preprocedure review by the IME medical services unit will be required if payment under Medicaid is to be made for certain frequently performed surgical procedures which have a wide variation in the relative frequency the procedures are performed. Preprocedure surgical review applies

to surgeries performed in hospitals (outpatient and inpatient) and ambulatory surgical centers. Approval by the IME medical services unit will be granted only if the procedures are determined to be medically necessary based on the condition of the patient and on the criteria established by the department and the IME medical services unit. If not so approved by the IME medical services unit, payment will not be made under the program to the physician or to the facility in which the surgery is performed. The criteria are available from the IME medical services unit.

- g.* Enclosed beds. Payment shall be approved pursuant to the criteria at 78.10(5)“a.”
- h.* Prior authorization is required for external insulin infusion pumps and is granted according to Medicare coverage criteria. (Cross reference 78.10(2)“c”)
- i.* Oral nutritional products. Payment shall be approved pursuant to the criteria at 78.10(5)“m.”
- j.* Vest airway clearance system. Payment shall be approved pursuant to the criteria at 78.10(5)“c.”
- k.* Diabetic equipment and supplies. Payment will be approved pursuant to the criteria at 78.10(5)“e.”
- l.* Reimbursement over the established Medicaid fee schedule amount. Payment shall be approved pursuant to the criteria at 78.10(5)“n.”
- m.* Bathtub/shower chair, bench. Payment shall be approved pursuant to the criteria at 78.10(5)“g.”
- n.* Patient lift, nonstandard. Payment shall be approved pursuant to the criteria at 78.10(5)“h.”
- o.* Power wheelchair attendant control. Payment shall be approved pursuant to the criteria at 78.10(5)“i.”
- p.* Shower commode chair. Payment shall be approved pursuant to the criteria at 78.10(5)“j.”
- q.* Ventilator, secondary. Payment shall be approved pursuant to the Medicare coverage criteria.
- r.* Customized wheelchairs for members who are residents of nursing facilities, subject to the requirements of 78.10(2)“a”(4).

78.28(2) Dental services. Dental services which require prior approval are as follows:

- a.* The following periodontal services:
 - (1) Periodontal scaling and root planing. Payment will be approved pursuant to the criteria at 78.4(4)“b.”
 - (2) Pedicle soft tissue graft, free soft tissue graft, and subepithelial tissue graft. Payment will be approved pursuant to the criteria at 78.4(4)“d.”
 - (3) Periodontal maintenance therapy. Payment will be approved pursuant to the criteria at 78.4(4)“e.”
 - (4) Tissue regeneration. Payment will be approved pursuant to the criteria at 78.4(4)“f.”
 - (5) Localized delivery of antimicrobial agents. Payment will be approved pursuant to the criteria at 78.4(4)“g.”
- b.* The following prosthetic services:
 - (1) A removable partial denture replacing anterior teeth. Payment will be approved pursuant to the criteria at 78.4(7)“b.”
 - (2) A fixed partial denture replacing anterior teeth. Payment will be approved pursuant to the criteria at 78.4(7)“d.”
 - (3) A removable partial denture replacing posterior teeth. Payment will be approved pursuant to the criteria at 78.4(7)“c.”
 - (4) A fixed partial denture replacing posterior teeth. Payment will be approved pursuant to the criteria at 78.4(7)“e.”
 - (5) Dental implants and related services. Payment will be approved pursuant to the criteria at 78.4(7)“k.”
 - (6) Replacement of complete or partial dentures in less than a five-year period. Payment will be approved pursuant to the criteria at 78.4(7)“l.”
 - (7) A complete or partial denture rebase. Payment will be approved pursuant to the criteria at 78.4(7)“m.”

(8) An oral appliance for obstructive sleep apnea. Payment will be approved pursuant to the criteria at 78.4(7)“n.”

c. The following orthodontic services:

(1) Minor treatment to control harmful habits. Payment will be approved pursuant to the criteria at 78.4(8)“a.”

(2) Interceptive orthodontic treatment. Payment will be approved pursuant to the criteria at 78.4(8)“b.”

(3) Comprehensive orthodontic treatment. Payment will be approved pursuant to the criteria at 78.4(8)“c.”

d. The following restorative services:

(1) Laboratory-fabricated crowns other than stainless steel. Payment will be approved pursuant to the criteria at 78.4(3)“d”(3).

(2) Crowns with noble or high noble metals. Payment will be approved pursuant to the criteria at 78.4(3)“d”(4).

e. Endodontic retreatment of a tooth. Payment will be approved pursuant to the criteria at 78.4(5)“d.”

f. Occlusal guard. Payment will be approved pursuant to the criteria at 78.4(9)“g.”

78.28(3) Optometric services and ophthalmic materials which must be submitted for prior approval are as follows:

a. A second lens correction within a 24-month period for members eight years of age and older. Payment shall be made when the member’s vision has at least a five-tenths diopter of change in sphere or cylinder or ten-degree change in axis in either eye.

b. Visual therapy may be authorized when warranted by case history or diagnosis for a period of time not greater than 90 days. Should continued therapy be warranted, the prior approval process should be reaccomplished, accompanied by a report showing satisfactory progress. Approved diagnoses are convergence insufficiency and amblyopia. Visual therapy is not covered when provided by opticians.

c. Subnormal visual aids where near visual acuity is better than 20/100 at 16 inches, 2M print. Prior authorization is not required if near visual acuity as described above is less than 20/100. Subnormal aids include, but are not limited to, hand magnifiers, loupes, telescopic spectacles or reverse Galilean telescope systems.

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(4) Hearing aids that must be submitted for prior approval are:

a. Replacement of a hearing aid less than four years old (except when the member is under 21 years of age). The department shall approve payment when the original hearing aid is lost or broken beyond repair or there is a significant change in the person’s hearing that would require a different hearing aid. (Cross reference 78.14(7)“d”(1))

b. A hearing aid costing more than \$650. The department shall approve payment for either of the following purposes (Cross reference 78.14(7)“d”(2)):

(1) Educational purposes when the member is participating in primary or secondary education or in a postsecondary academic program leading to a degree and an in-office comparison of an analog aid and a digital aid matched (+/- 5dB) for gain and output shows a significant improvement in either speech recognition in quiet or speech recognition in noise or an in-office comparison of two aids, one of which is single channel, shows significantly improved audibility.

(2) Vocational purposes when documentation submitted indicates the necessity, such as varying amounts of background noise in the work environment and a need to converse in order to do the job and an in-office comparison of an analog aid and a digital aid matched (+/- 5dB) for gain and output

shows a significant improvement in either speech recognition in quiet or speech recognition in noise or an in-office comparison of two aids, one of which is single channel, shows significantly improved audibility.

78.28(5) Hospital services which must be subject to prior approval, preprocedure review or preadmission review are:

a. Any medical or surgical procedure requiring prior approval as set forth in Chapter 78 is subject to the conditions for payment set forth although a request form does not need to be submitted by the hospital as long as the approval is obtained by the physician. (Cross reference 441—78.1(249A))

b. All inpatient hospital admissions are subject to 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(6) Ambulatory surgical centers are subject to prior approval and preprocedure review as follows:

a. Any medical or surgical procedure requiring prior approval as set forth in Chapter 78 is subject to the conditions for payment set forth although a request form does not need to be submitted by the ambulatory surgical center as long as the prior approval is obtained by the physician.

b. Preprocedure review by the IFMC is required if ambulatory surgical centers are to be reimbursed for surgical procedures as set forth in subrule 78.1(19). Approval by the IFMC will be granted only if the procedures are determined to be necessary based on the condition of the patient and criteria established by the IFMC and the department. The criteria are available from IFMC, 6000 Westown Parkway, Suite 350E, West Des Moines, Iowa 50265-7771, or in local hospital utilization review offices.

78.28(7) 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(8) 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(9) Private duty nursing or personal care services provided by a home health agency provider for persons aged 20 or under require prior approval and shall be approved if determined to be medically necessary. Payment shall be made on an hourly unit of service.

a. Definitions.

(1) Private duty nursing services are those services which are provided by a registered nurse or a licensed practical nurse under the direction of the member's physician to a member in the member's place of residence or outside the member's residence, when normal life activities take the member outside the place of residence. Place of residence does not include nursing facilities, intermediate care facilities for the mentally retarded, or hospitals.

Services shall be provided according to a written plan of care authorized by a licensed physician. The home health agency is encouraged to collaborate with the member, or in the case of a child with the child's caregiver, in the development and implementation of the plan of treatment. These services shall exceed intermittent guidelines as defined in subrule 78.9(3). Private duty nursing and personal care services shall be inclusive of all home health agency services personally provided to the member.

Private duty nursing services do not include:

1. Respite care, which is a temporary intermission or period of rest for the caregiver.
2. Nurse supervision services including chart review, case discussion or scheduling by a registered nurse.
3. Services provided to other persons in the member's household.
4. Services requiring prior authorization that are provided without regard to the prior authorization process.

(2) Personal care services are those services provided by a home health aide or certified nurse's aide and which are delegated and supervised by a registered nurse under the direction of the member's physician to a member in the member's place of residence or outside the member's residence, when normal life activities take the member outside the place of residence. Place of residence does not include nursing facilities, intermediate care facilities for the mentally retarded, or hospitals. Payment for personal care services for persons aged 20 and under that exceed intermittent guidelines may be approved if determined to be medically necessary as defined in subrule 78.9(7). These services shall be in accordance with the member's plan of care and authorized by a physician. The home health agency is encouraged to collaborate with the member, or in the case of a child with the child's caregiver, in the development and implementation of the plan of treatment.

Medical necessity means the service is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent the worsening of conditions that endanger life, cause pain, result in illness or infirmity, threaten to cause or aggravate a disability or chronic illness, and no other equally effective course of treatment is available or suitable for the member requesting a service.

b. Requirements.

(1) Private duty nursing or personal care services shall be ordered in writing by a physician as evidenced by the physician's signature on the plan of care.

(2) Private duty nursing or personal care services shall be authorized by the department or the department's designated review agent prior to payment.

(3) Prior authorization shall be requested at the time of initial submission of the plan of care or at any time the plan of care is substantially amended and shall be renewed with the department or the department's designated review agent. Initial request for and request for renewal of prior authorization shall be submitted to the department's designated review agent. The provider of the service is responsible for requesting prior authorization and for obtaining renewal of prior authorization.

The request for prior authorization shall include a nursing assessment, the plan of care, and supporting documentation. The request for prior authorization shall include all items previously identified as required treatment plan information and shall further include: any planned surgical interventions and projected time frame; information regarding caregiver's desire to become involved in the member's care, to adhere to program objectives, to work toward treatment plan goals, and to work toward maximum independence; and identify the types and service delivery levels of all other services to the member whether or not the services are reimbursable by Medicaid. Providers shall indicate the expected number of private duty nursing RN hours, private duty nursing LPN hours, or home health aide hours per day, the number of days per week, and the number of weeks or months of service per discipline. If the member is currently hospitalized, the projected date of discharge shall be included.

Prior authorization approvals shall not be granted for treatment plans that exceed 16 hours of home health agency services per day. (Cross reference 78.9(10))

78.28(10) Replacement of vibrotactile aids less than four years old shall be approved when the original aid is broken beyond repair or lost. (Cross reference 78.10(3) "b")

78.28(11) High-technology radiology procedures.

a. Except as provided in paragraph 78.28(11)“*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(11)“*a*,” prior authorization is not required when any of the following applies:

- (1) Radiology procedures are billed on a CMS 1500 claim for places of service “hospital inpatient” (POS 21) or “hospital emergency room” (POS 23), or on a UB04 claim with revenue code 45X;
- (2) The member has Medicare coverage;
- (3) The member received notice of retroactive Medicaid eligibility after receiving a radiology procedure at a time prior to the member’s receipt of such notice (see paragraph 78.28(11)“*e*”); or
- (4) A radiology procedure is ordered or requested by the department of human services, a state district court, law enforcement, or other similar entity for the purposes of a child abuse/neglect investigation, as documented by the provider.

c. Prior approval will be granted if the procedure requested meets the requirements of 441—subrule 79.9(2), based on diagnosis, symptoms, history of illness, course of treatment, and treatment plan, as documented by the provider requesting prior approval.

d. Required requests for prior approval of radiology procedures must be submitted through the online system operated by the department’s contractor for prior approval of high-technology radiology procedures.

e. Services are billed for members with retroactive eligibility.

(1) When a member has received notice of retroactive Medicaid eligibility after receiving a radiology procedure for a date of service prior to the member’s receipt of such notice and otherwise requiring prior approval pursuant to this rule, a retroactive authorization request must be submitted on Form 470-0829, Request for Prior Authorization, before any claim for payment is submitted.

(2) Payment will be authorized only if the prior approval criteria were met and the service was provided to the member prior to the retroactive eligibility notification, as documented by the provider requesting retroactive authorization.

(3) Retroactive authorizations will not be granted when sought for reasons other than a member’s retroactive Medicaid eligibility. Examples of such reasons include, but are not limited to, the following:

1. The provider was unaware of the high-technology radiology prior authorization requirement.
2. The provider was unaware that the member had current Medicaid eligibility or coverage.
3. The provider forgot to complete the required prior authorization process.

This rule is intended to implement Iowa Code section 249A.4.

[ARC 7548B, IAB 2/11/09, effective 4/1/09; ARC 8714B, IAB 5/5/10, effective 5/1/10; ARC 9440B, IAB 4/6/11, effective 4/1/11; ARC 9702B, IAB 9/7/11, effective 9/1/11; ARC 9883B, IAB 11/30/11, effective 1/4/12; ARC 0305C, IAB 9/5/12, effective 11/1/12; ARC 0631C, IAB 3/6/13, effective 5/1/13; ARC 0632C, IAB 3/6/13, effective 5/1/13; ARC 0823C, IAB 7/10/13, effective 9/1/13; ARC 1151C, IAB 10/30/13, effective 1/1/14; ARC 1696C, IAB 10/29/14, effective 1/1/15; ARC 2361C, IAB 1/6/16, effective 1/1/16]

441—78.29(249A) Behavioral health services. Payment shall be made for medically necessary behavioral health services provided by a participating marital and family therapist, independent social worker, master social worker, mental health counselor, or certified alcohol and drug counselor within the practitioner’s scope of practice pursuant to state law and subject to the limitations and exclusions set forth in this rule.

78.29(1) Limitations.

a. An assessment and a treatment plan are required.

b. Services provided by a licensed master social worker must be provided under the supervision of an independent social worker qualified to participate in the Medicaid program.

78.29(2) Exclusions. Payment will not be approved for the following services:

a. Services provided in a medical institution.

b. Services performed without relationship to a specific condition, risk factor, symptom, or complaint.

c. Services provided for nonspecific conditions of distress such as job dissatisfaction or general unhappiness.

d. Sensitivity training, marriage enrichment, assertiveness training, and growth groups or marathons.

78.29(3) Payment.

a. Payment shall be made only for time spent in face-to-face consultation with the member.

b. A unit of service is 15 minutes. Time spent with members shall be rounded to the quarter hour, where applicable.

This rule is intended to implement Iowa Code section 249A.4.

[ARC 9649B, IAB 8/10/11, effective 8/1/11]

441—78.30(249A) Birth centers. Payment will be made for prenatal, delivery, and postnatal services.

78.30(1) Risk assessment. Risk assessment, using Form 470-2942, Medicaid Prenatal Risk Assessment, shall be completed at the initial visit during a Medicaid member's pregnancy.

a. If the risk assessment reflects a low-risk pregnancy, the assessment shall be completed again at approximately the twenty-eighth week of pregnancy.

b. If the risk assessment reflects a high-risk pregnancy, referral shall be made for enhanced services. (See description of enhanced services at subrule 78.25(3).)

78.30(2) Vaccines. In order to be paid for the administration of a vaccine covered under the Vaccines for Children (VFC) Program, a birth center must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

This rule is intended to implement Iowa Code section 249A.4.

[ARC 0065C, IAB 4/4/12, effective 6/1/12]

441—78.31(249A) Hospital outpatient services.

78.31(1) Covered hospital outpatient services. Payment will be approved only for the following outpatient hospital services and medical services when provided on the licensed premises of the hospital or pursuant to subrule 78.31(5). Hospitals with alternate sites approved by the department of inspections and appeals are acceptable sites. All outpatient services listed in paragraphs "g" to "m" are subject to a random sample retrospective review for medical necessity by the IME medical services unit. All services may also be subject to a more intensive retrospective review if abuse is suspected. Services in paragraphs "a" to "f" shall be provided in hospitals on an outpatient basis and are subject to no further limitations except medical necessity of the service.

Services listed in paragraphs "g" to "m" shall be provided by hospitals on an outpatient basis and must be certified by the department before payment may be made. Other limitations apply to these services.

a. Emergency service.

b. Outpatient surgery.

c. Laboratory, X-ray and other diagnostic services.

d. General or family medicine.

e. Follow-up or after-care specialty clinics.

f. Physical medicine and rehabilitation.

g. Alcoholism and substance abuse.

h. Eating disorders.

i. Cardiac rehabilitation.

j. Mental health.

k. Pain management.

l. Diabetic education.

m. Pulmonary rehabilitation.

n. Nutritional counseling for persons aged 20 and under.

78.31(2) Requirements for all outpatient services.

a. Need for service. It must be clearly established that the service meets a documented need in the area served by the hospital. There must be documentation of studies completed, consultations with other health care facilities and health care professionals in the area, community leaders, and organizations to determine the need for the service and to tailor the service to meet that particular need.

b. Professional direction. All outpatient services must be provided by or at the direction and under the supervision of a medical doctor or osteopathic physician except for mental health services which may be provided by or at the direction and under the supervision of a medical doctor, osteopathic physician, or certified health service provider in psychology.

c. Goals and objectives. The goals and objectives of the program must be clearly stated. Paragraphs “d” and “f” and the organization and administration of the program must clearly contribute to the fulfillment of the stated goals and objectives.

d. Treatment modalities used. The service must employ multiple treatment modalities and professional disciplines. The modalities and disciplines employed must be clearly related to the condition or disease being treated.

e. Criteria for selection and continuing treatment of patients. The condition or disease which is proposed to be treated must be clearly stated. Any indications for treatment or contraindications for treatment must be set forth together with criteria for determining the continued medical necessity of treatment.

f. Length of program. There must be established parameters that limit the program either in terms of its overall length or in terms of number of visits, etc.

g. Monitoring of services. The services provided by the program must be monitored and evaluated to determine the degree to which patients are receiving accurate assessments and effective treatment.

The monitoring of the services must be an ongoing plan and systematic process to identify problems in patient care or opportunities to improve patient care.

The monitoring and evaluation of the services are based on the use of clinical indicators that reflect those components of patient care important to quality.

h. Vaccines. In order to be paid for the outpatient administration of a vaccine covered under the Vaccines for Children (VFC) Program, a hospital must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

78.31(3) Application for certification. Hospital outpatient programs listed in subrule 78.31(1), paragraphs “g” to “m,” must submit an application to the Iowa Medicaid enterprise provider services unit for certification before payment will be made. The provider services unit will review the application against the requirements for the specific type of outpatient service and notify the provider whether certification has been approved.

Applications will consist of a narrative providing the following information:

a. Documented need for the program including studies, needs assessments, and consultations with other health care professionals.

b. Goals and objectives of the program.

c. Organization and staffing including how the program fits with the rest of the hospital, the number of staff, staff credentials, and the staff’s relationship to the program, e.g., hospital employee, contractual consultant.

d. Policies and procedures including admission criteria, patient assessment, treatment plan, discharge plan and postdischarge services, and the scope of services provided, including treatment modalities.

e. Any accreditations or other types of approvals from national or state organizations.

f. The physical facility and any equipment to be utilized, and whether the facility is part of the hospital license.

78.31(4) Requirements for specific types of service.

a. Alcoholism and substance abuse.

(1) Approval by joint commission or substance abuse commission. In addition to certification by the department, alcoholism and substance abuse programs must also be approved by either the joint commission on the accreditation of hospitals or the Iowa substance abuse commission.

(2) General characteristics. The services must be designed to identify and respond to the biological, psychological and social antecedents, influences and consequences associated with the recipient's dependence.

These needed services must be provided either directly by the facility or through referral, consultation or contractual arrangements or agreements.

Special treatment needs of recipients by reason of age, gender, sexual orientation, or ethnic origin are evaluated and services for children and adolescents (as well as adults, if applicable) address the special needs of these age groups, including but not limited to, learning problems in education, family involvement, developmental status, nutrition, and recreational and leisure activities.

(3) Diagnostic and treatment staff. Each person who provides diagnostic or treatment services shall be determined to be competent to provide the services by reason of education, training, and experience.

Professional disciplines which must be represented on the diagnostic and treatment staff, either through employment by the facility (full-time or part-time), contract or referral, are a physician (M.D. or D.O.), a licensed psychologist and a substance abuse counselor certified by the Iowa board of substance abuse certification. Psychiatric consultation must be available and the number of staff should be appropriate to the patient load of the facility.

(4) Initial assessment. A comprehensive assessment of the biological, psychological, social, and spiritual orientation of the patient must be conducted which shall include:

A history of the use of alcohol and other drugs including age of onset, duration, patterns, and consequences of use; use of alcohol and drugs by family members and types of and responses to previous treatment.

A comprehensive medical history and physical examination including the history of physical problems associated with dependence.

Appropriate laboratory screening tests based on findings of the history and physical examination and tests for communicable diseases when indicated.

Any history of physical abuse.

A systematic mental status examination with special emphasis on immediate recall and recent and remote memory.

A determination of current and past psychiatric and psychological abnormality.

A determination of any degree of danger to self or others.

The family's history of alcoholism and other drug dependencies.

The patient's educational level, vocational status, and job performance history.

The patient's social support networks, including family and peer relationships.

The patient's perception of the patient's strengths, problem areas, and dependencies.

The patient's leisure, recreational, or vocational interests and hobbies.

The patient's ability to participate with peers and in programs and social activities.

Interview of family members and significant others as available with the patient's written or verbal permission.

Legal problems, if applicable.

(5) Admission criteria. Both of the first two criteria and one additional criterion from the following list must be present for a patient to be accepted for treatment.

Alcohol or drugs taken in greater amounts over a longer period than the person intended.

Two or more unsuccessful efforts to cut down or control use of alcohol or drugs.

Continued alcohol or drug use despite knowledge of having a persistent or recurrent family, social, occupational, psychological, or physical problem that is caused or exacerbated by the use of alcohol or drugs.

Marked tolerance: the need for markedly increased amounts of alcohol or drugs (i.e., at least a 50 percent increase) in order to achieve intoxication or desired effect or markedly diminished effect with continued use of same amount.

Characteristic withdrawal symptoms.

Alcohol or drugs taken often to relieve or avoid withdrawal symptoms.

(6) Plan of treatment. For each patient there is a written comprehensive and individualized description of treatment to be undertaken. The treatment plan is based on the problems and needs identified in the assessment and specifies the regular times at which the plan will be reassessed.

The patient's perception of needs and, when appropriate and available, the family's perception of the patient's needs shall be documented.

The patient's participation in the development of the treatment plan is sought and documented.

Each patient is reassessed to determine current clinical problems, needs, and responses to treatment. Changes in treatment are documented.

(7) Discharge plan. For each patient before discharge, a plan for discharge is designed to provide appropriate continuity of care which meets the following requirements:

The plan for continuing care must describe and facilitate the transfer of the patient and the responsibility for the patient's continuing care to another phase or modality of the program, other programs, agencies, persons or to the patient and the patient's personal support system.

The plan is in accordance with the patient's reassessed needs at the time of transfer.

The plan is developed in collaboration with the patient and, as appropriate and available, with the patient's written verbal permission with family members.

The plan is implemented in a manner acceptable to the patient and the need for confidentiality.

Implementation of the plan includes timely and direct communication with and transfer of information to the other programs, agencies, or persons who will be providing continuing care.

(8) Restrictions and limitations on payment. Medicaid will reimburse for a maximum of 28 treatment days. Payment beyond 28 days is made when documentation indicates that the patient has not reached an exit level.

If an individual has completed all or part of the basic 28-day program, a repeat of the program will be reimbursed with justification. The program will include an aftercare component meeting weekly for at least one year without charge.

b. Eating disorders.

(1) General characteristics. Eating disorders are characterized by gross disturbances in eating behavior. Eating disorders include anorexia nervosa or bulimia nervosa. Compulsive overeaters are not approved for this program.

(2) Diagnostic and treatment staff. Each person who provides diagnostic or treatment services shall be determined to be competent to provide the services by reason of education, training, and experience.

Professional disciplines which must be represented on the diagnostic and treatment staff, either through employment by a facility (full-time or part-time), contract or referral, are a physician (M.D. or D.O.), a licensed psychologist, a counselor with a master's or bachelor's degree and experience, a dietitian with a bachelor's degree and registered dietitian's certificate, and a licensed occupational therapist. The number of staff should be appropriate to the patient load of the facility.

(3) Initial assessment. A comprehensive assessment of the biological, psychological, social, and family orientation of the patient must be conducted. The assessment must include a weight history and a history of the patient's eating and dieting behavior, including binge eating, onset, patterns, and consequences. The assessment shall include the following:

A family history as well as self-assessment regarding chronic dieting, obesity, anorexia, bulimia, drug abuse, alcohol problems, depression, hospitalization for psychiatric reasons, and threatened or attempted suicide.

A history of purging behavior including frequency and history of vomiting, use of laxatives, history and frequency of use of diuretics, history and frequency of use of diet pills, ipecac, or any other weight control measures, and frequency of eating normal meals without vomiting.

A history of exercise behavior, including type, frequency, and duration.

A complete history of current alcohol and other drug use.

Any suicidal thoughts or attempts.

Sexual history, including sexual preference and activity. Sexual interest currently as compared to prior to the eating disorder is needed.

History of experiencing physical or sexual (incest or rape) abuse.

History of other counseling experiences.

Appropriate psychological assessment, including psychological orientation to the above questions.

A medical history, including a physical examination, covering the information listed in subparagraph (4) below.

Appropriate laboratory screening tests based on findings of the history and physical examination and tests for communicable diseases when indicated.

The patient's social support networks, including family and peer relationships.

The patient's educational level, vocational status, and job or school performance history, as appropriate.

The patient's leisure, recreational, or vocational interests and hobbies.

The patient's ability to participate with peers and programs and social activities.

Interview of family members and significant others as available with the patient's written or verbal permission as appropriate.

Legal problems, if applicable.

(4) Admission criteria. In order to be accepted for treatment, the patient shall meet the diagnostic criteria for anorexia nervosa or bulimia nervosa as established by the current version of the DSM (Diagnostic and Statistical Manual of Mental Disorders) published by the American Psychiatric Association.

In addition to the diagnostic criteria, the need for treatment will be determined by a demonstrable loss of control of eating behaviors and the failure of the patient in recent attempts at voluntary self-control of the problem. Demonstrable impairment, dysfunction, disruption or harm of physical health, emotional health (e.g., significant depression withdrawal, isolation, suicidal ideas), vocational or educational functioning, or interpersonal functioning (e.g., loss of relationships, legal difficulties) shall have occurred.

The need for treatment may be further substantiated by substance abuse, out-of-control spending, incidence of stealing to support habit, or compulsive gambling.

The symptoms shall have been present for at least six months and three of the following criteria must be present:

Medical criteria including endocrine and metabolic factors (e.g., amenorrhea, menstrual irregularities, decreased reflexes, cold intolerance, hypercarotenemia, parotid gland enlargement, lower respiration rate, hair loss, abnormal cholesterol or triglyceride levels).

Other cardiovascular factors including hypotension, hypertension, arrhythmia, ipecac poisoning, fainting, or bradycardia.

Renal considerations including diuretic abuse, dehydration, elevated BUN, renal calculi, edema, or hypokalemia.

Gastrointestinal factors including sore throats, Mallory-Weiss tears, decreased gastric emptying, constipation, abnormal liver enzymes, rectal bleeding, laxative abuse, or esophagitis.

Hematologic considerations including anemia, leukopenia, or thrombocytopenia.

Ear, nose, and throat factors including headaches or dizziness.

Skin considerations including lanugo or dry skin.

Aspiration pneumonia, a pulmonary factor.

The presence of severe symptoms and complications as evaluated and documented by the medical director may require a period of hospitalization to establish physical or emotional stability.

(5) Plan of treatment. For each patient there is a written comprehensive and individualized description of treatment to be undertaken. The treatment plan is based on problems and needs identified in the assessment and specifies the regular times at which the plan will be reassessed.

The patient's perceptions of needs and, when appropriate and available, the family's perceptions of the patient's needs shall be documented.

The patient's participation in the development of the treatment plans is sought and documented.

Each patient is reassessed to determine current clinical problems, needs, and responses to treatment. Changes in treatment are documented.

(6) Discharge plan. Plans for discharge shall meet the requirements for discharge plans for alcohol and substance abuse patients in subrule 78.31(3), paragraph "a," subparagraph (6).

(7) Restriction and limitations on payment. Medicaid will pay for a maximum of 30 days of a structured outpatient treatment program. Payment beyond 30 days is made when documentation indicates that the patient has not reached an exit level.

Eating disorder programs will include an aftercare component meeting weekly for at least one year without charge.

Family counseling groups held in conjunction with the eating disorders program will be part of the overall treatment charge.

c. Cardiac rehabilitation.

(1) General characteristics. Cardiac rehabilitation programs shall provide a supportive educational environment in which to facilitate behavior change with respect to the accepted cardiac risk factors, initiate prescribed exercise as a mode of facilitating the return of the patient to everyday activities by improving cardiovascular functional capacity and work performance, and promote a long-term commitment to lifestyle changes that could positively affect the course of the cardiovascular disease process.

(2) Treatment staff. Professional disciplines who must be represented on the treatment staff, either by employment by the facility (full-time or part-time), contract or referral, are as follows:

At least one physician responsible for responding to emergencies must be physically present in the hospital when patients are receiving cardiac rehabilitation services. The physician must be trained and certified at least to the level of basic life support.

A medical consultant shall oversee the policies and procedures of the outpatient cardiac rehabilitation area. The director shall meet with the cardiac rehabilitation staff on a regular basis to review exercise prescriptions and any concerns of the team.

A cardiac rehabilitation nurse shall carry out the exercise prescription after assessment of the patient. The nurse shall be able to interpret cardiac dysrhythmia and be able to initiate emergency action if necessary. The nurse shall assess and implement a plan of care for cardiac risk factor modification. The nurse shall have at least one year of experience in a coronary care unit.

A physical therapist shall offer expertise in unusual exercise prescriptions where a patient has an unusual exercise problem.

A dietitian shall assess the dietary needs of persons and appropriately instruct them on their prescribed diets.

A social worker shall provide counseling as appropriate and facilitate a spouse support group. A licensed occupational therapist shall be available as necessary.

(3) Admission criteria. Candidates for the program must be referred by the attending physician. The following conditions are eligible for the program:

Postmyocardial infarction (within three months postdischarge).

Postcardiac surgery (within three months postdischarge).

Poststreptokinase.

Postpercutaneous transluminal angioplasty (within three months postdischarge).

Patient with severe angina being treated medically because of client or doctor preference or inoperable cardiac disease.

(4) Physical environment and equipment. A cardiac rehabilitation unit must be an autonomous physical unit specifically equipped with the necessary telemetry monitoring equipment, exercise equipment, and appropriate equipment and supplies for cardiopulmonary resuscitation (CPR). The exercise equipment must have the capacity to measure the intensity, speed, and length of the exercises. The equipment must be periodically inspected and maintained in accordance with the hospital's preventive maintenance program.

(5) Medical records. Medical records for each cardiac rehabilitation patient shall consist of at least the following:

Referral form.

Physician's orders.

- Laboratory reports.
- Electrocardiogram reports.
- History and physical examination.
- Angiogram report, if applicable.
- Operative report, if applicable.
- Preadmission interview.
- Exercise prescription.
- Rehabilitation plan, including participant's goals.
- Documentation for exercise sessions and progress notes.
- Nurse's progress reports.
- Discharge instructions.

(6) Discharge plan. The patient will be discharged from the program when the physician, staff, and patient agree that the work level is functional for them and little benefit could be derived from further continuation of the program, dysrhythmia disturbances are resolved, and appropriate cardiovascular response to exercise is accomplished.

(7) Monitoring of services. The program should be monitored by the hospital on a periodic basis using measuring criteria for evaluating cardiac rehabilitation services provided.

(8) Restrictions and limitations. Payment will be made for a maximum of three visits per week for a period of 12 weeks. Payment beyond 12 weeks is made when documentation indicates that the patient has not reached an exit level.

d. Mental health.

(1) General characteristics. To be covered, mental health services must be prescribed by a physician or certified health service provider in psychology, provided under an individualized treatment plan and reasonable and necessary for the diagnosis or treatment of the patient's condition. This means the services must be for the purpose of diagnostic study or the services must reasonably be expected to improve the patient's condition.

(2) Individualized treatment plan. The individualized written plan of treatment shall be established by a physician or certified health service provider in psychology after any needed consultation with appropriate staff members. The plan must state the type, amount, frequency and duration of the services to be furnished and indicate the diagnoses and anticipated goals. (A plan is not required if only a few brief services will be furnished.)

(3) Supervision and evaluation. Services must be supervised and periodically evaluated by a physician, certified health service provider in psychology, or both within the scopes of their respective practices if clinically indicated to determine the extent to which treatment goals are being realized. The evaluation must be based on periodic consultation and conference with therapists and staff. The physician or certified health service provider in psychology must also provide supervision and direction to any therapist involved in the patient's treatment and see the patient periodically to evaluate the course of treatment and to determine the extent to which treatment goals are being realized and whether changes in direction or services are required.

(4) Reasonable expectation of improvement. Services must be for the purpose of diagnostic study or reasonably be expected to improve the patient's condition. The treatment must at a minimum be designed to reduce or control the patient's psychiatric or psychological symptoms so as to prevent relapse or hospitalization and improve or maintain the patient's level of functioning.

It is not necessary that a course of therapy have as its goal restoration of the patient to the level of functioning exhibited prior to the onset of the illness although this may be appropriate for some patients. For many other patients, particularly those with long-term chronic conditions, control of symptoms and maintenance of a functional level to avoid further deterioration or hospitalization is an acceptable expectation of improvement. "Improvement" in this context is measured by comparing the effect of continuing versus discontinuing treatment. Where there is a reasonable expectation that if treatment services were withdrawn, the patient's condition would deteriorate, relapse further, or require hospitalization, this criterion would be met.

(5) Diagnostic and treatment staff. Each person who provides diagnostic or treatment services shall be determined to be competent to provide the services by reason of education, training, and experience. The number of the above staff employed by the facility must be appropriate to the facility's patient load. The staff may be employees of the hospital, on contract, or the service may be provided through referral.

The diagnostic and treatment staff shall consist of a physician, a psychologist, social workers or counselors meeting the requirements for "mental health professionals" as set forth in rule 441—33.1(225C,230A).

(6) Initial assessment. A comprehensive assessment of the biological, psychological, social, and spiritual orientation of the patient must be conducted, which shall include:

A history of the mental health problem, including age of onset, duration, patterns of symptoms, consequences of symptoms, and responses to previous treatment.

A comprehensive clinical history, including the history of physical problems associated with the mental health problem. Appropriate referral for physical examination for determination of any communicable diseases.

Any history of physical abuse.

A systematic mental health examination, with special emphasis on any change in cognitive, social or emotional functioning.

A determination of current and past psychiatric and psychological abnormality.

A determination of any degree of danger to self or others.

The family's history of mental health problems.

The patient's educational level, vocational status, and job performance history.

The patient's social support network, including family and peer relationship.

The patient's perception of the patient's strengths, problem areas, and dependencies.

The patient's leisure, recreational or vocational interests and hobbies.

The patient's ability to participate with peers in programs and social activities.

Interview of family members and significant others, as available, with the patient's written or verbal permission.

Legal problems if applicable.

(7) Covered services. Services covered for the treatment of psychiatric conditions are:

1. Individual and group therapy with physicians, psychologists, social workers, counselors, or psychiatric nurses.

2. Occupational therapy services if the services require the skills of a qualified occupational therapist and must be performed by or under the supervision of a licensed occupational therapist or by an occupational therapy assistant.

3. Drugs and biologicals furnished to outpatients for therapeutic purposes only if they are of the type which cannot be self-administered and are not "covered Part D drugs" as defined by 42 U.S.C. Section 1395w-102(e)(1)-(2) for a "Part D eligible individual" as defined in 42 U.S.C. Section 1395w-101(a)(3)(A), including an individual who is not enrolled in a Part D plan.

4. Activity therapies which are individualized and essential for the treatment of the patient's condition. The treatment plan must clearly justify the need for each particular therapy utilized and explain how it fits into the patient's treatment.

5. Family counseling services are covered only if the primary purpose of the counseling is the treatment of the patient's condition.

6. Partial hospitalization and day treatment services to reduce or control a person's psychiatric or psychological symptoms so as to prevent relapse or hospitalization, improve or maintain the person's level of functioning and minimize regression. These services include all psychiatric services needed by the patient during the day.

Partial hospitalization services means an active treatment program that provides intensive and structured support that assists persons during periods of acute psychiatric or psychological distress or during transition periods, generally following acute inpatient hospitalization episodes.

Service components may include individual and group therapy, reality orientation, stress management and medication management.

Services are provided for a period for four to eight hours per day.

Day treatment services means structured, long-term services designed to assist in restoring, maintaining or increasing levels of functioning, minimizing regression and preventing hospitalization.

Service components include training in independent functioning skills necessary for self-care, emotional stability and psychosocial interactions, and training in medication management.

Services are structured with an emphasis on program variation according to individual need.

Services are provided for a period of three to five hours per day, three or four times per week.

7. Partial hospitalization and day treatment for persons aged 20 or under. Payment to a hospital will be approved for day treatment services for persons aged 20 or under if the hospital is certified by the department for hospital outpatient mental health services. All conditions for the day treatment program for persons aged 20 or under as outlined in subrule 78.16(7) for community mental health centers shall apply to hospitals. All conditions of the day treatment program for persons aged 20 or under as outlined in subrule 78.16(7) for community mental health centers shall be applicable for the partial hospitalization program for persons aged 20 or under with the exception that the maximum hours shall be 25 hours per week.

(8) Restrictions and limitations on coverage. The following are generally not covered except as indicated:

Activity therapies, group activities, or other services and programs which are primarily recreational or diversional in nature. Outpatient psychiatric day treatment programs that consist entirely of activity therapies are not covered.

Geriatric day-care programs, which provide social and recreational activities to older persons who need some supervision during the day while other family members are away from home. These programs are not covered because they are not considered reasonable and necessary for a diagnosed psychiatric disorder.

Vocational training. While occupational therapy may include vocational and prevocational assessment of training, when the services are related solely to specific employment opportunities, work skills, or work setting, they are not covered.

(9) Frequency and duration of services. There are no specific limits on the length of time that services may be covered. There are many factors that affect the outcome of treatment. Among them are the nature of the illness, prior history, the goals of treatment, and the patient's response. As long as the evidence shows that the patient continues to show improvement in accordance with the individualized treatment plan and the frequency of services is within acceptable norms of medical practice, coverage will be continued.

(10) Documentation requirements. The provider shall develop and maintain sufficient written documentation to support each medical or remedial therapy, service, activity, or session for which billing is made. All outpatient mental health services shall include:

1. The specific services rendered.
2. The date and actual time the services were rendered.
3. Who rendered the services.
4. The setting in which the services were rendered.
5. The amount of time it took to deliver the services.
6. The relationship of the services to the treatment regimen described in the plan of care.
7. Updates describing the patient's progress.

For services that are not specifically included in the patient's treatment plan, a detailed explanation of how the services being billed relate to the treatment regimen and objectives contained in the patient's plan of care and the reason for the departure from the plan shall be given.

e. Pain management.

(1) Approval by commission on accreditation of rehabilitation facilities. In addition to certification by the department, pain management programs must also be approved by the commission on accreditation of rehabilitation facilities (CARF).

(2) General characteristics. A chronic pain management program shall provide coordinated, goal-oriented, interdisciplinary team services to reduce pain, improve quality of life, and decrease

dependence on the health care system for persons with pain which interferes with physical, psychosocial, and vocational functioning.

(3) Treatment staff. Each person who provides treatment services shall be determined to be competent to provide the services by reason of education, training, and experience. Professional disciplines which must be represented on the treatment staff, either through employment by the facility (full-time or part-time), contract or referral, are a physician (M.D. or D.O.), a registered nurse, a licensed physical therapist and a licensed clinical psychologist or psychiatrist. The number of staff should be appropriate to the patient load of the facility.

(4) Admission criteria. Candidates for the program shall meet the following guidelines:

The person must have had adequate medical evaluation and treatment in the months preceding admission to the program including an orthopedic or neurological consultation if the problem is back pain or a neurological evaluation if the underlying problem is headaches.

The person must be free of any underlying psychosis or severe neurosis.

The person cannot be toxic on any addictive drugs.

The person must be capable of self-care; including being able to get to meals and to perform activities of daily living.

(5) Plan of treatment. For each patient there is a written comprehensive and individualized description of treatment to be undertaken. The treatment plan is based on the problems and needs identified in the assessment and specifies the times at which the plan will be reassessed.

The patient's perception of needs and, when appropriate and available, the family's perception of the patient's needs shall be documented.

The patient's participation in the development of the treatment plan is sought and documented.

Each patient is reassessed to determine current clinical problems, needs, and responses to treatment. Changes in treatment are documented.

(6) Discharge plan. For each patient before discharge, a plan for discharge is designed to provide appropriate continuity of care which meets the following requirements:

The plan for continuing care must describe and facilitate the transfer of the patient and the responsibility for the patient's continuing care to another phase or modality of the program, other programs, agencies, persons or to the patient and the patient's personal support system.

The plan is in accordance with the patient's reassessed needs at the time of transfer.

The plan is developed in collaboration with the patient and, as appropriate and available, with the patient's written verbal permission with the family members.

The plan is implemented in a manner acceptable to the patient and the need for confidentiality.

Implementation of the plan includes timely and direct communication with and transfer of information to the other programs, agencies, or persons who will be providing continuing care.

(7) Restrictions and limitations on payment. Medicaid will pay for a maximum of three weeks of a structured outpatient treatment program. When documentation indicates that the patient has not reached an exit level, coverage may be extended an extra week.

A repeat of the entire program for any patient will be covered only if a different disease process is causing the pain or a significant change in life situation can be demonstrated.

f. Diabetic education.

(1) Certification by department of public health. In addition to certification by the department for Medicaid, diabetic education programs must also be certified by the department of public health. (See department of public health rules 641—Chapter 9.)

(2) General characteristics. An outpatient diabetes self-management education program shall provide instruction which will enable people with diabetes and their families to understand the diabetes disease process and the daily management of diabetes. People with diabetes must learn to balance their special diet and exercise requirements with drug therapy (insulin or oral agents). They must learn self-care techniques such as monitoring their own blood glucose. And often, they must learn to self-treat insulin reactions, protect feet that are numb and have seriously compromised circulation, and accommodate their regimen to changes in blood glucose because of stress or infections.

(3) Program staff. Each person who provides services shall be determined to be competent to provide the services by reason of education, training and experience. Professional disciplines which must be represented on the staff, either through employment by the facility (full-time or part-time), contract or referral, are a physician (M.D. or D.O.), a registered nurse, a registered dietitian and a licensed pharmacist. The number of staff should be appropriate to the patient load of the facility.

(4) Admission criteria. Candidates for the program shall meet the following guidelines:

The person must have Type I or Type II diabetes.

The person must be referred by the attending physician.

The person shall demonstrate an ability to follow through with self-management.

(5) Health assessment. An individualized and documented assessment of needs shall be developed with the patient's participation. Follow-up assessments, planning and identification of problems shall be provided.

(6) Restrictions and limitations on payment. Medicaid will pay for a diabetic self-management education program. Diabetic education programs will include follow-up assessments at 3 and 12 months without charge. A complete diabetic education program is payable once in the lifetime of a recipient.

g. Pulmonary rehabilitation.

(1) General characteristics. Pulmonary rehabilitation is an individually tailored, multidisciplinary program through which accurate diagnosis, therapy, emotional support, and education stabilizes or reverses both the physio- and psychopathology of pulmonary diseases and attempts to return the patient to the highest possible functional capacity allowed by the pulmonary handicap and overall life situation.

(2) Diagnostic and treatment staff. Each person who provides diagnostic or treatment services shall be determined to be competent to provide the services by reason of education, training, and experience.

Professional disciplines which must be represented by the diagnostic and treatment staff, either through employment by the facility (full-time or part-time), contract, or referral, are a physician (doctor of medicine or osteopathy), a respiratory therapist, a licensed physical therapist, and a registered nurse.

(3) Initial assessment. A comprehensive assessment must occur initially, including:

A diagnostic workup which entails proper identification of the patient's specific respiratory ailment, appropriate pulmonary function studies, a chest radiograph, an electrocardiogram and, when indicated, arterial blood gas measurements at rest and during exercise, sputum analysis and blood theophylline measurements.

Behavioral considerations include emotional screening assessments and treatment or counseling when required, estimating the patient's learning skills and adjusting the program to the patient's ability, assessing family and social support, potential employment skills, employment opportunities, and community resources.

(4) Admission criteria. Criteria include a patient's being diagnosed and symptomatic of chronic obstructive pulmonary disease (COPD), having cardiac stability, social, family, and financial resources, ability to tolerate periods of sitting time; and being a nonsmoker for six months, or if a smoker, willingness to quit and a physician's order to participate anyway.

Factors which would make a person ineligible include acute or chronic illness that may interfere with rehabilitation, any illness or disease state that affects comprehension or retention of information, a strong history of medical noncompliance, unstable cardiac or cardiovascular problems, and orthopedic difficulties that would prohibit exercise.

(5) Plan of treatment. Individualized long- and short-term goals will be developed for each patient. The treatment goals will be based on the problems and needs identified in the assessment and specify the regular times at which the plan will be reassessed.

The patients and their families need to help determine and fully understand the goals, so that they realistically approach the treatment phase.

Patients are reassessed to determine current clinical problems, needs, and responses to treatment. Changes in treatment are documented.

Components of pulmonary rehabilitation to be included are physical therapy and relaxation techniques, exercise conditioning or physical conditioning for those with exercise limitations,

respiratory therapy, education, an emphasis on the importance of smoking cessation, and nutritional information.

(6) Discharge plan. Ongoing care will generally be the responsibility of the primary care physician. Periodic reassessment will be conducted to evaluate progress and allow for educational reinforcement.

(7) Restrictions and limitations on payment. Medicaid will pay for a maximum of 25 treatment days. Payment beyond 25 days is made when documentation indicates that the patient has not reached an exit level.

h. Nutritional counseling. Payment will be made for persons aged 20 and under for nutritional counseling provided by a licensed dietitian employed by or under contract with a hospital for a nutritional problem or condition of a degree of severity that nutritional counseling beyond that normally expected as part of the standard medical management is warranted. For persons eligible for the WIC program, a WIC referral is required. Medical necessity for nutritional counseling services exceeding those available through WIC shall be documented.

78.31(5) *Services rendered by advanced registered nurse practitioners certified in family, pediatric, or psychiatric mental health specialties and employed by a hospital.* Rescinded IAB 10/15/03, effective 12/1/03.

This rule is intended to implement Iowa Code section 249A.4.
[ARC 0065C, IAB 4/4/12, effective 6/1/12; ARC 2164C, IAB 9/30/15, effective 10/1/15; ARC 2361C, IAB 1/6/16, effective 1/1/16]

441—78.32(249A) Area education agencies. Payment will be made for physical therapy, occupational therapy, psychological evaluations and counseling, psychotherapy, speech-language therapy, and audiological, nursing, and vision services provided by an area education agency (AEA). Services shall be provided directly by the AEA or through contractual arrangement with the AEA.

This rule is intended to implement Iowa Code section 249A.4.

441—78.33(249A) Case management services. Payment will be approved for targeted case management services that are provided pursuant to 441—Chapter 90 to:

1. Members who are 18 years of age or over and have a primary diagnosis of intellectual disability, developmental disabilities, or chronic mental illness as defined in rule 441—90.1(249A).
2. Members who are under 18 years of age and are receiving services under the HCBS intellectual disability waiver or children's mental health waiver.

This rule is intended to implement Iowa Code section 249A.4.
[ARC 9403B, IAB 3/9/11, effective 5/1/11; ARC 9588B, IAB 6/29/11, effective 9/1/11; ARC 0848C, IAB 7/24/13, effective 7/1/13; ARC 1051C, IAB 10/2/13, effective 11/6/13; ARC 2361C, IAB 1/6/16, effective 1/1/16]

441—78.34(249A) HCBS ill and handicapped waiver services. Payment will be approved for the following services to members eligible for HCBS ill and handicapped waiver services as established in 441—Chapter 83 and as identified in the member's service plan. Effective March 17, 2022, payment shall only be made for services provided in integrated, community-based settings that support full access of members receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.

78.34(1) Homemaker services. Homemaker services are those services provided when the member lives alone or when the person who usually performs these functions for the member needs assistance with performing the functions. A unit of service is 15 minutes. Components of the service must be directly related to the care of the member and may include only the following:

- a.* Essential shopping: shopping for basic need items such as food, clothing or personal care items, or drugs.
- b.* Limited housecleaning: maintenance cleaning such as vacuuming, dusting, scrubbing floors, defrosting refrigerators, cleaning stoves, cleaning medical equipment, washing and mending clothes, washing personal items used by the member, and washing dishes.
- c.* Meal preparation: planning and preparing balanced meals.

78.34(2) Home health services. Home health services are personal or direct care services provided to the client which are not payable under Medicaid as set forth in rule 441—78.9(249A). A unit of service is a visit.

a. Components of the service include, but are not limited to:

- (1) Observation and reporting of physical or emotional needs.
- (2) Helping a client with bath, shampoo, or oral hygiene.
- (3) Helping a client with toileting.
- (4) Helping a client in and out of bed and with ambulation.
- (5) Helping a client reestablish activities of daily living.
- (6) Assisting with oral medications ordered by the physician which are ordinarily self-administered.
- (7) Performing incidental household services which are essential to the client's health care at home and are necessary to prevent or postpone institutionalization in order to complete a full unit of service.
- (8) Accompaniment to medical services or transport to and from school.

b. In some cases, a nurse may provide home health services if the health of the client is such that the agency is unable to place an aide in that situation due to limitations by state law or in the event that the agency's Medicare certification requirements prohibit the aide from providing the service. It is not permitted for the convenience of the provider.

c. Skilled nursing care is not covered.

78.34(3) Adult day care services. Adult day care services provide an organized program of supportive care in a group environment to persons who need a degree of supervision and assistance on a regular or intermittent basis in a day care center. A unit of service is 15 minutes (up to four units per day), a half day (1.25 to 4 hours per day), a full day (4.25 to 8 hours per day), or an extended day (8.25 to 12 hours per day). Components of the service include health-related care, social services, and other related support services.

78.34(4) Nursing care services. Nursing care services are services which are included in the plan of treatment approved by the physician and which are provided by licensed nurses to consumers in the home and community. The services shall be reasonable and necessary to the treatment of an illness or injury and include all nursing tasks recognized by the Iowa board of nursing. A unit of service is a visit.

78.34(5) Respite care services. Respite care services are services provided to the member that give temporary relief to the usual caregiver and provide all the necessary care that the usual caregiver would provide during that period. The purpose of respite care is to enable the member to remain in the member's current living situation.

a. Services provided outside the member's home shall not be reimbursable if the living unit where respite is provided is reserved for another person on a temporary leave of absence.

b. Member-to-staff ratios shall be appropriate to the individual needs of the member as determined by the member's interdisciplinary team.

c. A unit of service is 15 minutes.

d. Respite care is not to be provided to members during the hours in which the usual caregiver is employed except when the member is attending a 24-hour residential camp. Respite care shall not be used as a substitute for a child's day care. Respite cannot be provided to a member whose usual caregiver is a consumer-directed attendant care provider for the member.

e. The interdisciplinary team shall determine if the member will receive basic individual respite, specialized respite, or group respite as defined in 441—Chapter 83.

f. A maximum of 14 consecutive days of 24-hour respite care may be reimbursed.

g. Respite services provided for a period exceeding 24 consecutive hours to three or more individuals who require nursing care because of a mental or physical condition must be provided by a health care facility licensed as described in Iowa Code chapter 135C.

h. Respite services shall not be provided simultaneously with other residential, nursing, or home health aide services provided through the medical assistance program.

78.34(6) Counseling services. Counseling services are face-to-face mental health services provided to the member and caregiver by a mental health professional as defined in rule 441—24.1(225C) to facilitate home management of the member and prevent institutionalization. Counseling services are

nonpsychiatric services necessary for the management of depression, assistance with the grief process, alleviation of psychosocial isolation and support in coping with a disability or illness, including terminal illness. Counseling services may be provided both for the purpose of training the member's family or other caregiver to provide care and for the purpose of helping the member and those caring for the member to adjust to the member's disability or terminal condition. Counseling services may be provided to the member's caregiver only when included in the case plan for the member.

Payment will be made for individual and group counseling. A unit of individual counseling for the waiver member or the waiver member and the member's caregiver is 15 minutes. A unit of group counseling is 15 minutes. Payment for group counseling is based on the group rate divided by six, or, if the number of persons who comprise the group exceeds six, the actual number of persons who comprise the group.

78.34(7) Consumer-directed attendant care service. Consumer-directed attendant care services are service activities performed by a person to help a member with self-care tasks which the member would typically do independently if the member were otherwise able. Covered service activities are limited to the nonskilled activities listed in paragraph 78.34(7) "f" and the skilled activities listed in paragraph 78.34(7) "g." Covered service activities must be essential to the health, safety, and welfare of the member. Services may be provided in the absence of a parent or guardian if the parent or guardian has given advance direction for the service provision.

a. Service planning.

(1) The member, parent, guardian, or attorney in fact under a durable power of attorney for health care shall:

1. Select the individual or agency that will provide the components of the attendant care services.
2. Determine with the selected provider what components of attendant care services the provider shall perform, subject to confirmation by the service worker or case manager that those components are consistent with the assessment and are authorized covered services.
3. Complete, sign, and date Form 470-3372, HCBS Consumer-Directed Attendant Care Agreement, to indicate the frequency, scope, and duration of services (a description of each service component and the time agreed on for that component). The case manager or service worker and provider shall also sign the agreement.
4. Submit the completed agreement to the service worker or case manager. The agreement shall be part of the member's service plan and shall be kept in the member's records, in the provider's records, and in the service worker's or case manager's records. Any service component that is not listed in the agreement shall not be payable.

(2) Whenever a legal representative acts as a provider of consumer-directed attendant care as allowed by 441—paragraph 79.9(7) "b," the following shall apply:

1. The payment rate for the legal representative must be based on the skill level of the legal representative and may not exceed the median statewide reimbursement rate for the service unless the higher rate receives prior approval from the department;
2. The legal representative may not be paid for more than 40 hours of service per week; and
3. A contingency plan must be established in the member's service plan to ensure service delivery in the event the legal representative is unable to provide services due to illness or other unexpected event.

b. Supervision of skilled services. Skilled consumer-directed attendant care services shall be provided under the supervision of a licensed nurse or licensed therapist working under the direction of a physician. The licensed nurse or therapist shall:

- (1) Retain accountability for actions that are delegated.
- (2) Ensure appropriate assessment, planning, implementation, and evaluation.
- (3) Make on-site supervisory visits every two weeks with the service provider present.

c. Service documentation. The consumer-directed attendant care provider must complete Form 470-4389, Consumer-Directed Attendant Care (CDAC) Service Record, for each day of service. Any service component that is not documented in accordance with rule 441—79.3(249A) shall not be payable.

d. Role of guardian or attorney. If the member has a guardian or attorney in fact under a durable power of attorney for health care:

(1) The service worker's or case manager's service plan shall address how consumer-directed attendant care services will be monitored to ensure that the member's needs are being adequately met. If the guardian or attorney in fact is the service provider, the service plan shall address how the service worker or case manager shall oversee service provision.

(2) The guardian or attorney in fact shall sign the claim form in place of the member, indicating that the service has been provided as presented on the claim.

e. Service units and billing. A unit of service is 15 minutes provided by an individual or agency. Each service shall be billed in whole units.

f. Nonskilled services. Covered nonskilled service activities are limited to help with the following activities:

- (1) Dressing.
- (2) Bathing, shampooing, hygiene, and grooming.
- (3) Access to and from bed or a wheelchair, transferring, ambulation, and mobility in general.
- (4) Toileting, including bowel, bladder, and catheter assistance (emptying the catheter bag, collecting a specimen, and cleaning the external area around the catheter).
- (5) Meal preparation, cooking, and assistance with feeding, not including the cost of meals themselves. Meal preparation and cooking shall be provided only in the member's home.
- (6) Housekeeping, laundry, and shopping essential to the member's health care at home.
- (7) Taking medications ordinarily self-administered, including those ordered by a physician or other qualified health care provider.
- (8) Minor wound care.
- (9) Going to or returning from a place of employment and job-related tasks while the member is on the job site. Transportation for the member and assistance with understanding or performing the essential job functions are not included in consumer-directed attendant care services.
- (10) Tasks, such as financial management and scheduling, that require cognitive or physical assistance.
- (11) Communication essential to the health and welfare of the member, through interpreting and reading services and use of assistive devices for communication.
- (12) Using transportation essential to the health and welfare of the member. The cost of the transportation is not included.

g. Skilled services. Covered skilled service activities are limited to help with the following activities:

- (1) Tube feedings of members unable to eat solid foods.
- (2) Intravenous therapy administered by a registered nurse.
- (3) Parenteral injections required more than once a week.
- (4) Catheterizations, continuing care of indwelling catheters with supervision of irrigations, and changing of Foley catheters when required.
- (5) Respiratory care including inhalation therapy and tracheotomy care or tracheotomy care and ventilator.
- (6) Care of decubiti and other ulcerated areas, noting and reporting to the nurse or therapist.
- (7) Rehabilitation services including, but not limited to, bowel and bladder training, range of motion exercises, ambulation training, restorative nursing services, respiratory care and breathing programs, reality orientation, reminiscing therapy, remotivation, behavior modification, and reteaching of the activities of daily living.
- (8) Colostomy care.
- (9) Care of uncontrolled medical conditions, such as brittle diabetes, and comfort care of terminal conditions.
- (10) Postsurgical nursing care.
- (11) Monitoring medications requiring close supervision because of fluctuating physical or psychological conditions, e.g., antihypertensives, digitalis preparations, mood-altering or psychotropic drugs, or narcotics.
- (12) Preparing and monitoring response to therapeutic diets.

(13) Recording and reporting of changes in vital signs to the nurse or therapist.

h. Excluded services and costs. Services, activities, costs and time that are not covered as consumer-directed attendant care include the following (not an exclusive list):

(1) Any activity related to supervising a member. Only direct services are billable.

(2) Any activity that the member is able to perform.

(3) Costs of food.

(4) Costs for the supervision of skilled services by the nurse or therapist. The supervising nurse or therapist may be paid from private insurance, Medicare, or other third-party payment sources, or may be paid as another Medicaid service, including early and periodic screening, diagnosis and treatment services.

(5) Exercise that does not require skilled services.

(6) Parenting or child care for or on behalf of the member.

(7) Reminders and cueing.

(8) Services provided simultaneously with any other similar service regardless of funding source, including other waiver services and state supplementary assistance in-home health-related care services.

(9) Transportation costs.

(10) Wait times for any activity.

78.34(8) *Interim medical monitoring and treatment services.* Interim medical monitoring and treatment (IMMT) services are monitoring and treatment of a medical nature for children or adults whose medical needs make alternative care unavailable, inadequate, or insufficient. IMMT services are not intended to provide day care but to supplement available resources. Services must be ordered by a physician.

a. Need for service. The member must be currently receiving home health agency services under rule 441—78.9(249A) and require medical assessment, medical monitoring, and regular medical intervention or intervention in a medical emergency during those services. The service worker or case manager must identify the need for IMMT services after evaluating the member's living environment, family and natural supports, ability to perform activities of daily living, and health care needs. The services must be needed:

(1) To allow the member's usual caregivers to be employed,

(2) During a search for employment by a usual caregiver,

(3) To allow for academic or vocational training of a usual caregiver,

(4) Due to the hospitalization of a usual caregiver for treatment for physical or mental illness, or

(5) Due to the death of a usual caregiver.

b. Service requirements. Interim medical monitoring and treatment services shall:

(1) Provide experiences for each member's social, emotional, intellectual, and physical development;

(2) Include comprehensive developmental care and any special services for a member with special needs; and

(3) Include medical assessment, medical monitoring, and medical intervention as needed on a regular or emergency basis. Medical intervention means the ability to assess the situation and contact the appropriate medical professional, not the direct application of medical care.

c. Interim medical monitoring and treatment services may include supervision while the member is being transported to and from school.

d. Limitations.

(1) A maximum of 12 hours of service is available per day.

(2) Covered services do not include a complete nutritional regimen.

(3) Interim medical monitoring and treatment services may not duplicate any regular Medicaid or waiver services provided under the state plan. Services under the state plan, including home health agency services under rule 441—78.9(249A), must be exhausted before IMMT services are accessed.

(4) Interim medical monitoring and treatment services shall be provided in the following settings that are approved by the department as integrated, community-based settings: the member's home; a

registered child development home; a licensed child care center, residential care facility, or adult day care facility; or during the time when the member is being transported to and from school.

(5) The member-to-staff ratio shall not be more than six members to one staff person.

(6) The parent or guardian of the member shall be responsible for the usual and customary nonmedical cost of day care during the time in which the member is receiving IMMT services. Medical care necessary for monitoring and treatment is an allowable IMMT cost. If the cost of care goes above the usual and customary cost of day care services due to the member's medical condition, the costs above the usual and customary cost shall be covered as IMMT services.

e. A unit of service is 15 minutes.

78.34(9) Home and vehicle modification. Covered home or vehicle modifications are physical modifications to the member's home or vehicle that directly address the member's medical or remedial need. Covered modifications must be necessary to provide for the health, welfare, or safety of the member and enable the member to function with greater independence in the home or vehicle.

a. Modifications that are necessary or desirable without regard to the member's medical or remedial need and that would be expected to increase the fair market value of the home or vehicle, such as furnaces, fencing, or adding square footage to the residence, are excluded except as specifically included below. Purchasing or leasing of a motorized vehicle is excluded. Home and vehicle repairs are also excluded.

b. Only the following modifications are covered:

- (1) Kitchen counters, sink space, cabinets, special adaptations to refrigerators, stoves, and ovens.
- (2) Bathtubs and toilets to accommodate transfer, special handles and hoses for shower heads, water faucet controls, and accessible showers and sink areas.
- (3) Grab bars and handrails.
- (4) Turnaround space adaptations.
- (5) Ramps, lifts, and door, hall and window widening.
- (6) Fire safety alarm equipment specific for disability.
- (7) Voice-activated, sound-activated, light-activated, motion-activated, and electronic devices directly related to the member's disability.
- (8) Vehicle lifts, driver-specific adaptations, remote-start systems, including such modifications already installed in a vehicle.
- (9) Keyless entry systems.
- (10) Automatic opening device for home or vehicle door.
- (11) Special door and window locks.
- (12) Specialized doorknobs and handles.
- (13) Plexiglas replacement for glass windows.
- (14) Modification of existing stairs to widen, lower, raise or enclose open stairs.
- (15) Motion detectors.
- (16) Low-pile carpeting or slip-resistant flooring.
- (17) Telecommunications device for the deaf.
- (18) Exterior hard-surface pathways.
- (19) New door opening.
- (20) Pocket doors.
- (21) Installation or relocation of controls, outlets, switches.
- (22) Air conditioning and air filtering if medically necessary.
- (23) Heightening of existing garage door opening to accommodate modified van.
- (24) Bath chairs.

c. A unit of service is the completion of needed modifications or adaptations.

d. All modifications and adaptations shall be provided in accordance with applicable federal, state, and local building and vehicle codes.

e. Services shall be performed following prior department approval of the modification as specified in 441—subrule 79.1(17) and a binding contract between the provider and the member.

f. All contracts for home or vehicle modification shall be awarded through competitive bidding. The contract shall include the scope of work to be performed, the time involved, supplies needed, the cost, diagrams of the project whenever applicable, and an assurance that the provider has liability and workers' compensation coverage and the applicable permit and license.

g. Service payment shall be made to the enrolled home or vehicle modification provider. If applicable, payment will be forwarded to the subcontracting agency by the enrolled home or vehicle modification provider following completion of the approved modifications. Payment of up to \$6,366.64 per year may be made to certified providers upon satisfactory completion of the service.

h. Services shall be included in the member's service plan and shall exceed the Medicaid state plan services.

78.34(10) *Personal emergency response or portable locator system.*

a. A personal emergency response system is an electronic device that transmits a signal to a central monitoring station to summon assistance in the event of an emergency.

(1) The required components of the system are:

1. An in-home medical communications transceiver.
2. A remote, portable activator.
3. A central monitoring station with backup systems staffed by trained attendants at all times.
4. Current data files at the central monitoring station containing response protocols and personal, medical, and emergency information for each member.

(2) The service shall be identified in the member's service plan.

(3) A unit of service is a one-time installation fee or one month of service.

(4) Maximum units per state fiscal year shall be the initial installation and 12 months of service.

b. A portable locator system is an electronic device that transmits a signal to a monitoring device. The system allows a member to access assistance in the event of an emergency and allows law enforcement or the monitoring system provider to locate a member who is unable to request help or to activate a system independently. The member must be unable to access assistance in an emergency situation due to the member's age or disability.

(1) The required components of the portable locator system are:

1. A portable communications transceiver or transmitter to be worn or carried by the member.
2. Monitoring by the provider at a central location with response protocols and personal, medical, and emergency information for each member as applicable.

(2) The service shall be identified in the member's service plan.

(3) Payable units of service are purchase of equipment, an installation or set-up fee, and monthly fees.

(4) Maximum units per state fiscal year shall be one equipment purchase, one installation or set-up fee, and 12 months of service.

78.34(11) *Home-delivered meals.* Home-delivered meals are meals prepared elsewhere and delivered to a member at the member's residence.

a. Each meal shall ensure the member receives a minimum of one-third of the daily recommended dietary allowance as established by the Food and Nutrition Board of the National Research Council of the National Academy of Sciences. The meal may also be a liquid supplement that meets the minimum one-third standard.

b. When a restaurant provides the home-delivered meal, the member is required to have a nutritional consultation. The nutritional consultation includes contact with the restaurant to explain the dietary needs of the member and what constitutes the minimum one-third daily dietary allowance.

c. A unit of service is a meal (morning, noon, evening, or liquid supplement). Any maximum combination of any two meals (morning, noon, evening, or liquid supplement) is allowed per day. Duplication of a meal in any one day is not allowed. The number of approved meals (morning, noon, evening, or liquid supplement) is contained in the member's service plan.

d. The number of meals delivered for any morning, noon, evening, or liquid supplement meal cannot exceed the number of calendar days in a calendar month; nor can the number of delivered meals exceed the number of authorized days in a month. Meals billed in excess of the calendar days in a

calendar month and those billed in excess of the number of authorized days in a month are subject to recoupment or denial of payment.

78.34(12) *Nutritional counseling.* Nutritional counseling services may be provided for a nutritional problem or condition of such a degree of severity that nutritional counseling beyond that normally expected as part of the standard medical management is warranted. A unit of service is 15 minutes.

78.34(13) *Consumer choices option.* The consumer choices option provides a member with a flexible monthly individual budget that is based on the member's service needs. With the individual budget, the member shall have the authority to purchase goods and services to meet the member's assessed needs and may choose to employ providers of services and supports. The services, supports, and items that are purchased with an individual budget must be directly related to a member's assessed need or goal established in the member's service plan. Components of this service are set forth below.

a. Agreement. As a condition of participating in the consumer choices option, a member shall sign Form 470-4289, HCBS Consumer Choices Informed Consent and Risk Agreement, to document that the member has been informed of the responsibilities and risks of electing the consumer choices option.

b. Individual budget amount. A monthly individual budget amount shall be established for each member based on the assessed needs of the member and based on the services and supports authorized in the member's service plan. The member shall be informed of the individual budget amount during the development of the service plan.

(1) Services that may be included in determining the individual budget amount for a member in the HCBS 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) The department shall determine an average unit cost for each service listed in subparagraph 78.34(13) "b"(1) based on actual unit costs from the previous fiscal year plus a cost-of-living adjustment.

(3) In aggregate, costs for individual budget services shall not exceed the current costs of waiver program services. In order to maintain cost neutrality, the department shall apply a utilization adjustment factor to the amount of service authorized in the member's service plan before calculating the value of that service to be included in the individual budget amount.

(4) The department shall compute the utilization adjustment factor for each service by dividing the net costs of all claims paid for the service by the total of the authorized costs for that service, using at least 12 consecutive months of aggregate service data. The utilization adjustment factor shall be no lower than 60 percent. The department shall analyze and adjust the utilization adjustment factor at least annually in order to maintain cost neutrality.

(5) Individual budgets for respite services shall be computed based on the average cost for services identified in subparagraph 78.34(13) "b"(2). Respite services are not subject to the utilization adjustment factor in subparagraph 78.34(13) "b"(3).

(6) Anticipated costs for home and vehicle modification are not subject to the average cost in subparagraph 78.34(13) "b"(2) or the utilization adjustment factor in subparagraph 78.34(13) "b"(3). Anticipated costs for home and vehicle modification shall not include the costs of the financial management services or the independent support broker. Before becoming part of the individual budget, all home and vehicle modifications shall be identified in the member's service plan and approved by the case manager or service worker. Costs for home and vehicle modification may be paid to the financial management services provider in a one-time payment.

(7) The individual budget amount may be changed only at the first of the month and shall remain fixed for the entire month.

c. Required service components. To participate in the consumer choices option, a member must hire an independent support broker and must work with a financial management service that is enrolled as a Medicaid provider. Before hiring the independent support broker, the member shall receive the results of the background check conducted pursuant to 441—Chapter 119.

d. Optional service components. A member who elects the consumer choices option may purchase the following goods, services and supports, which shall be provided in the member's home or at an integrated community setting:

(1) Self-directed personal care services. Self-directed personal care services are services or goods that provide a range of assistance in activities of daily living and incidental activities of daily living that help the member remain in the home and community. These services must be identified in the member's service plan developed by the member's case manager or service worker.

(2) Self-directed community supports and employment. Self-directed community supports and employment are services that support the member in developing and maintaining independence and community integration. These services must be identified in the member's service plan developed by the member's case manager or service worker.

(3) Individual-directed goods and services. Individual-directed goods and services are services, equipment, or supplies not otherwise provided through the Medicaid program that address an assessed need or goal identified in the member's service plan. The item or service shall meet the following requirements:

1. Promote opportunities for community living and inclusion.
2. Increase independence or substitute for human assistance, to the extent the expenditures would otherwise be made for that human assistance.
3. Be accommodated within the member's budget without compromising the member's health and safety.
4. Be provided to the member or directed exclusively toward the benefit of the member.
5. Be the least costly to meet the member's needs.
6. Not be available through another source.

e. Development of the individual budget. The independent support broker shall assist the member in developing and implementing the member's individual budget. The individual budget shall include:

(1) The costs of the financial management service.

(2) The costs of the independent support broker. The independent support broker may be compensated for up to 6 hours of service for assisting with the implementation of the initial individual budget. The independent support broker shall not be paid for more than 30 hours of service for an individual member during a 12-month period without prior approval by the department.

(3) The costs of any optional service component chosen by the member as described in paragraph 78.34(13) "d." Costs of the following items and services shall not be covered by the individual budget:

1. Child care services.
2. Clothing not related to an assessed medical need.
3. Conference, meeting or similar venue expenses other than the costs of approved services the member needs while attending the conference, meeting or similar venue.
4. Costs associated with shipping items to the member.
5. Experimental and non-FDA-approved medications, therapies, or treatments.
6. Goods or services covered by other Medicaid programs.
7. Home furnishings.
8. Home repairs or home maintenance.
9. Homeopathic treatments.
10. Insurance premiums or copayments.
11. Items purchased on installment payments.
12. Motorized vehicles.
13. Nutritional supplements.
14. Personal entertainment items.
15. Repairs and maintenance of motor vehicles.
16. Room and board, including rent or mortgage payments.
17. School tuition.
18. Service animals.

19. Services covered by third parties or services that are the responsibility of a non-Medicaid program.

20. Sheltered workshop services.

21. Social or recreational purchases not related to an assessed need or goal identified in the member's service plan.

22. Vacation expenses, other than the costs of approved services the member needs while on vacation.

(4) The costs of any approved home or vehicle modification. When authorized, the budget may include an amount allocated for a home or vehicle modification. Before becoming part of the individual budget, all home and vehicle modifications shall be identified in the member's service plan and approved by the case manager or service worker. The authorized amount shall not be used for anything other than the specific modification.

(5) Any amount set aside in a savings plan to reserve funds for the future purchase of self-directed personal care, individual-directed goods and services, or self-directed community supports and services as defined in paragraph 78.34(13)“d.” The savings plan shall meet the requirements in paragraph 78.34(13)“f.”

f. Savings plan. A member savings plan must be in writing and be approved by the department before the start of the savings plan. Amounts allocated to the savings plan must result from efficiencies in meeting identified needs of the member.

(1) The savings plan shall identify:

1. The specific goods, services, supports or supplies to be purchased through the savings plan.

2. The amount of the individual budget allocated each month to the savings plan.

3. The amount of the individual budget allocated each month to meet the member's identified service needs.

4. How the member's assessed needs will continue to be met through the individual budget when funds are placed in savings.

(2) With the exception of funds allocated for respite care, the savings plan shall not include funds budgeted for direct services that were not received. The budgeted amount associated with unused direct services other than respite care shall revert to the Medicaid program at the end of each month. Funds from unused respite services may be allocated to the savings plan but shall not be used for anything other than future respite care.

(3) Funds accumulated under a savings plan shall be used only to purchase items that increase independence or substitute for human assistance to the extent that expenditures would otherwise be made for human assistance, including additional goods, supports, services or supplies. The self-directed personal care, individual-directed goods and services, or self-directed community supports and services purchased with funds from a savings plan must:

1. Be used to meet a member's identified need,

2. Be medically necessary, and

3. Be approved by the member's case manager or service worker.

(4) All funds allocated to a savings plan that are not expended by December 31 of each year shall revert to the Medicaid program.

(5) The annual reassessment of a member's needs must take into account the purchases of goods and services that substitute for human assistance. Adjustments shall be made to the services used to determine the individual budget based on the reassessment.

g. Budget authority. The member shall have authority over the individual budget authorized by the department to perform the following tasks:

(1) Contract with entities to provide services and supports as described in this subrule.

(2) Determine the amount to be paid for services. Reimbursement rates shall be consistent with rates paid by others in the community for the same or substantially similar services. Reimbursement rates for the independent support broker and the financial management service are subject to the limits in 441—subrule 79.1(2). The reimbursement rate for a member's legal representative who provides services to the member as allowed by 441—paragraph 79.9(7)“b” 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.

(3) Schedule the provision of services. Whenever a member's legal representative provides services to the member as allowed by 441—paragraph 79.9(7) "b," the legal representative may not be paid for more than 40 hours of service per week and 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.

(4) Authorize payment for optional service components identified in the individual budget.

(5) Reallocate funds among services included in the budget. Every purchase of a good or service must be identified and approved in the individual budget before the purchase is made.

h. Delegation of budget authority. The member may delegate responsibility for the individual budget to a representative in addition to the independent support broker.

(1) The representative must be at least 18 years old.

(2) The representative shall not be a current provider of service to the member.

(3) The member shall sign a consent form that designates who the member has chosen as a representative and what responsibilities the representative shall have.

(4) The representative shall not be paid for this service.

i. Employer authority. The member shall have the authority to be the common-law employer of employees providing services and support under the consumer choices option. A common-law employer has the right to direct and control the performance of the services. The member may perform the following functions:

(1) Recruit employees.

(2) Select employees from a worker registry.

(3) Verify employee qualifications.

(4) Specify additional employee qualifications.

(5) Determine employee duties.

(6) Determine employee wages and benefits.

(7) Schedule employees.

(8) Train and supervise employees.

j. Employment agreement. Any person employed by the member to provide services under the consumer choices option shall sign an employment agreement with the member that outlines the employee's and member's responsibilities.

k. Responsibilities of the independent support broker. The independent support broker shall perform the following services as directed by the member or the member's representative:

(1) Assist the member with developing the member's initial and subsequent individual budgets and with making any changes to the individual budget.

(2) Have monthly contact with the member for the first four months of implementation of the initial individual budget and have quarterly contact thereafter.

(3) Complete the required employment packet with the financial management service.

(4) Assist with interviewing potential employees and entities providing services and supports if requested by the member.

(5) Assist the member with determining whether a potential employee meets the qualifications necessary to perform the job.

(6) Assist the member with obtaining a signed consent from a potential employee to conduct background checks if requested by the member.

(7) Assist the member with negotiating with entities providing services and supports if requested by the member.

(8) Assist the member with contracts and payment methods for services and supports if requested by the member.

(9) Assist the member with developing an emergency backup plan. The emergency backup plan shall address any health and safety concerns.

(10) Review expenditure reports from the financial management service to ensure that services and supports in the individual budget are being provided.

(11) Document in writing on the independent support broker timecard every contact the broker has with the member. Contact documentation shall include information on the extent to which the member's individual budget has addressed the member's needs and the satisfaction of the member.

1. Responsibilities of the financial management service. The financial management service shall perform all of the following services:

(1) Receive Medicaid funds in an electronic transfer.
(2) Process and pay invoices for approved goods and services included in the individual budget.
(3) Enter the individual budget into the web-based tracking system chosen by the department and enter expenditures as they are paid.

(4) Provide real-time individual budget account balances for the member, the independent support broker, and the department, available at a minimum during normal business hours (9 a.m. to 5 p.m., Monday through Friday).

(5) Conduct criminal background checks on potential employees pursuant to 441—Chapter 119.

(6) Verify for the member an employee's citizenship or alien status.

(7) Assist the member with fiscal and payroll-related responsibilities including, but not limited to:

1. Verifying that hourly wages comply with federal and state labor rules.

2. Collecting and processing timecards.

3. Withholding, filing, and paying federal, state and local income taxes, Medicare and Social Security (FICA) taxes, and federal (FUTA) and state (SUTA) unemployment and disability insurance taxes, as applicable.

4. Computing and processing other withholdings, as applicable.

5. Processing all judgments, garnishments, tax levies, or other withholding on an employee's pay as may be required by federal, state, or local laws.

6. Preparing and issuing employee payroll checks.

7. Preparing and disbursing IRS Forms W-2 and W-3 annually.

8. Processing federal advance earned income tax credit for eligible employees.

9. Refunding over-collected FICA, when appropriate.

10. Refunding over-collected FUTA, when appropriate.

(8) Assist the member in completing required federal, state, and local tax and insurance forms.

(9) Establish and manage documents and files for the member and the member's employees.

(10) Monitor timecards, receipts, and invoices to ensure that they are consistent with the individual budget. Keep records of all timecards and invoices for each member for a total of five years.

(11) Provide to the department, the independent support broker, and the member monthly and quarterly status reports that include a summary of expenditures paid and amount of budget unused.

(12) Establish an accessible customer service system and a method of communication for the member and the independent support broker that includes alternative communication formats.

(13) Establish a customer services complaint reporting system.

(14) Develop a policy and procedures manual that is current with state and federal regulations and update as necessary.

(15) Develop a business continuity plan in the case of emergencies and natural disasters.

(16) Provide to the department an annual independent audit of the financial management service.

(17) Assist in implementing the state's quality management strategy related to the financial management service.

78.34(14) General service standards. All ill and handicapped waiver services must be provided in accordance with the following standards:

a. Reimbursement shall not be available under the waiver for any services that the member can obtain as other nonwaiver Medicaid services or through any other funding source.

b. All services provided under the waiver must be delivered in the least restrictive environment possible and in conformity with the member's service plan.

c. All rights restrictions must be implemented in accordance with 441—subrule 77.25(4). The member service plan or treatment plan shall include documentation of:

- (1) Any restrictions on the member's rights, including the rights of privacy, dignity, respect, and freedom from coercion and restraint.
- (2) The need for the restriction.
- (3) The less intrusive methods of meeting the need that have been tried but did not work.
- (4) Either a plan to restore those rights or written documentation that a plan is not necessary or appropriate.
- (5) Established time limits for periodic reviews to determine if the restriction is still necessary or can be terminated.

- (6) The informed consent of the member.
- (7) An assurance that the interventions and supports will cause no harm to the member.
- (8) A regular collection and review of data to measure the ongoing effectiveness of the restriction.

d. Services must be billed in whole units.

e. For all services with a 15-minute unit of service, the following rounding process will apply:

- (1) Add together the minutes spent on all billable activities during a calendar day for a daily total.
- (2) For each day, divide the total minutes spent on billable activities by 15 to determine the number of full 15-minute units for that day.
- (3) Round the remainder using these guidelines: Round 1 to 7 minutes down to zero units; round 8 to 14 minutes up to one unit.
- (4) Add together the number of full units and the number of rounded units to determine the total number of units to bill for that day.

This rule is intended to implement Iowa Code section 249A.4.

[ARC 9045B, IAB 9/8/10, effective 11/1/10; ARC 9403B, IAB 3/9/11, effective 5/1/11 (See Delay note at end of chapter); ARC 9704B, IAB 9/7/11, effective 9/1/11; ARC 9884B, IAB 11/30/11, effective 1/4/12; ARC 0707C, IAB 5/1/13, effective 7/1/13; ARC 0709C, IAB 5/1/13, effective 7/1/13; ARC 0757C, IAB 5/29/13, effective 8/1/13; ARC 0842C, IAB 7/24/13, effective 7/1/13; ARC 1056C, IAB 10/2/13, effective 11/6/13; ARC 1610C, IAB 9/3/14, effective 8/13/14; ARC 2848C, IAB 12/7/16, effective 11/15/16; ARC 2936C, IAB 2/1/17, effective 3/8/17; ARC 3552C, IAB 1/3/18, effective 2/7/18; ARC 3874C, IAB 7/4/18, effective 8/8/18]

441—78.35(249A) Occupational therapist services. Payment will be approved for the same services provided by an occupational therapist that are payable under Title XVIII of the Social Security Act (Medicare).

This rule is intended to implement Iowa Code section 249A.4.

441—78.36(249A) Hospice services.

78.36(1) General characteristics. A hospice is a public agency or private organization or a subdivision of either that is primarily engaged in providing care to terminally ill individuals. A hospice provides palliative and supportive services to meet the physical, psychosocial, social and spiritual needs of a terminally ill individual and the individual's family or other persons caring for the individual regardless of where the individual resides. Hospice services are those services to control pain and provide support to individuals to continue life with as little disruption as possible.

a. Covered services. Covered services shall include, in accordance with Medicare guidelines, the following:

- (1) Nursing care.
- (2) Medical social services.
- (3) Physician services.
- (4) Counseling services provided to the terminally ill individual and the individual's family members or other persons caring for the individual at the individual's place of residence, including bereavement, dietary, and spiritual counseling.
- (5) Short-term inpatient care provided in a participating hospice inpatient unit or a participating hospital or nursing facility that additionally meets the special hospice standards regarding staffing and patient areas for pain control, symptom management and respite purposes.

(6) Medical appliances and supplies, including drugs and biologicals, as needed for the palliation and management of the individual's terminal illness and related conditions, except for "covered Part D drugs" as defined by 42 U.S.C. Section 1395w-102(e)(1)-(2) for a "Part D eligible individual" as defined in 42 U.S.C. Section 1395w-101(a)(3)(A), including an individual who is not enrolled in a Part D plan.

(7) Homemaker and home health aide services.

(8) Physical therapy, occupational therapy and speech-language pathology unless this provision has been waived under the Medicare program for a specific provider.

(9) Other items or services specified in the resident's plan that would otherwise be paid under the Medicaid program.

Nursing care, medical social services, and counseling are core hospice services and must routinely be provided directly by hospice employees. The hospice may contract with other providers to provide the remaining services. Bereavement counseling, consisting of counseling services provided after the individual's death to the individual's family or other persons caring for the individual, is a required hospice service but is not reimbursable.

b. Noncovered services.

(1) Covered services not related to the terminal illness. In accordance with Medicare guidelines, all medical services related to the terminal illness are the responsibility of the hospice. Services unrelated to the terminal illness are to be billed separately by the respective provider.

(2) Administrative duties performed by the medical director, any hospice-employed physician, or any consulting physician are included in the normal hospice rates. Patient care provided by the medical director, hospice-employed physician, attending physician, or consulting physician is separately reimbursable. Payment to the attending or consulting physician includes other partners in practice.

(3) Hospice care provided by a hospice other than the hospice designated by the individual unless provided under arrangements made by the designated hospice.

(4) AZT (Retrovir) and other curative antiviral drugs targeted at the human immunodeficiency virus for the treatment of AIDS.

78.36(2) *Categories of care.* Hospice care entails the following four categories of daily care. Guidelines for core and other services must be adhered to for all categories of care.

a. Routine home care is care provided in the place of residence that is not continuous.

b. Continuous home care is provided only during a period of crisis when an individual requires continuous care which is primarily nursing care to achieve palliation or management of acute medical symptoms. Nursing care must be provided by either a registered nurse or a licensed practical nurse and a nurse must be providing care for more than half of the period of care. A minimum of eight hours of care per day must be provided during a 24-hour day to qualify as continuous care. Homemaker and aide services may also be provided to supplement the nursing care.

c. Inpatient respite care is provided to the individual only when necessary to relieve the family members or other persons caring for the individual at home. Respite care may be provided only on an occasional basis and may not be reimbursed for more than five consecutive days at a time. Respite care may not be provided when the individual is a resident of a nursing facility.

d. General inpatient care is provided in periods of acute medical crisis when the individual is hospitalized or in a participating hospice inpatient unit or nursing facility for pain control or acute or chronic symptom management.

78.36(3) *Residence in a nursing facility.* For purposes of the Medicaid hospice benefit, a nursing facility can be considered the residence of a beneficiary. When the person does reside in a nursing facility, the requirement that the care of a resident of a nursing facility must be provided under the immediate direction of either the facility or the resident's personal physician does not apply if all of the following conditions are met:

a. The resident is terminally ill.

b. The resident has elected to receive hospice services under the Medicaid program from a Medicaid-enrolled hospice program.

c. The nursing facility and the Medicaid-enrolled hospice program have entered into a written agreement under which the hospice program takes full responsibility for the professional management of the resident's hospice care and the facility agrees to provide room and board to the resident.

78.36(4) Approval for hospice benefits. Payment will be approved for hospice services to individuals who are certified as terminally ill, that is, the individuals have a medical prognosis that their life expectancy is six months or less if the illness runs its normal course, and who elect hospice care rather than active treatment for the illness.

a. *Physician certification process.* The hospice must obtain certification that an individual is terminally ill in accordance with the following procedures:

(1) The hospice may obtain verbal orders to initiate hospice service from the medical director of the hospice or the physician member of the hospice interdisciplinary group and by the individual's attending physician (if the individual has an attending physician). The verbal order shall be noted in the patient's record. The verbal order must be given within two days of the start of care and be followed up in writing no later than eight calendar days after hospice care is initiated. The certification must include the statement that the individual's medical prognosis is that the individual's life expectancy is six months or less if the illness runs its normal course.

(2) When verbal orders are not secured, the hospice must obtain, no later than two calendar days after hospice care is initiated, written certification signed by the medical director of the hospice or the physician member of the hospice interdisciplinary group and by the individual's attending physician (if the individual has an attending physician). The certification must include the statement that the individual's medical prognosis is that the individual's life expectancy is six months or less, if the illness runs its normal course.

(3) Hospice care benefit periods consist of up to two periods of 90 days each and an unlimited number of subsequent 60-day periods as elected by the individual. The medical director or a physician must recertify at the beginning of each benefit period that the individual is terminally ill.

b. *Election procedures.* Individuals who are dually eligible for Medicare and Medicaid must receive hospice coverage under Medicare.

(1) Election statement. An individual, or individual's representative, elects to receive the hospice benefit by filing an election statement, Form 470-2618, Election of Medicaid Hospice Benefit, or a Medicare election of hospice benefit form, with a particular hospice. The hospice may provide the individual with another election form to use provided the form includes the following information:

1. Identification of the hospice that will provide the care.
2. Acknowledgment that the recipient has been given a full understanding of hospice care.
3. Acknowledgment that the recipient waives the right to regular Medicaid benefits, except for payment to the regular physician and treatment for medical conditions unrelated to the terminal illness.
4. Acknowledgment that recipients are not responsible for copayment or other deductibles.
5. The recipient's Medicaid number.
6. The effective date of election.
7. The recipient's signature.

(2) Change of designation. An individual may change the designation of the particular hospice from which the individual elects to receive hospice care one time only.

(3) Effective date. An individual may designate an effective date for the hospice benefit that begins with the first day of the hospice care or any subsequent day of hospice care, but an individual may not designate an effective date that is earlier than the date that the election is made.

(4) Duration of election. The election to receive hospice care will be considered to continue until one of the following occurs:

1. The individual dies.
2. The individual or the individual's representative revokes the election.
3. The individual's situation changes so that the individual no longer qualifies for the hospice benefit.
4. The hospice elects to terminate the recipient's enrollment in accordance with the hospice's established discharge policy.

(5) Revocation. Form 470-2619, Revocation of Medicaid Hospice Benefit, is completed when an individual or the individual's representative revokes the hospice benefit allowed under Medicaid. When an individual revokes the election of Medicaid coverage of hospice care, the individual resumes Medicaid coverage of the benefits waived when hospice care was elected.

This rule is intended to implement Iowa Code section 249A.4.
[ARC 3553C, IAB 1/3/18, effective 2/7/18]

441—78.37(249A) HCBS elderly waiver services. Payment will be approved for the following services to members eligible for the HCBS elderly waiver services as established in 441—Chapter 83 and as identified in the member's service plan. Effective March 17, 2022, payment shall only be made for services provided in integrated, community-based settings that support full access of members receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.

78.37(1) Adult day care services. Adult day care services provide an organized program of supportive care in a group environment to persons who need a degree of supervision and assistance on a regular or intermittent basis in a day care center. A unit of service is 15 minutes (up to four units per day), a half day (1.25 to 4 hours per day), a full day (4.25 to 8 hours per day), or an extended day (8.25 to 12 hours per day). Components of the service include health-related care, social services, and other related support services.

78.37(2) Personal emergency response or portable locator system.

a. A personal emergency response system is an electronic device that transmits a signal to a central monitoring station to summon assistance in the event of an emergency.

(1) The necessary components of a system are:

1. An in-home medical communications transceiver.
2. A remote, portable activator.
3. A central monitoring station with backup systems staffed by trained attendants at all times.
4. Current data files at the central monitoring station containing response protocols and personal, medical, and emergency information for each member.

(2) The service shall be identified in the member's service plan.

(3) A unit of service is a one-time installation fee or one month of service.

(4) Maximum units per state fiscal year shall be the initial installation and 12 months of service.

b. A portable locator system is an electronic device that transmits a signal to a monitoring device. The system allows a member to access assistance in the event of an emergency and allows law enforcement or the monitoring system provider to locate a member who is unable to request help or to activate a system independently. The member must be unable to access assistance in an emergency situation due to the member's age or disability.

(1) The required components of the portable locator system are:

1. A portable communications transceiver or transmitter to be worn or carried by the member.
2. Monitoring by the provider at a central location with response protocols and personal, medical, and emergency information for each member as applicable.

(2) The service shall be identified in the member's service plan.

(3) Payable units of service are purchase of equipment, an installation or set-up fee, and monthly fees.

(4) Maximum units per state fiscal year shall be one equipment purchase, one installation or set-up fee, and 12 months of service.

78.37(3) Home health aide services. Home health aide services are personal or direct care services provided to the client which are not payable under Medicaid as set forth in rule 441—78.9(249A). A unit of service is a visit. Components of the service include:

a. Observation and reporting of physical or emotional needs.

b. Helping a client with bath, shampoo, or oral hygiene.

- c. Helping a client with toileting.
- d. Helping a client in and out of bed and with ambulation.
- e. Helping a client reestablish activities of daily living.
- f. Assisting with oral medications ordinarily self-administered and ordered by a physician.
- g. Performing incidental household services which are essential to the client's health care at home and are necessary to prevent or postpone institutionalization in order to complete a full unit of service.

78.37(4) Homemaker services. Homemaker services are those services provided when the member lives alone or when the person who usually performs these functions for the member needs assistance with performing the functions. A unit of service is 15 minutes. Components of the service must be directly related to the care of the member and may include only the following:

- a. Essential shopping: shopping for basic need items such as food, clothing or personal care items, or drugs.
- b. Limited housecleaning: maintenance cleaning such as vacuuming, dusting, scrubbing floors, defrosting refrigerators, cleaning stoves, cleaning medical equipment, washing and mending clothes, washing personal items used by the member, and washing dishes.
- c. Meal preparation: planning and preparing balanced meals.

78.37(5) Nursing care services. Nursing care services are services provided by licensed agency nurses to clients in the home which are ordered by and included in the plan of treatment established by the physician. The services are reasonable and necessary to the treatment of an illness or injury and include: observation; evaluation; teaching; training; supervision; therapeutic exercise; bowel and bladder care; administration of medications; intravenous, hypodermoclysis, and enteral feedings; skin care; preparation of clinical and progress notes; coordination of services and informing the physician and other personnel of changes in the patient's condition and needs.

A unit of service is one visit. Nursing care service can pay for a maximum of eight nursing visits per month for intermediate level of care persons. There is no limit on the maximum visits for skilled level of care persons.

78.37(6) Respite care services. Respite care services are services provided to the member that give temporary relief to the usual caregiver and provide all the necessary care that the usual caregiver would provide during that period. The purpose of respite care is to enable the member to remain in the member's current living situation.

- a. Services provided outside the member's home shall not be reimbursable if the living unit where respite is provided is reserved for another person on a temporary leave of absence.
- b. Member-to-staff ratios shall be appropriate to the individual needs of the member as determined by the member's interdisciplinary team.
- c. A unit of service is 15 minutes.
- d. Respite care is not to be provided to members during the hours in which the usual caregiver is employed except when the member is attending a 24-hour residential camp. Respite cannot be provided to a member whose usual caregiver is a consumer-directed attendant care provider for the member.
- e. The interdisciplinary team shall determine if the member will receive basic individual respite, specialized respite or group respite as defined in 441—Chapter 83.
- f. A maximum of 14 consecutive days of 24-hour respite care may be reimbursed.
- g. Respite services provided for a period exceeding 24 consecutive hours to three or more individuals who require nursing care because of a mental or physical condition must be provided by a health care facility licensed as described in Iowa Code chapter 135C.
- h. Respite services shall not be provided simultaneously with other residential, nursing, or home health aide services provided through the medical assistance program.

78.37(7) Chore services. Chore services provide assistance with the household maintenance activities listed in paragraph 78.37(7) "a," as necessary to allow a member to remain in the member's own home safely and independently. A unit of service is 15 minutes.

- a. Chore services are limited to the following services:
 - (1) Window and door maintenance, such as hanging screen windows and doors, replacing windowpanes, and washing windows;

- (2) Minor repairs to walls, floors, stairs, railings and handles;
 - (3) Heavy cleaning which includes cleaning attics or basements to remove fire hazards, moving heavy furniture, extensive wall washing, floor care, painting, and trash removal;
 - (4) Lawn mowing and removal of snow and ice from sidewalks and driveways.
- b.* Leaf raking, bush and tree trimming, trash burning, stick removal, and tree removal are not covered services.

78.37(8) Home-delivered meals. Home-delivered meals are meals prepared elsewhere and delivered to a member at the member's residence.

a. Each meal shall ensure the member receives a minimum of one-third of the daily recommended dietary allowance as established by the Food and Nutrition Board of the National Research Council of the National Academy of Sciences. The meal may also be a liquid supplement which meets the minimum one-third standard.

b. When a restaurant provides the home-delivered meal, the member is required to have a nutritional consultation. The nutritional consultation includes contact with the restaurant to explain the dietary needs of the member and what constitutes the minimum one-third daily dietary allowance.

c. A unit of service is a meal (morning, noon, evening, or liquid supplement). Any maximum combination of any two meals (morning, noon, evening, or liquid supplement) is allowed per day. Duplication of a meal in any one day is not allowed. The number of approved meals (morning, noon, evening, or liquid supplement) is contained in the member's service plan.

d. The number of meals delivered for any morning, noon, evening, or liquid supplement meal cannot exceed the number of calendar days in a calendar month; nor can the number of delivered meals exceed the number of authorized days in a month. Meals billed in excess of the calendar days in a calendar month and those billed in excess of the number of authorized days in a month are subject to recoupment or denial of payment.

78.37(9) Home and vehicle modification. Covered home or vehicle modifications are physical modifications to the member's home or vehicle that directly address the member's medical or remedial need. Covered modifications must be necessary to provide for the health, welfare, or safety of the member and enable the member to function with greater independence in the home or vehicle.

a. Modifications that are necessary or desirable without regard to the member's medical or remedial need and that would be expected to increase the fair market value of the home or vehicle, such as furnaces, fencing, or adding square footage to the residence, are excluded except as specifically included below. Purchasing or leasing of a motorized vehicle is excluded. Home and vehicle repairs are also excluded.

b. Only the following modifications are covered:

- (1) Kitchen counters, sink space, cabinets, special adaptations to refrigerators, stoves, and ovens.
- (2) Bathtubs and toilets to accommodate transfer, special handles and hoses for shower heads, water faucet controls, and accessible showers and sink areas.
- (3) Grab bars and handrails.
- (4) Turnaround space adaptations.
- (5) Ramps, lifts, and door, hall and window widening.
- (6) Fire safety alarm equipment specific for disability.
- (7) Voice-activated, sound-activated, light-activated, motion-activated, and electronic devices directly related to the member's disability.
- (8) Vehicle lifts, driver-specific adaptations, remote-start systems, including such modifications already installed in a vehicle.
- (9) Keyless entry systems.
- (10) Automatic opening device for home or vehicle door.
- (11) Special door and window locks.
- (12) Specialized doorknobs and handles.
- (13) Plexiglas replacement for glass windows.
- (14) Modification of existing stairs to widen, lower, raise or enclose open stairs.
- (15) Motion detectors.

- (16) Low-pile carpeting or slip-resistant flooring.
- (17) Telecommunications device for the deaf.
- (18) Exterior hard-surface pathways.
- (19) New door opening.
- (20) Pocket doors.
- (21) Installation or relocation of controls, outlets, switches.
- (22) Air conditioning and air filtering if medically necessary.
- (23) Heightening of existing garage door opening to accommodate modified van.
- (24) Bath chairs.

c. A unit of service is the completion of needed modifications or adaptations.

d. All modifications and adaptations shall be provided in accordance with applicable federal, state, and local building and vehicle codes.

e. Services shall be performed following prior department approval of the modification as specified in 441—subrule 79.1(17) and a binding contract between the provider and the member.

f. All contracts for home or vehicle modification shall be awarded through competitive bidding. The contract shall include the scope of work to be performed, the time involved, supplies needed, the cost, diagrams of the project whenever applicable, and an assurance that the provider has liability and workers' compensation coverage and the applicable permit and license.

g. Service payment shall be made to the enrolled home or vehicle modification provider. If applicable, payment will be forwarded to the subcontracting agency by the enrolled home or vehicle modification provider following completion of the approved modifications.

h. Services shall be included in the member's service plan and shall exceed the Medicaid state plan services.

78.37(10) *Mental health outreach.* Mental health outreach services are services provided in a recipient's home to identify, evaluate, and provide treatment and psychosocial support. The services can only be provided on the basis of a referral from the consumer's interdisciplinary team established pursuant to 441—subrule 83.22(2). A unit of service is 15 minutes.

78.37(11) *Transportation.* Transportation services may be provided for members to conduct business errands and essential shopping and to reduce social isolation. A unit of service is one mile of transportation or one one-way trip.

78.37(12) *Nutritional counseling.* Nutritional counseling services may be provided for a nutritional problem or condition of such a degree of severity that nutritional counseling beyond that normally expected as part of the standard medical management is warranted. A unit of service is 15 minutes.

78.37(13) *Assistive devices.* Assistive devices means practical equipment products to assist persons with activities of daily living and instrumental activities of daily living to allow the person more independence. They include, but are not limited to: long-reach brush, extra long shoehorn, nonslip grippers to pick up and reach items, dressing aids, shampoo rinse tray and inflatable shampoo tray, double-handled cup and sipper lid. A unit is an item.

a. The service shall be included in the member's service plan and shall exceed the services available under the Medicaid state plan.

b. The service shall be provided following prior approval by the Iowa Medicaid enterprise.

c. Payment for most items shall be based on a fee schedule. The amount of the fee shall be determined as directed in 441—subrule 79.1(17).

78.37(14) *Senior companion.* Senior companion services are nonmedical care supervision, oversight, and respite. Companions may assist with such tasks as meal preparation, laundry, shopping and light housekeeping tasks. This service cannot provide hands-on nursing or medical care. A unit of service is 15 minutes.

78.37(15) *Consumer-directed attendant care service.* Consumer-directed attendant care services are service activities performed by a person to help a member with self-care tasks which the member would typically do independently if the member were otherwise able. Covered service activities are limited to the nonskilled activities listed in paragraph 78.37(15)“*f*” and the skilled activities listed in paragraph 78.37(15)“*g*.” Covered service activities must be essential to the health, safety, and welfare

of the member. Services may be provided in the absence of a parent or guardian if the parent or guardian has given advance direction for the service provision.

a. Service planning.

(1) The member, parent, guardian, or attorney in fact under a durable power of attorney for health care shall:

1. Select the individual, agency or assisted living facility that will provide the components of the attendant care services.

2. Determine with the selected provider what components of attendant care services the provider shall perform, subject to confirmation by the service worker or case manager that those components are consistent with the assessment and are authorized covered services.

3. Complete, sign, and date Form 470-3372, HCBS Consumer-Directed Attendant Care Agreement, to indicate the frequency, scope, and duration of services (a description of each service component and the time agreed on for that component). The case manager or service worker and provider shall also sign the agreement.

4. Submit the completed agreement to the service worker or case manager. The agreement shall be part of the member's service plan and shall be kept in the member's records, in the provider's records, and in the service worker's or case manager's records. Any service component that is not listed in the agreement shall not be payable.

(2) Assisted living agreements with Iowa Medicaid members must specify the services to be considered covered under the assisted living occupancy agreement and those CDAC services to be covered under the elderly waiver. The funding stream for each service must be identified.

(3) Whenever a legal representative acts as a provider of consumer-directed attendant care as allowed by 441—paragraph 79.9(7) “b,” the following shall apply:

1. The payment rate for the legal representative must be based on the skill level of the legal representative and may not exceed the median statewide reimbursement rate for the service unless the higher rate receives prior approval from the department;

2. The legal representative may not be paid for more than 40 hours of service per week; and

3. A contingency plan must be established in the member's service plan to ensure service delivery in the event the legal representative is unable to provide services due to illness or other unexpected event.

b. Supervision of skilled services. Skilled consumer-directed attendant care services shall be provided under the supervision of a licensed nurse or licensed therapist working under the direction of a physician. The licensed nurse or therapist shall:

(1) Retain accountability for actions that are delegated.

(2) Ensure appropriate assessment, planning, implementation, and evaluation.

(3) Make on-site supervisory visits every two weeks with the service provider present.

c. Service documentation. The consumer-directed attendant care individual and agency providers must complete Form 470-4389, Consumer-Directed Attendant Care (CDAC) Service Record, for each day of service. Assisted living facilities may choose to use Form 470-4389 or may devise another system that adheres to the requirements of rule 441—79.3(249A). Any service component that is not documented in accordance with rule 441—79.3(249A) shall not be payable.

d. Role of guardian or attorney. If the member has a guardian or attorney in fact under a durable power of attorney for health care:

(1) The service worker's or case manager's service plan shall address how consumer-directed attendant care services will be monitored to ensure that the member's needs are being adequately met. If the guardian or attorney in fact is the service provider, the service plan shall address how the service worker or case manager shall oversee service provision.

(2) The guardian or attorney in fact shall sign the claim form in place of the member, indicating that the service has been provided as presented on the claim.

e. Service units and billing. A unit of service is 15 minutes provided by an individual, agency or assisted living facility. Each service shall be billed in whole units.

f. Nonskilled services. Covered nonskilled service activities are limited to help with the following activities:

- (1) Dressing.
- (2) Bathing, shampooing, hygiene, and grooming.
- (3) Access to and from bed or a wheelchair, transferring, ambulation, and mobility in general.
- (4) Toileting, including bowel, bladder, and catheter assistance (emptying the catheter bag, collecting a specimen, and cleaning the external area around the catheter).
- (5) Meal preparation, cooking, and assistance with feeding, not including the cost of meals themselves. Meal preparation and cooking shall be provided only in the member's home.
- (6) Housekeeping, laundry, and shopping essential to the member's health care at home.
- (7) Taking medications ordinarily self-administered, including those ordered by a physician or other qualified health care provider.
- (8) Minor wound care.
- (9) Going to or returning from a place of employment and job-related tasks while the member is on the job site. Transportation for the member and assistance with understanding or performing the essential job functions are not included in consumer-directed attendant care services.
- (10) Tasks, such as financial management and scheduling, that require cognitive or physical assistance.
- (11) Communication essential to the health and welfare of the member, through interpreting and reading services and use of assistive devices for communication.
- (12) Using transportation essential to the health and welfare of the member. The cost of the transportation is not included.

g. Skilled services. Covered skilled service activities are limited to help with the following activities:

- (1) Tube feedings of members unable to eat solid foods.
- (2) Intravenous therapy administered by a registered nurse.
- (3) Parenteral injections required more than once a week.
- (4) Catheterizations, continuing care of indwelling catheters with supervision of irrigations, and changing of Foley catheters when required.
- (5) Respiratory care including inhalation therapy and tracheotomy care or tracheotomy care and ventilator.
- (6) Care of decubiti and other ulcerated areas, noting and reporting to the nurse or therapist.
- (7) Rehabilitation services including, but not limited to, bowel and bladder training, range of motion exercises, ambulation training, restorative nursing services, respiratory care and breathing programs, reality orientation, reminiscing therapy, remotivation, behavior modification, and reteaching of the activities of daily living.
- (8) Colostomy care.
- (9) Care of uncontrolled medical conditions, such as brittle diabetes, and comfort care of terminal conditions.
- (10) Postsurgical nursing care.
- (11) Monitoring medications requiring close supervision because of fluctuating physical or psychological conditions, e.g., antihypertensives, digitalis preparations, mood-altering or psychotropic drugs, or narcotics.
- (12) Preparing and monitoring response to therapeutic diets.
- (13) Recording and reporting of changes in vital signs to the nurse or therapist.

h. Excluded services and costs. Services, activities, costs and time that are not covered as consumer-directed attendant care include the following (not an exclusive list):

- (1) Any activity related to supervising a member. Only direct services are billable.
- (2) Any activity that the member is able to perform.
- (3) Costs of food.
- (4) Costs for the supervision of skilled services by the nurse or therapist. The supervising nurse or therapist may be paid from private insurance, Medicare, or other third-party payment sources, or may be paid as another Medicaid service, including early and periodic screening, diagnosis and treatment services.

- (5) Exercise that does not require skilled services.
- (6) Parenting or child care for or on behalf of the member.
- (7) Reminders and cueing.
- (8) Services provided simultaneously with any other similar service regardless of funding source, including other waiver services and state supplementary assistance in-home health-related care services.
- (9) Transportation costs.
- (10) Wait times for any activity.

78.37(16) Consumer choices option. The consumer choices option provides a member with a flexible monthly individual budget that is based on the member's service needs. With the individual budget, the member shall have the authority to purchase goods and services to meet the member's assessed needs and may choose to employ providers of services and supports. The services, supports, and items that are purchased with an individual budget must be directly related to a member's assessed need or goal established in the member's service plan. Components of this service are set forth below.

a. Agreement. As a condition of participating in the consumer choices option, a member shall sign Form 470-4289, HCBS Consumer Choices Informed Consent and Risk Agreement, to document that the member has been informed of the responsibilities and risks of electing the consumer choices option.

b. Individual budget amount. A monthly individual budget amount shall be established for each member based on the assessed needs of the member and on the services and supports authorized in the member's service plan. The member shall be informed of the individual budget amount during the development of the service plan.

(1) Services that may be included in determining the individual budget amount for a member in the HCBS elderly waiver are:

1. Assistive devices.
2. Chore service.
3. Consumer-directed attendant care (unskilled).
4. Home and vehicle modification.
5. Home-delivered meals.
6. Homemaker service.
7. Basic individual respite care.
8. Senior companion.
9. Transportation.

(2) The department shall determine an average unit cost for each service listed in subparagraph 78.37(16) "b"(1) based on actual unit costs from the previous fiscal year plus a cost-of-living adjustment.

(3) In aggregate, costs for individual budget services shall not exceed the current costs of waiver program services. In order to maintain cost neutrality, the department shall apply a utilization adjustment factor to the amount of service authorized in the member's service plan before calculating the value of that service to be included in the individual budget amount.

(4) The department shall compute the utilization adjustment factor for each service by dividing the net costs of all claims paid for the service by the total of the authorized costs for that service, using at least 12 consecutive months of aggregate service data. The utilization adjustment factor shall be no lower than 60 percent. The department shall analyze and adjust the utilization adjustment factor at least annually in order to maintain cost neutrality.

(5) Individual budgets for respite services shall be computed based on the average cost for services identified in subparagraph 78.37(16) "b"(2). Respite services are not subject to the utilization adjustment factor in subparagraph 78.37(16) "b"(3).

(6) Anticipated costs for home and vehicle modification and assistive devices are not subject to the average cost in subparagraph 78.37(16) "b"(2) or the utilization adjustment factor in subparagraph 78.37(16) "b"(3). Anticipated costs for home and vehicle modification and assistive devices shall not include the costs of the financial management services or the independent support broker. Before becoming part of the individual budget, all home and vehicle modifications and assistive devices shall be identified in the member's service plan and approved by the case manager or service worker. Costs

for home and vehicle modification and assistive devices may be paid to the financial management services provider in a one-time payment.

(7) The individual budget amount may be changed only at the first of the month and shall remain fixed for the entire month.

c. Required service components. To participate in the consumer choices option, a member must hire an independent support broker and must work with a financial management service that is enrolled as a Medicaid provider. Before hiring the independent support broker, the member shall receive the results of the background check conducted pursuant to 441—Chapter 119.

d. Optional service components. A member who elects the consumer choices option may purchase the following goods, services and supports, which shall be provided in the member's home or at an integrated community setting:

(1) Self-directed personal care services. Self-directed personal care services are services or goods that provide a range of assistance in activities of daily living and incidental activities of daily living that help the member remain in the home and community. These services must be identified in the member's service plan developed by the member's case manager or service worker.

(2) Self-directed community supports and employment. Self-directed community supports and employment are services that support the member in developing and maintaining independence and community integration. These services must be identified in the member's service plan developed by the member's case manager or service worker.

(3) Individual-directed goods and services. Individual-directed goods and services are services, equipment, or supplies not otherwise provided through the Medicaid program that address an assessed need or goal identified in the member's service plan. The item or service shall meet the following requirements:

1. Promote opportunities for community living and inclusion.
2. Increase independence or substitute for human assistance, to the extent the expenditures would otherwise be made for that human assistance.
3. Be accommodated within the member's budget without compromising the member's health and safety.
4. Be provided to the member or directed exclusively toward the benefit of the member.
5. Be the least costly to meet the member's needs.
6. Not be available through another source.

e. Development of the individual budget. The independent support broker shall assist the member in developing and implementing the member's individual budget. The individual budget shall include:

- (1) The costs of the financial management service.
- (2) The costs of the independent support broker. The independent support broker may be compensated for up to 6 hours of service for assisting with the implementation of the initial individual budget. The independent support broker shall not be paid for more than 30 hours of service for an individual member during a 12-month period without prior approval by the department.

(3) The costs of any optional service component chosen by the member as described in paragraph 78.37(16) "d." Costs of the following items and services shall not be covered by the individual budget:

1. Child care services.
2. Clothing not related to an assessed medical need.
3. Conference, meeting or similar venue expenses other than the costs of approved services the member needs while attending the conference, meeting or similar venue.
4. Costs associated with shipping items to the member.
5. Experimental and non-FDA-approved medications, therapies, or treatments.
6. Goods or services covered by other Medicaid programs.
7. Home furnishings.
8. Home repairs or home maintenance.
9. Homeopathic treatments.
10. Insurance premiums or copayments.
11. Items purchased on installment payments.

12. Motorized vehicles.
13. Nutritional supplements.
14. Personal entertainment items.
15. Repairs and maintenance of motor vehicles.
16. Room and board, including rent or mortgage payments.
17. School tuition.
18. Service animals.
19. Services covered by third parties or services that are the responsibility of a non-Medicaid program.
20. Sheltered workshop services.
21. Social or recreational purchases not related to an assessed need or goal identified in the member's service plan.
22. Vacation expenses, other than the costs of approved services the member needs while on vacation.

(4) The costs of any approved home or vehicle modification or assistive device. When authorized, the budget may include an amount allocated for a home or vehicle modification or an assistive device. Before becoming part of the individual budget, all home and vehicle modifications and assistive devices shall be identified in the member's service plan and approved by the case manager or service worker. The authorized amount shall not be used for anything other than the specific modification or device.

(5) Any amount set aside in a savings plan to reserve funds for the future purchase of self-directed personal care, individual-directed goods and services, or self-directed community supports and services as defined in paragraph 78.37(16)“d.” The savings plan shall meet the requirements in paragraph 78.37(16)“f.”

f. Savings plan. A member savings plan must be in writing and be approved by the department before the start of the savings plan. Amounts allocated to the savings plan must result from efficiencies in meeting identified needs of the member.

- (1) The savings plan shall identify:
 1. The specific goods, services, supports or supplies to be purchased through the savings plan.
 2. The amount of the individual budget allocated each month to the savings plan.
 3. The amount of the individual budget allocated each month to meet the member's identified service needs.
 4. How the member's assessed needs will continue to be met through the individual budget when funds are placed in savings.

(2) With the exception of funds allocated for respite care, the savings plan shall not include funds budgeted for direct services that were not received. The budgeted amount associated with unused direct services other than respite care shall revert to the Medicaid program at the end of each month. Funds from unused respite services may be allocated to the savings plan but shall not be used for anything other than future respite care.

(3) Funds accumulated under a savings plan shall be used only to purchase items that increase independence or substitute for human assistance to the extent that expenditures would otherwise be made for human assistance, including additional goods, supports, services or supplies. The self-directed personal care, individual-directed goods and services, or self-directed community supports and services purchased with funds from a savings plan must:

1. Be used to meet a member's identified need,
 2. Be medically necessary, and
 3. Be approved by the member's case manager or service worker.
- (4) All funds allocated to a savings plan that are not expended by December 31 of each year shall revert to the Medicaid program.

(5) The annual reassessment of a member's needs must take into account the purchases of goods and services that substitute for human assistance. Adjustments shall be made to the services used to determine the individual budget based on the reassessment.

g. Budget authority. The member shall have authority over the individual budget authorized by the department to perform the following tasks:

- (1) Contract with entities to provide services and supports as described in this subrule.
- (2) Determine the amount to be paid for services. Reimbursement rates shall be consistent with rates paid by others in the community for the same or substantially similar services. Reimbursement rates for the independent support broker and the financial management service are subject to the limits in 441—subrule 79.1(2). The reimbursement rate for a member’s legal representative who provides services to the member as allowed by 441—paragraph 79.9(7) “b” 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.
- (3) Schedule the provision of services. Whenever a member’s legal representative provides services to the member as allowed by 441—paragraph 79.9(7) “b,” the legal representative may not be paid for more than 40 hours of service per week and 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.
- (4) Authorize payment for optional service components identified in the individual budget.
- (5) Reallocate funds among services included in the budget. Every purchase of a good or service must be identified and approved in the individual budget before the purchase is made.

h. Delegation of budget authority. The member may delegate responsibility for the individual budget to a representative in addition to the independent support broker.

- (1) The representative must be at least 18 years old.
- (2) The representative shall not be a current provider of service to the member.
- (3) The member shall sign a consent form that designates who the member has chosen as a representative and what responsibilities the representative shall have.
- (4) The representative shall not be paid for this service.

i. Employer authority. The member shall have the authority to be the common-law employer of employees providing services and support under the consumer choices option. A common-law employer has the right to direct and control the performance of the services. The member may perform the following functions:

- (1) Recruit employees.
- (2) Select employees from a worker registry.
- (3) Verify employee qualifications.
- (4) Specify additional employee qualifications.
- (5) Determine employee duties.
- (6) Determine employee wages and benefits.
- (7) Schedule employees.
- (8) Train and supervise employees.

j. Employment agreement. Any person employed by the member to provide services under the consumer choices option shall sign an employment agreement with the member that outlines the employee’s and member’s responsibilities.

k. Responsibilities of the independent support broker. The independent support broker shall perform the following services as directed by the member or the member’s representative:

- (1) Assist the member with developing the member’s initial and subsequent individual budgets and with making any changes to the individual budget.
- (2) Have monthly contact with the member for the first four months of implementation of the initial individual budget and have quarterly contact thereafter.
- (3) Complete the required employment packet with the financial management service.
- (4) Assist with interviewing potential employees and entities providing services and supports if requested by the member.
- (5) Assist the member with determining whether a potential employee meets the qualifications necessary to perform the job.

(6) Assist the member with obtaining a signed consent from a potential employee to conduct background checks if requested by the member.

(7) Assist the member with negotiating with entities providing services and supports if requested by the member.

(8) Assist the member with contracts and payment methods for services and supports if requested by the member.

(9) Assist the member with developing an emergency backup plan. The emergency backup plan shall address any health and safety concerns.

(10) Review expenditure reports from the financial management service to ensure that services and supports in the individual budget are being provided.

(11) Document in writing on the independent support broker timecard every contact the broker has with the member. Contact documentation shall include information on the extent to which the member's individual budget has addressed the member's needs and the satisfaction of the member.

l. Responsibilities of the financial management service. The financial management service shall perform all of the following services:

(1) Receive Medicaid funds in an electronic transfer.

(2) Process and pay invoices for approved goods and services included in the individual budget.

(3) Enter the individual budget into the web-based tracking system chosen by the department and enter expenditures as they are paid.

(4) Provide real-time individual budget account balances for the member, the independent support broker, and the department, available at a minimum during normal business hours (9 a.m. to 5 p.m., Monday through Friday).

(5) Conduct criminal background checks on potential employees pursuant to 441—Chapter 119.

(6) Verify for the member an employee's citizenship or alien status.

(7) Assist the member with fiscal and payroll-related responsibilities including, but not limited to:

1. Verifying that hourly wages comply with federal and state labor rules.

2. Collecting and processing timecards.

3. Withholding, filing, and paying federal, state and local income taxes, Medicare and Social Security (FICA) taxes, and federal (FUTA) and state (SUTA) unemployment and disability insurance taxes, as applicable.

4. Computing and processing other withholdings, as applicable.

5. Processing all judgments, garnishments, tax levies, or other withholding on an employee's pay as may be required by federal, state, or local laws.

6. Preparing and issuing employee payroll checks.

7. Preparing and disbursing IRS Forms W-2 and W-3 annually.

8. Processing federal advance earned income tax credit for eligible employees.

9. Refunding over-collected FICA, when appropriate.

10. Refunding over-collected FUTA, when appropriate.

(8) Assist the member in completing required federal, state, and local tax and insurance forms.

(9) Establish and manage documents and files for the member and the member's employees.

(10) Monitor timecards, receipts, and invoices to ensure that they are consistent with the individual budget. Keep records of all timecards and invoices for each member for a total of five years.

(11) Provide to the department, the independent support broker, and the member monthly and quarterly status reports that include a summary of expenditures paid and amount of budget unused.

(12) Establish an accessible customer service system and a method of communication for the member and the independent support broker that includes alternative communication formats.

(13) Establish a customer services complaint reporting system.

(14) Develop a policy and procedures manual that is current with state and federal regulations and update as necessary.

(15) Develop a business continuity plan in the case of emergencies and natural disasters.

(16) Provide to the department an annual independent audit of the financial management service.

(17) Assist in implementing the state's quality management strategy related to the financial management service.

78.37(17) Case management services. Case management services are services that assist Medicaid members who reside in a community setting or are transitioning to a community setting in gaining access to needed medical, social, educational, housing, transportation, vocational, and other appropriate services in order to ensure the health, safety, and welfare of the member. Case management is provided at the direction of the member and the interdisciplinary team established pursuant to 441—subrule 83.22(2).

a. Case management services shall be provided as set forth in rules 441—90.5(249A) and 441—90.8(249A).

b. Case management shall not include the provision of direct services by the case managers.

c. Payment for case management shall not be made until the consumer is enrolled in the waiver. Payment shall be made only for case management services performed on behalf of the consumer during a month when the consumer is enrolled.

78.37(18) Assisted living service. The assisted living service includes unanticipated and unscheduled personal care and supportive services that are furnished to waiver participants who reside in a homelike, noninstitutional setting. The service includes the 24-hour on-site response capability to meet unpredictable member needs as well as member safety and security through incidental supervision. Assisted living service is not reimbursable if performed at the same time as any service included in an approved consumer-directed attendant care (CDAC) agreement.

a. A unit of service is one day.

b. A day of assisted living service is billable only if both the following requirements are met:

(1) The member was present in the facility during that day's bed census.

(2) The assisted living provider has documented at least one assisted living service encounter for that day, in accordance with rule 441—79.3(249A). The documentation must include the member's response to the service. The documented assisted living service cannot also be an authorized CDAC service.

78.37(19) General service standards. All elderly waiver services must be provided in accordance with the following standards:

a. Reimbursement shall not be available under the waiver for any services that the member can obtain as other nonwaiver Medicaid services or through any other funding source.

b. All services provided under the waiver must be delivered in the least restrictive environment possible and in conformity with the member's service plan.

c. All rights restrictions must be implemented in accordance with 441—subrule 77.25(4). The member service plan or treatment plan shall include documentation of:

(1) Any restrictions on the member's rights, including the rights of privacy, dignity, respect, and freedom from coercion and restraint.

(2) The need for the restriction.

(3) The less intrusive methods of meeting the need that have been tried but did not work.

(4) Either a plan to restore those rights or written documentation that a plan is not necessary or appropriate.

(5) Established time limits for periodic reviews to determine if the restriction is still necessary or can be terminated.

(6) The informed consent of the member.

(7) An assurance that the interventions and supports will cause no harm to the member.

(8) A regular collection and review of data to measure the ongoing effectiveness of the restriction.

d. Services must be billed in whole units.

e. For all services with a 15-minute unit of service, the following rounding process will apply:

(1) Add together the minutes spent on all billable activities during a calendar day for a daily total.

(2) For each day, divide the total minutes spent on billable activities by 15 to determine the number of full 15-minute units for that day.

(3) Round the remainder using these guidelines: Round 1 to 7 minutes down to zero units; round 8 to 14 minutes up to one unit.

(4) Add together the number of full units and the number of rounded units to determine the total number of units to bill for that day.

This rule is intended to implement Iowa Code section 249A.4.

[ARC 7957B, IAB 7/15/09, effective 7/1/09; ARC 9045B, IAB 9/8/10, effective 11/1/10; ARC 9403B, IAB 3/9/11, effective 5/1/11; ARC 9704B, IAB 9/7/11, effective 9/1/11; ARC 9884B, IAB 11/30/11, effective 1/4/12; ARC 0545C, IAB 1/9/13, effective 3/1/13; ARC 0707C, IAB 5/1/13, effective 7/1/13; ARC 0709C, IAB 5/1/13, effective 7/1/13; ARC 1071C, IAB 10/2/13, effective 10/1/13; ARC 1610C, IAB 9/3/14, effective 8/13/14; ARC 2050C, IAB 7/8/15, effective 7/1/15; ARC 2340C, IAB 1/6/16, effective 2/10/16; ARC 3552C, IAB 1/3/18, effective 2/7/18; ARC 3874C, IAB 7/4/18, effective 8/8/18]

441—78.38(249A) HCBS AIDS/HIV waiver services. Payment will be approved for the following services to members eligible for the HCBS AIDS/HIV waiver services as established in 441—Chapter 83 and as identified in the member’s service plan. Effective March 17, 2022, payment shall only be made for services provided in integrated, community-based settings that support full access of members receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.

78.38(1) Counseling services. Counseling services are face-to-face mental health services provided to the member and caregiver by a mental health professional as defined in rule 441—24.1(225C) to facilitate home management of the member and prevent institutionalization. Counseling services are nonpsychiatric services necessary for the management of depression, assistance with the grief process, alleviation of psychosocial isolation and support in coping with a disability or illness, including terminal illness. Counseling services may be provided both for the purpose of training the member’s family or other caregiver to provide care, and for the purpose of helping the member and those caring for the member to adjust to the member’s disability or terminal condition. Counseling services may be provided to the member’s caregiver only when included in the case plan for the member.

Payment will be made for individual and group counseling. A unit of individual counseling for the waiver member or the waiver member and the member’s caregiver is 15 minutes. A unit of group counseling is 15 minutes. Payment for group counseling is based on the group rate divided by six, or, if the number of persons who comprise the group exceeds six, the actual number of persons who comprise the group.

78.38(2) Home health aide services. Home health aide services are personal or direct care services provided to the client which are not payable under Medicaid as set forth in rule 441—78.9(249A). A unit of service is a visit. Components of the service are:

- a. Observation and reporting of physical or emotional needs.
- b. Helping a client with bath, shampoo, or oral hygiene.
- c. Helping a client with toileting.
- d. Helping a client in and out of bed and with ambulation.
- e. Helping a client reestablish activities of daily living.
- f. Assisting with oral medications ordinarily self-administered and ordered by a physician.
- g. Performing incidental household services which are essential to the client’s health care at home and are necessary to prevent or postpone institutionalization in order to complete a full unit of service.

78.38(3) Homemaker services. Homemaker services are those services provided when the member lives alone or when the person who usually performs these functions for the member needs assistance with performing the functions. A unit of service is 15 minutes. Components of the service must be directly related to the care of the member and may include only the following:

- a. Essential shopping: shopping for basic need items such as food, clothing or personal care items, or drugs.
- b. Limited housecleaning: maintenance cleaning such as vacuuming, dusting, scrubbing floors, defrosting refrigerators, cleaning stoves, cleaning medical equipment, washing and mending clothes, washing personal items used by the member, and washing dishes.
- c. Meal preparation: planning and preparing balanced meals.

78.38(4) Nursing care services. Nursing care services are services provided by licensed agency nurses to clients in the home which are ordered by and included in the plan of treatment established by the physician. The services shall be reasonable and necessary to the treatment of an illness or injury and include: observation; evaluation; teaching; training; supervision; therapeutic exercise; bowel and bladder care; administration of medications; intravenous and enteral feedings; skin care; preparation of clinical and progress notes; coordination of services; and informing the physician and other personnel of changes in the patient's conditions and needs. A unit of service is a visit.

78.38(5) Respite care services. Respite care services are services provided to the member that give temporary relief to the usual caregiver and provide all the necessary care that the usual caregiver would provide during that period. The purpose of respite care is to enable the member to remain in the member's current living situation.

a. Services provided outside the member's home shall not be reimbursable if the living unit where respite is provided is reserved for another person on a temporary leave of absence.

b. Member-to-staff ratios shall be appropriate to the individual needs of the member as determined by the member's interdisciplinary team.

c. A unit of service is 15 minutes.

d. Respite care is not to be provided to members during the hours in which the usual caregiver is employed except when the member is attending a 24-hour residential camp. Respite cannot be provided to a member whose usual caregiver is a consumer-directed attendant care provider for the member.

e. The interdisciplinary team shall determine if the member will receive basic individual respite, specialized respite or group respite as defined in 441—Chapter 83.

f. A maximum of 14 consecutive days of 24-hour respite care may be reimbursed.

g. Respite services provided for a period exceeding 24 consecutive hours to three or more individuals who require nursing care because of a mental or physical condition must be provided by a health care facility licensed as described in Iowa Code chapter 135C.

h. Respite services shall not be provided simultaneously with other residential, nursing, or home health aide services provided through the medical assistance program.

78.38(6) Home-delivered meals. Home-delivered meals are meals prepared elsewhere and delivered to a member at the member's residence.

a. Each meal shall ensure the member receives a minimum of one-third of the daily recommended dietary allowance as established by the Food and Nutrition Board of the National Research Council of the National Academy of Sciences. The meal may also be a liquid supplement which meets the minimum one-third standard.

b. When a restaurant provides the home-delivered meal, the member is required to have a nutritional consultation. The nutritional consultation includes contact with the restaurant to explain the dietary needs of the member and what constitutes the minimum one-third daily dietary allowance.

c. A unit of service is a meal (morning, noon, evening, or liquid supplement). Any maximum combination of any two meals (morning, noon, evening, or liquid supplement) is allowed per day. Duplication of a meal in any one day is not allowed. The number of approved meals (morning, noon, evening, or liquid supplement) is contained in the member's service plan.

d. The number of meals delivered for any morning, noon, evening, or liquid supplement meal cannot exceed the number of calendar days in a calendar month; nor can the number of delivered meals exceed the number of authorized days in a month. Meals billed in excess of the calendar days in a calendar month and those billed in excess of the number of authorized days in a month are subject to recoupment or denial of payment.

78.38(7) Adult day care services. Adult day care services provide an organized program of supportive care in a group environment to persons who need a degree of supervision and assistance on a regular or intermittent basis in a day care center. A unit of service is 15 minutes (up to four units per day), a half day (1.25 to 4 hours per day), a full day (4.25 to 8 hours per day), or an extended day (8.25 to 12 hours per day). Components of the service include health-related care, social services, and other related support services.

78.38(8) Consumer-directed attendant care service. Consumer-directed attendant care services are service activities performed by a person to help a member with self-care tasks which the member would typically do independently if the member were otherwise able. Covered service activities are limited to the nonskilled activities listed in paragraph 78.38(8)“f” and the skilled activities listed in paragraph 78.38(8)“g.” Covered service activities must be essential to the health, safety, and welfare of the member. Services may be provided in the absence of a parent or guardian if the parent or guardian has given advance direction for the service provision.

a. Service planning.

(1) The member, parent, guardian, or attorney in fact under a durable power of attorney for health care shall:

1. Select the individual or agency that will provide the components of the attendant care services.
2. Determine with the selected provider what components of attendant care services the provider shall perform, subject to confirmation by the service worker or case manager that those components are consistent with the assessment and are authorized covered services.

3. Complete, sign, and date Form 470-3372, HCBS Consumer-Directed Attendant Care Agreement, to indicate the frequency, scope, and duration of services (a description of each service component and the time agreed on for that component). The case manager or service worker and provider shall also sign the agreement.

4. Submit the completed agreement to the service worker or case manager. The agreement shall be part of the member’s service plan and shall be kept in the member’s records, in the provider’s records, and in the service worker’s or case manager’s records. Any service component that is not listed in the agreement shall not be payable.

(2) Whenever a legal representative acts as a provider of consumer-directed attendant care as allowed by 441—paragraph 79.9(7)“b,” the following shall apply:

1. The payment rate for the legal representative must be based on the skill level of the legal representative and may not exceed the median statewide reimbursement rate for the service unless the higher rate receives prior approval from the department;
2. The legal representative may not be paid for more than 40 hours of service per week; and
3. A contingency plan must be established in the member’s service plan to ensure service delivery in the event the legal representative is unable to provide services due to illness or other unexpected event.

b. Supervision of skilled services. Skilled consumer-directed attendant care services shall be provided under the supervision of a licensed nurse or licensed therapist working under the direction of a physician. The licensed nurse or therapist shall:

- (1) Retain accountability for actions that are delegated.
- (2) Ensure appropriate assessment, planning, implementation, and evaluation.
- (3) Make on-site supervisory visits every two weeks with the service provider present.

c. Service documentation. The consumer-directed attendant care provider must complete Form 470-4389, Consumer-Directed Attendant Care (CDAC) Service Record, for each day of service. Any service component that is not documented in accordance with rule 441—79.3(249A) shall not be payable.

d. Role of guardian or attorney. If the member has a guardian or attorney in fact under a durable power of attorney for health care:

(1) The service worker’s or case manager’s service plan shall address how consumer-directed attendant care services will be monitored to ensure that the member’s needs are being adequately met. If the guardian or attorney in fact is the service provider, the service plan shall address how the service worker or case manager shall oversee service provision.

(2) The guardian or attorney in fact shall sign the claim form in place of the member, indicating that the service has been provided as presented on the claim.

e. Service units and billing. A unit of service is 15 minutes provided by an individual or agency. Each service shall be billed in whole units.

f. Nonskilled services. Covered nonskilled service activities are limited to help with the following activities:

- (1) Dressing.

- (2) Bathing, shampooing, hygiene, and grooming.
- (3) Access to and from bed or a wheelchair, transferring, ambulation, and mobility in general.
- (4) Toileting, including bowel, bladder, and catheter assistance (emptying the catheter bag, collecting a specimen, and cleaning the external area around the catheter).
- (5) Meal preparation, cooking, and assistance with feeding, not including the cost of meals themselves. Meal preparation and cooking shall be provided only in the member's home.
- (6) Housekeeping, laundry, and shopping essential to the member's health care at home.
- (7) Taking medications ordinarily self-administered, including those ordered by a physician or other qualified health care provider.
- (8) Minor wound care.
- (9) Going to or returning from a place of employment and job-related tasks while the member is on the job site. Transportation for the member and assistance with understanding or performing the essential job functions are not included in consumer-directed attendant care services.
- (10) Tasks, such as financial management and scheduling, that require cognitive or physical assistance.
- (11) Communication essential to the health and welfare of the member, through interpreting and reading services and use of assistive devices for communication.
- (12) Using transportation essential to the health and welfare of the member. The cost of the transportation is not included.

g. Skilled services. Covered skilled service activities are limited to help with the following activities:

- (1) Tube feedings of members unable to eat solid foods.
- (2) Intravenous therapy administered by a registered nurse.
- (3) Parenteral injections required more than once a week.
- (4) Catheterizations, continuing care of indwelling catheters with supervision of irrigations, and changing of Foley catheters when required.
- (5) Respiratory care including inhalation therapy and tracheotomy care or tracheotomy care and ventilator.
- (6) Care of decubiti and other ulcerated areas, noting and reporting to the nurse or therapist.
- (7) Rehabilitation services including, but not limited to, bowel and bladder training, range of motion exercises, ambulation training, restorative nursing services, respiratory care and breathing programs, reality orientation, reminiscing therapy, remotivation, behavior modification, and reteaching of the activities of daily living.
- (8) Colostomy care.
- (9) Care of uncontrolled medical conditions, such as brittle diabetes, and comfort care of terminal conditions.
- (10) Postsurgical nursing care.
- (11) Monitoring medications requiring close supervision because of fluctuating physical or psychological conditions, e.g., antihypertensive, digitalis preparations, mood-altering or psychotropic drugs, or narcotics.
- (12) Preparing and monitoring response to therapeutic diets.
- (13) Recording and reporting of changes in vital signs to the nurse or therapist.

h. Excluded services and costs. Services, activities, costs and time that are not covered as consumer-directed attendant care include the following (not an exclusive list):

- (1) Any activity related to supervising a member. Only direct services are billable.
- (2) Any activity that the member is able to perform.
- (3) Costs of food.
- (4) Costs for the supervision of skilled services by the nurse or therapist. The supervising nurse or therapist may be paid from private insurance, Medicare, or other third-party payment sources, or may be paid as another Medicaid service, including early and periodic screening, diagnosis and treatment services.
- (5) Exercise that does not require skilled services.

- (6) Parenting or child care for or on behalf of the member.
- (7) Reminders and cueing.
- (8) Services provided simultaneously with any other similar service regardless of funding source, including other waiver services and state supplementary assistance in-home health-related care services.
- (9) Transportation costs.
- (10) Wait times for any activity.

78.38(9) Consumer choices option. The consumer choices option provides a member with a flexible monthly individual budget that is based on the member's service needs. With the individual budget, the member shall have the authority to purchase goods and services to meet the member's assessed needs and may choose to employ providers of services and supports. The services, supports, and items that are purchased with an individual budget must be directly related to a member's assessed need or goal established in the member's service plan. Components of this service are set forth below.

a. Agreement. As a condition of participating in the consumer choices option, a member shall sign Form 470-4289, HCBS Consumer Choices Informed Consent and Risk Agreement, to document that the member has been informed of the responsibilities and risks of electing the consumer choices option.

b. Individual budget amount. A monthly individual budget amount shall be established for each member based on the assessed needs of the member and on the services and supports authorized in the member's service plan. The member shall be informed of the individual budget amount during the development of the service plan.

(1) Services that may be included in determining the individual budget amount for a member in the HCBS AIDS/HIV waiver are:

1. Consumer-directed attendant care (unskilled).
2. Home-delivered meals.
3. Homemaker service.
4. Basic individual respite care.

(2) The department shall determine an average unit cost for each service listed in subparagraph 78.38(9) "b"(1) based on actual unit costs from the previous fiscal year plus a cost-of-living adjustment.

(3) In aggregate, costs for individual budget services shall not exceed the current costs of waiver program services. In order to maintain cost neutrality, the department shall apply a utilization adjustment factor to the amount of service authorized in the member's service plan before calculating the value of that service to be included in the individual budget amount.

(4) The department shall compute the utilization adjustment factor for each service by dividing the net costs of all claims paid for the service by the total of the authorized costs for that service, using at least 12 consecutive months of aggregate service data. The utilization adjustment factor shall be no lower than 60 percent. The department shall analyze and adjust the utilization adjustment factor at least annually in order to maintain cost neutrality.

(5) Individual budgets for respite services shall be computed based on the average cost for services identified in subparagraph 78.38(9) "b"(2). Respite services are not subject to the utilization adjustment factor in subparagraph 78.38(9) "b"(3).

(6) The individual budget amount may be changed only at the first of the month and shall remain fixed for the entire month.

c. Required service components. To participate in the consumer choices option, a member must hire an independent support broker and must work with a financial management service that is enrolled as a Medicaid provider. Before hiring the independent support broker, the member shall receive the results of the background check conducted pursuant to 441—Chapter 119.

d. Optional service components. A member who elects the consumer choices option may purchase the following goods, services and supports, which shall be provided in the member's home or at an integrated community setting:

(1) Self-directed personal care services. Self-directed personal care services are services or goods that provide a range of assistance in activities of daily living and incidental activities of daily living that help the member remain in the home and community. These services must be identified in the member's service plan developed by the member's case manager or service worker.

(2) Self-directed community supports and employment. Self-directed community supports and employment are services that support the member in developing and maintaining independence and community integration. These services must be identified in the member's service plan developed by the member's case manager or service worker.

(3) Individual-directed goods and services. Individual-directed goods and services are services, equipment, or supplies not otherwise provided through the Medicaid program that address an assessed need or goal identified in the member's service plan. The item or service shall meet the following requirements:

1. Promote opportunities for community living and inclusion.
2. Increase independence or substitute for human assistance, to the extent the expenditures would otherwise be made for that human assistance.
3. Be accommodated within the member's budget without compromising the member's health and safety.
4. Be provided to the member or directed exclusively toward the benefit of the member.
5. Be the least costly to meet the member's needs.
6. Not be available through another source.

e. Development of the individual budget. The independent support broker shall assist the member in developing and implementing the member's individual budget. The individual budget shall include:

- (1) The costs of the financial management service.
- (2) The costs of the independent support broker. The independent support broker may be compensated for up to 6 hours of service for assisting with the implementation of the initial individual budget. The independent support broker shall not be paid for more than 30 hours of service for an individual member during a 12-month period without prior approval by the department.

(3) The costs of any optional service component chosen by the member as described in paragraph 78.38(9) "d." Costs of the following items and services shall not be covered by the individual budget:

1. Child care services.
2. Clothing not related to an assessed medical need.
3. Conference, meeting or similar venue expenses other than the costs of approved services the member needs while attending the conference, meeting or similar venue.
4. Costs associated with shipping items to the member.
5. Experimental and non-FDA-approved medications, therapies, or treatments.
6. Goods or services covered by other Medicaid programs.
7. Home furnishings.
8. Home repairs or home maintenance.
9. Homeopathic treatments.
10. Insurance premiums or copayments.
11. Items purchased on installment payments.
12. Motorized vehicles.
13. Nutritional supplements.
14. Personal entertainment items.
15. Repairs and maintenance of motor vehicles.
16. Room and board, including rent or mortgage payments.
17. School tuition.
18. Service animals.
19. Services covered by third parties or services that are the responsibility of a non-Medicaid program.
20. Sheltered workshop services.
21. Social or recreational purchases not related to an assessed need or goal identified in the member's service plan.
22. Vacation expenses, other than the costs of approved services the member needs while on vacation.

(4) The costs of any approved home or vehicle modification. When authorized, the budget may include an amount allocated for a home or vehicle modification. Before becoming part of the individual budget, all home and vehicle modifications shall be identified in the member's service plan and approved by the case manager or service worker. The authorized amount shall not be used for anything other than the specific modification.

(5) Any amount set aside in a savings plan to reserve funds for the future purchase of self-directed personal care, individual-directed goods and services, or self-directed community supports and services as defined in paragraph 78.38(9) "d." The savings plan shall meet the requirements in paragraph 78.38(9) "f."

f. Savings plan. A member savings plan must be in writing and be approved by the department before the start of the savings plan. Amounts allocated to the savings plan must result from efficiencies in meeting identified needs of the member.

(1) The savings plan shall identify:

1. The specific goods, services, supports or supplies to be purchased through the savings plan.

2. The amount of the individual budget allocated each month to the savings plan.

3. The amount of the individual budget allocated each month to meet the member's identified service needs.

4. How the member's assessed needs will continue to be met through the individual budget when funds are placed in savings.

(2) With the exception of funds allocated for respite care, the savings plan shall not include funds budgeted for direct services that were not received. The budgeted amount associated with unused direct services other than respite care shall revert to the Medicaid program at the end of each month. Funds from unused respite services may be allocated to the savings plan but shall not be used for anything other than future respite care.

(3) Funds accumulated under a savings plan shall be used only to purchase items that increase independence or substitute for human assistance to the extent that expenditures would otherwise be made for human assistance, including additional goods, supports, services or supplies. The self-directed personal care, individual-directed goods and services, or self-directed community supports and services purchased with funds from a savings plan must:

1. Be used to meet a member's identified need,

2. Be medically necessary, and

3. Be approved by the member's case manager or service worker.

(4) All funds allocated to a savings plan that are not expended by December 31 of each year shall revert to the Medicaid program.

(5) The annual reassessment of a member's needs must take into account the purchases of goods and services that substitute for human assistance. Adjustments shall be made to the services used to determine the individual budget based on the reassessment.

g. Budget authority. The member shall have authority over the individual budget authorized by the department to perform the following tasks:

(1) Contract with entities to provide services and supports as described in this subrule.

(2) Determine the amount to be paid for services. Reimbursement rates shall be consistent with rates paid by others in the community for the same or substantially similar services. Reimbursement rates for the independent support broker and the financial management service are subject to the limits in 441—subrule 79.1(2). The reimbursement rate for a member's legal representative who provides services to the member as allowed by 441—paragraph 79.9(7) "b" 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.

(3) Schedule the provision of services. Whenever a member's legal representative provides services to the member as allowed by 441—paragraph 79.9(7) "b," the legal representative may not be paid for more than 40 hours of service per week and 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.

(4) Authorize payment for optional service components identified in the individual budget.
(5) Reallocate funds among services included in the budget. Every purchase of a good or service must be identified and approved in the individual budget before the purchase is made.

h. Delegation of budget authority. The member may delegate responsibility for the individual budget to a representative in addition to the independent support broker.

(1) The representative must be at least 18 years old.
(2) The representative shall not be a current provider of service to the member.
(3) The member shall sign a consent form that designates who the member has chosen as a representative and what responsibilities the representative shall have.
(4) The representative shall not be paid for this service.

i. Employer authority. The member shall have the authority to be the common-law employer of employees providing services and support under the consumer choices option. A common-law employer has the right to direct and control the performance of the services. The member may perform the following functions:

(1) Recruit employees.
(2) Select employees from a worker registry.
(3) Verify employee qualifications.
(4) Specify additional employee qualifications.
(5) Determine employee duties.
(6) Determine employee wages and benefits.
(7) Schedule employees.
(8) Train and supervise employees.

j. Employment agreement. Any person employed by the member to provide services under the consumer choices option shall sign an employment agreement with the member that outlines the employee's and member's responsibilities.

k. Responsibilities of the independent support broker. The independent support broker shall perform the following services as directed by the member or the member's representative:

(1) Assist the member with developing the member's initial and subsequent individual budgets and with making any changes to the individual budget.
(2) Have monthly contact with the member for the first four months of implementation of the initial individual budget and have quarterly contact thereafter.
(3) Complete the required employment packet with the financial management service.
(4) Assist with interviewing potential employees and entities providing services and supports if requested by the member.
(5) Assist the member with determining whether a potential employee meets the qualifications necessary to perform the job.
(6) Assist the member with obtaining a signed consent from a potential employee to conduct background checks if requested by the member.
(7) Assist the member with negotiating with entities providing services and supports if requested by the member.
(8) Assist the member with contracts and payment methods for services and supports if requested by the member.
(9) Assist the member with developing an emergency backup plan. The emergency backup plan shall address any health and safety concerns.
(10) Review expenditure reports from the financial management service to ensure that services and supports in the individual budget are being provided.

(11) Document in writing on the independent support broker timecard every contact the broker has with the member. Contact documentation shall include information on the extent to which the member's individual budget has addressed the member's needs and the satisfaction of the member.

l. Responsibilities of the financial management service. The financial management service shall perform all of the following services:

(1) Receive Medicaid funds in an electronic transfer.

- (2) Process and pay invoices for approved goods and services included in the individual budget.
- (3) Enter the individual budget into the web-based tracking system chosen by the department and enter expenditures as they are paid.
- (4) Provide real-time individual budget account balances for the member, the independent support broker, and the department, available at a minimum during normal business hours (9 a.m. to 5 p.m., Monday through Friday).
- (5) Conduct criminal background checks on potential employees pursuant to 441—Chapter 119.
- (6) Verify for the member an employee's citizenship or alien status.
- (7) Assist the member with fiscal and payroll-related responsibilities including, but not limited to:
 1. Verifying that hourly wages comply with federal and state labor rules.
 2. Collecting and processing timecards.
 3. Withholding, filing, and paying federal, state and local income taxes, Medicare and Social Security (FICA) taxes, and federal (FUTA) and state (SUTA) unemployment and disability insurance taxes, as applicable.
 4. Computing and processing other withholdings, as applicable.
 5. Processing all judgments, garnishments, tax levies, or other withholding on an employee's pay as may be required by federal, state, or local laws.
 6. Preparing and issuing employee payroll checks.
 7. Preparing and disbursing IRS Forms W-2 and W-3 annually.
 8. Processing federal advance earned income tax credit for eligible employees.
 9. Refunding over-collected FICA, when appropriate.
 10. Refunding over-collected FUTA, when appropriate.
- (8) Assist the member in completing required federal, state, and local tax and insurance forms.
- (9) Establish and manage documents and files for the member and the member's employees.
- (10) Monitor timecards, receipts, and invoices to ensure that they are consistent with the individual budget. Keep records of all timecards and invoices for each member for a total of five years.
- (11) Provide to the department, the independent support broker, and the member monthly and quarterly status reports that include a summary of expenditures paid and amount of budget unused.
- (12) Establish an accessible customer service system and a method of communication for the member and the independent support broker that includes alternative communication formats.
- (13) Establish a customer services complaint reporting system.
- (14) Develop a policy and procedures manual that is current with state and federal regulations and update as necessary.
- (15) Develop a business continuity plan in the case of emergencies and natural disasters.
- (16) Provide to the department an annual independent audit of the financial management service.
- (17) Assist in implementing the state's quality management strategy related to the financial management service.

78.38(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]

441—78.39(249A) Federally qualified health centers. Payment shall be made for services as defined in Section 1905(a)(2)(C) of the Social Security Act.

78.39(1) Utilization review. Utilization review shall be conducted of Medicaid members who access more than 24 outpatient visits in any 12-month period from physicians, advanced registered nurse practitioners, federally qualified health centers, other clinics, and emergency rooms. Refer to rule 441—76.9(249A) for further information concerning the member lock-in program.

78.39(2) Risk assessment. Risk assessment, using Form 470-2942, Medicaid Prenatal Risk Assessment, shall be completed at the initial visit during a Medicaid member's pregnancy.

a. If the risk assessment reflects a low-risk pregnancy, the assessment shall be completed again at approximately the twenty-eighth week of pregnancy.

b. If the risk assessment reflects a high-risk pregnancy, referral shall be made for enhanced services. (See description of enhanced services at subrule 78.25(3).)

78.39(3) Vaccines. In order to be paid for the administration of a vaccine covered under the Vaccines for Children (VFC) Program, a federally qualified health center must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

This rule is intended to implement Iowa Code section 249A.4.

[ARC 0065C, IAB 4/4/12, effective 6/1/12]

441—78.40(249A) Advanced registered nurse practitioners. Payment shall be approved for services provided by advanced registered nurse practitioners within their scope of practice and the limitations of state law, with the exception of services not payable to physicians under rule 441—78.1(249A) or otherwise not payable under any other applicable rule.

78.40(1) Direct payment. Payment shall be made to advanced registered nurse practitioners directly, without regard to whether the advanced registered nurse practitioner is employed by or associated with a physician, hospital, birth center, clinic or other health care provider recognized under state law. An established protocol between a physician and the advanced registered nurse practitioner shall not cause an advanced registered nurse practitioner to be considered auxiliary personnel of a physician, or an employee of a hospital, birth center, or clinic.

78.40(2) Location of service. Payment shall be approved for services rendered in any location in which the advanced registered nurse practitioner is legally authorized to provide services under state law. The nurse practitioner shall have promptly available the necessary equipment and personnel to handle emergencies.

78.40(3) Utilization review. Utilization review shall be conducted of Medicaid members who access more than 24 outpatient visits in any 12-month period from physicians, advanced registered

nurse practitioners, other clinics, and emergency rooms. Refer to rule 441—76.9(249A) for further information concerning the member lock-in program.

78.40(4) Vaccines. In order to be paid for the administration of a vaccine covered under the Vaccines for Children (VFC) Program, an advanced registered nurse practitioner must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

78.40(5) Prenatal risk assessment. Risk assessment, using Form 470-2942, Medicaid Prenatal Risk Assessment, shall be completed at the initial visit during a Medicaid member's pregnancy.

a. If the risk assessment reflects a low-risk pregnancy, the assessment shall be completed again at approximately the twenty-eighth week of pregnancy.

b. If the risk assessment reflects a high-risk pregnancy, referral shall be made for enhanced services. (See description of enhanced services at subrule 78.25(3).)

This rule is intended to implement Iowa Code section 249A.4.

[ARC 0065C, IAB 4/4/12, effective 6/1/12]

441—78.41(249A) HCBS intellectual disability waiver services. Payment will be approved for the following services to members eligible for the HCBS intellectual disability waiver as established in 441—Chapter 83 and as identified in the member's service plan. Effective March 17, 2022, payment shall only be made for services provided in integrated, community-based settings that support full access of members receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.

78.41(1) Supported community living services. Supported community living services are provided by the provider within the member's home and community, according to the individualized member need as identified in the service plan.

a. Available components of the service are personal and home skills training services, individual advocacy services, community skills training services, personal environment support services, transportation, and treatment services.

(1) Personal and home skills training services are activities which assist a member to develop or maintain skills for self-care, self-directedness, and care of the immediate environment.

(2) Individual advocacy is the act or process of representing the member's rights and interests in order to realize the rights to which the member is entitled and to remove barriers to meeting the member's needs.

(3) Community skills training services are activities which assist a member to develop or maintain skills allowing better participation in the community. Services shall focus on the following areas as they apply to the member being served:

1. Personal management skills training services are activities which assist a member to maintain or develop skills necessary to sustain the member in the physical environment and are essential to the management of the member's personal business and property. This includes self-advocacy skills. Examples of personal management skills are the ability to maintain a household budget, plan and prepare nutritional meals, use community resources such as public transportation and libraries, and select foods at the grocery store.

2. Socialization skills training services are activities which assist a member to develop or maintain skills which include self-awareness and self-control, social responsiveness, community participation, social amenities, and interpersonal skills.

3. Communication skills training services are activities which assist a member to develop or maintain skills including expressive and receptive skills in verbal and nonverbal language and the functional application of acquired reading and writing skills.

(4) Personal and environmental support services are activities and expenditures provided to or on behalf of a member in the areas of personal needs in order to allow the member to function in the least restrictive environment.

(5) Transportation services are activities and expenditures designed to assist the member to travel from one place to another to obtain services or carry out life's activities. The services exclude transportation provided as nonemergency medical transportation pursuant to rule 441—78.13(249A).

(6) Treatment services are activities designed to assist the member to maintain or improve physiological, emotional and behavioral functioning and to prevent conditions that would present barriers to the member's functioning. Treatment services include physical or physiological treatment and psychotherapeutic treatment.

1. Physiological treatment includes medication regimens designed to prevent, halt, control, relieve, or reverse symptoms or conditions that interfere with the normal functioning of the human body. Physiological treatment shall be provided by or under the direct supervision of a certified or licensed health care professional.

2. Psychotherapeutic treatment means activities provided to assist a member in the identification or modification of beliefs, emotions, attitudes, or behaviors in order to maintain or improve the member's functioning in response to the physical, emotional, and social environment.

b. The supported community living services are intended to provide for the daily living needs of the member and shall be available as needed during any 24-hour period. Activities do not include those associated with vocational services, academics, day care, medical services, Medicaid case management or other case management. Services are individualized supportive services provided in a variety of community-based, integrated settings.

(1) Supported community living services shall be available at a daily rate to members living outside the home of their family, legal representative, or foster family and for whom a provider has primary responsibility for supervision or structure during the month. This service will provide supervision or structure in identified periods when another resource is not available.

(2) Supported community living services shall be available at a 15-minute rate to members for whom a daily rate is not established.

c. Services may be provided to a child or an adult. A maximum of four persons may reside in a living unit.

(1) A member may live within the home of the member's family or legal representative or in another typical community living arrangement.

(2) A member living with the member's family or legal representative is not subject to the maximum of four residents in a living unit.

(3) A member may not live in a licensed medical or health care facility or in a setting that is required to be licensed as a medical or health care facility.

d. A member aged 17 or under living in the home of the member's family, legal representative, or foster family shall receive services based on development of adaptive, behavior, or health skills. Duration of services shall be based on age-appropriateness and individual attention span.

e. Maintenance and room and board costs are not reimbursable.

f. Provider budgets shall reflect costs associated with members' specific support needs as determined necessary by the interdisciplinary team for each member. The specific support needs must be identified in the Medicaid case manager's service plan, and the provider must maintain records to support the expenditures. A unit of service is:

(1) One full calendar day when a member residing in the living unit receives on-site staff supervision for eight or more hours per day as an average over a calendar month and the member's service plan identifies and reflects the need for this amount of supervision.

(2) Fifteen minutes when subparagraph 78.41(1)"j"(1) does not apply.

g. The maximum number of units available per member is as follows:

(1) 365 daily units per state fiscal year except a leap year when 366 daily units are available.

(2) 20,440 15-minute units are available per state fiscal year except a leap year when 20,496 15-minute units are available.

h. The service shall be identified in the member's service plan.

i. Supported community living services shall not be simultaneously reimbursed with other residential services or with respite, nursing, or home health aide services provided through Medicaid or the HCBS intellectual disability waiver.

78.41(2) Respite care services. Respite care services are services provided to the member that give temporary relief to the usual caregiver and provide all the necessary care that the usual caregiver would provide during that period. The purpose of respite care is to enable the member to remain in the member's current living situation.

a. Services provided outside the member's home shall not be reimbursable if the living unit where respite is provided is reserved for another person on a temporary leave of absence.

b. Member-to-staff ratios shall be appropriate to the individual needs of the member as determined by the member's interdisciplinary team.

c. A unit of service is 15 minutes.

d. Respite care is not to be provided to members during the hours in which the usual caregiver is employed except when the member is attending a 24-hour residential camp. Respite care shall not be used as a substitute for a child's day care. Respite cannot be provided to a member whose usual caregiver is a consumer-directed attendant care provider for the member.

e. The interdisciplinary team shall determine if the member will receive basic individual respite, specialized respite or group respite as defined in 441—Chapter 83.

f. A maximum of 14 consecutive days of 24-hour respite care may be reimbursed.

g. Respite services provided for a period exceeding 24 consecutive hours to three or more individuals who require nursing care because of a mental or physical condition must be provided by a health care facility licensed as described in Iowa Code chapter 135C.

h. Respite services shall not be simultaneously reimbursed with other residential, supported community living, nursing, or home health aide services provided through the medical assistance program.

i. Payment for respite services shall not exceed \$7,334.62 per the member's waiver year.

78.41(3) Personal emergency response or portable locator system.

a. The personal emergency response system is an electronic device that transmits a signal to a central monitoring station to summon assistance in the event of an emergency.

(1) The necessary components of the system are:

1. An in-home medical communications transceiver.

2. A remote, portable activator.

3. A central monitoring station with backup systems staffed by trained attendants at all times.

4. Current data files at the central monitoring station containing response protocols and personal, medical and emergency information for each member.

(2) The service shall be identified in the member's service plan.

(3) A unit of service is a one-time installation fee or one month of service.

(4) Maximum units per state fiscal year shall be the initial installation and 12 months of service.

b. A portable locator system is an electronic device that transmits a signal to a monitoring device. The system allows a member to access assistance in the event of an emergency and allows law enforcement or the monitoring system provider to locate a member who is unable to request help or to activate a system independently. The member must be unable to access assistance in an emergency situation due to the member's age or disability.

(1) The required components of the portable locator system are:

1. A portable communications transceiver or transmitter to be worn or carried by the member.

2. Monitoring by the provider at a central location with response protocols and personal, medical, and emergency information for each member as applicable.

(2) The service shall be identified in the member's service plan.

(3) Payable units of service are purchase of equipment, an installation or set-up fee, and monthly fees.

(4) Maximum units per state fiscal year shall be one equipment purchase, one installation or set-up fee, and 12 months of service.

78.41(4) Home and vehicle modification. Covered home or vehicle modifications are physical modifications to the member's home or vehicle that directly address the member's medical or remedial need. Covered modifications must be necessary to provide for the health, welfare, or safety of the member and enable the member to function with greater independence in the home or vehicle.

a. Modifications that are necessary or desirable without regard to the member's medical or remedial need and that would be expected to increase the fair market value of the home or vehicle, such as furnaces, fencing, or adding square footage to the residence, are excluded except as specifically included below. Purchasing or leasing of a motorized vehicle is excluded. Home and vehicle repairs are also excluded.

b. Only the following modifications are covered:

- (1) Kitchen counters, sink space, cabinets, special adaptations to refrigerators, stoves, and ovens.
- (2) Bathtubs and toilets to accommodate transfer, special handles and hoses for shower heads, water faucet controls, and accessible showers and sink areas.
- (3) Grab bars and handrails.
- (4) Turnaround space adaptations.
- (5) Ramps, lifts, and door, hall and window widening.
- (6) Fire safety alarm equipment specific for disability.
- (7) Voice-activated, sound-activated, light-activated, motion-activated, and electronic devices directly related to the member's disability.
- (8) Vehicle lifts, driver-specific adaptations, remote-start systems, including such modifications already installed in a vehicle.

(9) Keyless entry systems.

(10) Automatic opening device for home or vehicle door.

(11) Special door and window locks.

(12) Specialized doorknobs and handles.

(13) Plexiglas replacement for glass windows.

(14) Modification of existing stairs to widen, lower, raise or enclose open stairs.

(15) Motion detectors.

(16) Low-pile carpeting or slip-resistant flooring.

(17) Telecommunications device for the deaf.

(18) Exterior hard-surface pathways.

(19) New door opening.

(20) Pocket doors.

(21) Installation or relocation of controls, outlets, switches.

(22) Air conditioning and air filtering if medically necessary.

(23) Heightening of existing garage door opening to accommodate modified van.

(24) Bath chairs.

c. A unit of service is the completion of needed modifications or adaptations.

d. All modifications and adaptations shall be provided in accordance with applicable federal, state, and local building and vehicle codes.

e. Services shall be performed following prior department approval of the modification as specified in 441—subrule 79.1(17) and a binding contract between the provider and the member.

f. All contracts for home or vehicle modification shall be awarded through competitive bidding. The contract shall include the scope of work to be performed, the time involved, supplies needed, the cost, diagrams of the project whenever applicable, and an assurance that the provider has liability and workers' compensation coverage and the applicable permit and license.

g. Service payment shall be made to the enrolled home or vehicle modification provider. If applicable, payment will be forwarded to the subcontracting agency by the enrolled home or vehicle modification provider following completion of the approved modifications.

h. Services shall be included in the member's service plan and shall exceed the Medicaid state plan services.

78.41(5) *Nursing services.* Nursing services are individualized in-home medical services provided by licensed nurses. Services shall exceed the Medicaid state plan services and be included in the consumer's individual comprehensive plan.

a. A unit of service is one hour.

b. A maximum of ten units are available per week.

78.41(6) *Home health aide services.* Home health aide services are personal or direct care services provided to the member which are not payable under Medicaid as set forth in rule 441—78.9(249A). Services shall include unskilled medical services and shall exceed those services provided under HCBS intellectual disability waiver supported community living. Instruction, supervision, support or assistance in personal hygiene, bathing, and daily living shall be provided under supported community living.

a. Services shall be included in the member's service plan.

b. A unit is one hour.

c. A maximum of 14 units are available per week.

78.41(7) *Supported employment services.* Supported employment services are service activities provided pursuant to subrule 78.27(10).

78.41(8) *Consumer-directed attendant care service.* Consumer-directed attendant care services are service activities performed by a person to help a member with self-care tasks which the member would typically do independently if the member were otherwise able. Covered service activities are limited to the nonskilled activities listed in paragraph 78.41(8) "f" and the skilled activities listed in paragraph 78.41(8) "g." Covered service activities must be essential to the health, safety, and welfare of the member. Services may be provided in the absence of a parent or guardian if the parent or guardian has given advance direction for the service provision.

a. Service planning.

(1) The member, parent, guardian, or attorney in fact under a durable power of attorney for health care shall:

1. Select the individual or agency that will provide the components of the attendant care services.

2. Determine with the selected provider what components of attendant care services the provider shall perform, subject to confirmation by the service worker or case manager that those components are consistent with the assessment and are authorized covered services.

3. Complete, sign, and date Form 470-3372, HCBS Consumer-Directed Attendant Care Agreement, to indicate the frequency, scope, and duration of services (a description of each service component and the time agreed on for that component). The case manager or service worker and provider shall also sign the agreement.

4. Submit the completed agreement to the service worker or case manager. The agreement shall be part of the member's service plan and shall be kept in the member's records, in the provider's records, and in the service worker's or case manager's records. Any service component that is not listed in the agreement shall not be payable.

(2) Whenever a legal representative acts as a provider of consumer-directed attendant care as allowed by 441—paragraph 79.9(7) "b," the following shall apply:

1. The payment rate for the legal representative must be based on the skill level of the legal representative and may not exceed the median statewide reimbursement rate for the service unless the higher rate receives prior approval from the department;

2. The legal representative may not be paid for more than 40 hours of service per week; and

3. A contingency plan must be established in the member's service plan to ensure service delivery in the event the legal representative is unable to provide services due to illness or other unexpected event.

b. Supervision of skilled services. Skilled consumer-directed attendant care services shall be provided under the supervision of a licensed nurse or licensed therapist working under the direction of a physician. The licensed nurse or therapist shall:

(1) Retain accountability for actions that are delegated.

(2) Ensure appropriate assessment, planning, implementation, and evaluation.

(3) Make on-site supervisory visits every two weeks with the service provider present.

c. Service documentation. The consumer-directed attendant care provider must complete Form 470-4389, Consumer-Directed Attendant Care (CDAC) Service Record, for each day of service. Any service component that is not documented in accordance with rule 441—79.3(249A) shall not be payable.

d. Role of guardian or attorney. If the member has a guardian or attorney in fact under a durable power of attorney for health care:

(1) The service worker's or case manager's service plan shall address how consumer-directed attendant care services will be monitored to ensure that the member's needs are being adequately met. If the guardian or attorney in fact is the service provider, the service plan shall address how the service worker or case manager shall oversee service provision.

(2) The guardian or attorney in fact shall sign the claim form in place of the member, indicating that the service has been provided as presented on the claim.

e. Service units and billing. A unit of service is 15 minutes provided by an individual or agency. Each service shall be billed in whole units.

f. Nonskilled services. Covered nonskilled service activities are limited to help with the following activities:

(1) Dressing.

(2) Bathing, shampooing, hygiene, and grooming.

(3) Access to and from bed or a wheelchair, transferring, ambulation, and mobility in general.

(4) Toileting, including bowel, bladder, and catheter assistance (emptying the catheter bag, collecting a specimen, and cleaning the external area around the catheter).

(5) Meal preparation, cooking, and assistance with feeding, not including the cost of meals themselves. Meal preparation and cooking shall be provided only in the member's home.

(6) Housekeeping, laundry, and shopping essential to the member's health care at home.

(7) Taking medications ordinarily self-administered, including those ordered by a physician or other qualified health care provider.

(8) Minor wound care.

(9) Going to or returning from a place of employment and job-related tasks while the member is on the job site. Transportation for the member and assistance with understanding or performing the essential job functions are not included in consumer-directed attendant care services.

(10) Tasks, such as financial management and scheduling, that require cognitive or physical assistance.

(11) Communication essential to the health and welfare of the member, through interpreting and reading services and use of assistive devices for communication.

(12) Using transportation essential to the health and welfare of the member. The cost of the transportation is not included.

g. Skilled services. Covered skilled service activities are limited to help with the following activities:

(1) Tube feedings of members unable to eat solid foods.

(2) Intravenous therapy administered by a registered nurse.

(3) Parenteral injections required more than once a week.

(4) Catheterizations, continuing care of indwelling catheters with supervision of irrigations, and changing of Foley catheters when required.

(5) Respiratory care including inhalation therapy and tracheotomy care or tracheotomy care and ventilator.

(6) Care of decubiti and other ulcerated areas, noting and reporting to the nurse or therapist.

(7) Rehabilitation services including, but not limited to, bowel and bladder training, range of motion exercises, ambulation training, restorative nursing services, respiratory care and breathing programs, reality orientation, reminiscing therapy, remotivation, behavior modification, and reteaching of the activities of daily living.

(8) Colostomy care.

(9) Care of uncontrolled medical conditions, such as brittle diabetes, and comfort care of terminal conditions.

(10) Postsurgical nursing care.

(11) Monitoring medications requiring close supervision because of fluctuating physical or psychological conditions, e.g., antihypertensives, digitalis preparations, mood-altering or psychotropic drugs, or narcotics.

(12) Preparing and monitoring response to therapeutic diets.

(13) Recording and reporting of changes in vital signs to the nurse or therapist.

h. Excluded services and costs. Services, activities, costs and time that are not covered as consumer-directed attendant care include the following (not an exclusive list):

(1) Any activity related to supervising a member. Only direct services are billable.

(2) Any activity that the member is able to perform.

(3) Costs of food.

(4) Costs for the supervision of skilled services by the nurse or therapist. The supervising nurse or therapist may be paid from private insurance, Medicare, or other third-party payment sources, or may be paid as another Medicaid service, including early and periodic screening, diagnosis and treatment services.

(5) Exercise that does not require skilled services.

(6) Parenting or child care for or on behalf of the member.

(7) Reminders and cueing.

(8) Services provided simultaneously with any other similar service regardless of funding source, including other waiver services and state supplementary assistance in-home health-related care services.

(9) Transportation costs.

(10) Wait times for any activity.

78.41(9) Interim medical monitoring and treatment services. Interim medical monitoring and treatment (IMMT) services are monitoring and treatment of a medical nature for children or adults whose medical needs make alternative care unavailable, inadequate, or insufficient. IMMT services are not intended to provide day care but to supplement available resources. Services must be ordered by a physician.

a. Need for service. The member must be currently receiving home health agency services under rule 441—78.9(249A) and require medical assessment, medical monitoring, and regular medical intervention or intervention in a medical emergency during those services. The service worker or case manager must identify the need for IMMT services after evaluating the member's living environment, family and natural supports, ability to perform activities of daily living, and health care needs. The services must be needed:

(1) To allow the member's usual caregivers to be employed,

(2) During a search for employment by a usual caregiver,

(3) To allow for academic or vocational training of a usual caregiver,

(4) Due to the hospitalization of a usual caregiver for treatment for physical or mental illness, or

(5) Due to the death of a usual caregiver.

b. Service requirements. Interim medical monitoring and treatment services shall:

(1) Provide experiences for each member's social, emotional, intellectual, and physical development;

(2) Include comprehensive developmental care and any special services for a member with special needs; and

(3) Include medical assessment, medical monitoring, and medical intervention as needed on a regular or emergency basis. Medical intervention means the ability to assess the situation and contact the appropriate medical professional, not the direct application of medical care.

c. Interim medical monitoring and treatment services may include supervision while the member is being transported to and from school.

d. Limitations.

(1) A maximum of 12 hours of service is available per day.

- (2) Covered services do not include a complete nutritional regimen.
- (3) Interim medical monitoring and treatment services may not duplicate any regular Medicaid or waiver services provided under the state plan. Services under the state plan, including home health agency services under rule 441—78.9(249A), must be exhausted before IMMT services are accessed.
- (4) Interim medical monitoring and treatment services shall be provided in the following settings that are approved by the department as integrated, community-based settings: the member's home; a registered child development home; a licensed child care center, residential care facility, or adult day care facility; or during the time when the member is being transported to and from school.
- (5) The member-to-staff ratio shall not be more than six members to one staff person.
- (6) The parent or guardian of the member shall be responsible for the usual and customary nonmedical cost of day care during the time in which the member is receiving IMMT services. Medical care necessary for monitoring and treatment is an allowable IMMT cost. If the cost of care goes above the usual and customary cost of day care services due to the member's medical condition, the costs above the usual and customary cost shall be covered as IMMT services.
 - e. A unit of service is 15 minutes.

78.41(10) Residential-based supported community living services. Residential-based supported community living services are medical or remedial services provided to children under the age of 18 while living outside their home in a residential-based living environment furnished by the residential-based supported community living service provider. The services eliminate barriers to family reunification or develop self-help skills for maximum independence.

 - a. Allowable service components are the following:
 - (1) Daily living skills development. These are services to develop the child's ability to function independently in the community on a daily basis, including training in food preparation, maintenance of living environment, time and money management, personal hygiene, and self-care.
 - (2) Social skills development. These are services to develop a child's communication and socialization skills, including interventions to develop a child's ability to solve problems, resolve conflicts, develop appropriate relationships with others, and develop techniques for controlling behavior.
 - (3) Family support development. These are services necessary to allow a child to return to the child's family or another less restrictive service environment. These services must include counseling and therapy sessions that involve both the child and the child's family at least 50 percent of the time and that focus on techniques for dealing with the special care needs of the child and interventions needed to alleviate behaviors that are disruptive to the family or other group living unit.
 - (4) Counseling and behavior intervention services. These are services to halt, control, or reverse stress and social, emotional, or behavioral problems that threaten or have negatively affected the child's stability. Activities under this service include counseling and behavior intervention with the child, including interventions to ameliorate problem behaviors.
 - b. Residential-based supported community living services must also address the ordinary daily-living needs of the child, excluding room and board, such as needs for safety and security, social functioning, and other medical care.
 - c. Residential-based supported community living services do not include services associated with vocational needs, academics, day care, Medicaid case management, other case management, or any other services that the child can otherwise obtain through Medicaid.
 - d. Room and board costs are not reimbursable as residential-based supported community living services.
 - e. The scope of service shall be identified in the child's service plan pursuant to 441—paragraph 77.37(23)“d.”
 - f. Residential-based supported community living services shall not be simultaneously reimbursed with other residential services provided under an HCBS waiver or otherwise provided under the Medicaid program.
 - g. A unit of service is a day.

h. The maximum number of units of residential-based supported community living services available per child is 365 daily units per state fiscal year, except in a leap year when 366 daily units are available.

78.41(11) *Transportation.* Transportation services may be provided for members to conduct business errands and essential shopping, to travel to and from work or day programs, and to reduce social isolation. A unit of service is one mile of transportation or one one-way trip. Transportation may not be reimbursed when HCBS intellectual disability waiver daily supported community living service is authorized in a member's service plan.

78.41(12) *Adult day care services.* Adult day care services provide an organized program of supportive care in a group environment to persons who need a degree of supervision and assistance on a regular or intermittent basis in a day care center. A unit of service is 15 minutes (up to four units per day), a half day (1.25 to 4 hours per day), or a full day (4.25 to 12 hours per day). Components of the service include health-related care, social services, and other related support services.

78.41(13) *Prevocational services.* Prevocational services are service activities provided pursuant to subrule 78.27(9).

78.41(14) *Day habilitation services.*

a. Scope. Day habilitation services are services that assist or support the member in developing or maintaining life skills and community integration. Services must enable or enhance the member's intellectual functioning, physical and emotional health and development, language and communication development, cognitive functioning, socialization and community integration, functional skill development, behavior management, responsibility and self-direction, daily living activities, self-advocacy skills, or mobility.

b. Family training option. Day habilitation services may include training families in treatment and support methodologies or in the care and use of equipment. Family training may be provided in the member's home. The unit of service is 15 minutes. The units of services payable are limited to a maximum of 40 units per month.

c. Unit of service. Except as provided in paragraph 78.41(14) "b," the unit of service is 15 minutes (for up to 16 units per day) or a full day (4.25 to 8 hours per day).

d. Exclusions.

(1) Services shall not be provided in the member's home, except as provided in paragraph "b." For this purpose, services provided in a residential care facility where the member lives are not considered to be provided in the member's home.

(2) Services shall not include vocational or prevocational services and shall not involve paid work.

(3) Services shall not duplicate or replace education or related services defined in Public Law 94-142, the Education of the Handicapped Act.

(4) Services shall not be provided simultaneously with other Medicaid-funded services.

78.41(15) *Consumer choices option.* The consumer choices option provides a member with a flexible monthly individual budget that is based on the member's service needs. With the individual budget, the member shall have the authority to purchase goods and services to meet the member's assessed needs and may choose to employ providers of services and supports. The services, supports, and items that are purchased with an individual budget must be directly related to a member's assessed need or goal established in the member's service plan. Components of this service are set forth below.

a. Agreement. As a condition of participating in the consumer choices option, a member shall sign Form 470-4289, HCBS Consumer Choices Informed Consent and Risk Agreement, to document that the member has been informed of the responsibilities and risks of electing the consumer choices option.

b. Individual budget amount. A monthly individual budget amount shall be established for each member based on the assessed needs of the member and on the services and supports authorized in the member's service plan. The member shall be informed of the individual budget amount during the development of the service plan.

(1) Services that may be included in determining the individual budget amount for a member in the HCBS intellectual disabilities waiver are:

1. Consumer-directed attendant care (unskilled).

2. Day habilitation.
3. Home and vehicle modification.
4. Prevocational services.
5. Basic individual respite care.
6. Supported community living.
7. Supported employment.
8. Transportation.

(2) The department shall determine an average unit cost for each service listed in subparagraph 78.41(15)“b”(1) based on actual unit costs from the previous fiscal year plus a cost-of-living adjustment.

(3) In aggregate, costs for individual budget services shall not exceed the current costs of waiver program services. In order to maintain cost neutrality, the department shall apply a utilization adjustment factor to the amount of service authorized in the member’s service plan before calculating the value of that service to be included in the individual budget amount.

(4) The department shall compute the utilization adjustment factor for each service by dividing the net costs of all claims paid for the service by the total of the authorized costs for that service, using at least 12 consecutive months of aggregate service data. The utilization adjustment factor shall be no lower than 60 percent. The department shall analyze and adjust the utilization adjustment factor at least annually in order to maintain cost neutrality.

(5) Individual budgets for respite services shall be computed based on the average cost for services identified in subparagraph 78.41(15)“b”(2). Respite services are not subject to the utilization adjustment factor in subparagraph 78.41(15)“b”(3).

(6) Anticipated costs for home and vehicle modification and supported employment services to obtain a job are not subject to the average cost in subparagraph 78.41(15)“b”(2) or the utilization adjustment factor in subparagraph 78.41(15)“b”(3). Anticipated costs for these services shall not include the costs of the financial management services or the independent support broker. Costs for home and vehicle modification and supported employment services to obtain a job may be paid to the financial management services provider in a one-time payment. Before becoming part of the individual budget, all home and vehicle modifications and supported employment services to obtain a job shall be identified in the member’s service plan and approved by the case manager or service worker.

(7) The individual budget amount may be changed only at the first of the month and shall remain fixed for the entire month.

c. Required service components. To participate in the consumer choices option, a member must hire an independent support broker and must work with a financial management service that is enrolled as a Medicaid provider. Before hiring the independent support broker, the member shall receive the results of the background check conducted pursuant to 441—Chapter 119.

d. Optional service components. A member who elects the consumer choices option may purchase the following goods, services and supports, which shall be provided in the member’s home or at an integrated community setting:

(1) Self-directed personal care services. Self-directed personal care services are services or goods that provide a range of assistance in activities of daily living and incidental activities of daily living that help the member remain in the home and community. These services must be identified in the member’s service plan developed by the member’s case manager or service worker.

(2) Self-directed community supports and employment. Self-directed community supports and employment are services that support the member in developing and maintaining independence and community integration. These services must be identified in the member’s service plan developed by the member’s case manager or service worker.

(3) Individual-directed goods and services. Individual-directed goods and services are services, equipment, or supplies not otherwise provided through the Medicaid program that address an assessed need or goal identified in the member’s service plan. The item or service shall meet the following requirements:

1. Promote opportunities for community living and inclusion.

2. Increase independence or substitute for human assistance, to the extent the expenditures would otherwise be made for that human assistance.

3. Be accommodated within the member's budget without compromising the member's health and safety.

4. Be provided to the member or directed exclusively toward the benefit of the member.

5. Be the least costly to meet the member's needs.

6. Not be available through another source.

e. Development of the individual budget. The independent support broker shall assist the member in developing and implementing the member's individual budget. The individual budget shall include:

(1) The costs of the financial management service.

(2) The costs of the independent support broker. The independent support broker may be compensated for up to 6 hours of service for assisting with the implementation of the initial individual budget. The independent support broker shall not be paid for more than 30 hours of service for an individual member during a 12-month period without prior approval by the department.

(3) The costs of any optional service component chosen by the member as described in paragraph 78.41(15) "d." Costs of the following items and services shall not be covered by the individual budget:

1. Child care services.

2. Clothing not related to an assessed medical need.

3. Conference, meeting or similar venue expenses other than the costs of approved services the member needs while attending the conference, meeting or similar venue.

4. Costs associated with shipping items to the member.

5. Experimental and non-FDA-approved medications, therapies, or treatments.

6. Goods or services covered by other Medicaid programs.

7. Home furnishings.

8. Home repairs or home maintenance.

9. Homeopathic treatments.

10. Insurance premiums or copayments.

11. Items purchased on installment payments.

12. Motorized vehicles.

13. Nutritional supplements.

14. Personal entertainment items.

15. Repairs and maintenance of motor vehicles.

16. Room and board, including rent or mortgage payments.

17. School tuition.

18. Service animals.

19. Services covered by third parties or services that are the responsibility of a non-Medicaid program.

20. Sheltered workshop services.

21. Social or recreational purchases not related to an assessed need or goal identified in the member's service plan.

22. Vacation expenses, other than the costs of approved services the member needs while on vacation.

(4) The costs of any approved home or vehicle modification. When authorized, the budget may include an amount allocated for a home or vehicle modification. Before becoming part of the individual budget, all home and vehicle modifications shall be identified in the member's service plan and approved by the case manager or service worker. The authorized amount shall not be used for anything other than the specific modification.

(5) Any amount set aside in a savings plan to reserve funds for the future purchase of self-directed personal care, individual-directed goods and services, or self-directed community supports and services as defined in paragraph 78.41(15) "d." The savings plan shall meet the requirements in paragraph 78.41(15) "f."

f. Savings plan. A member savings plan must be in writing and be approved by the department before the start of the savings plan. Amounts allocated to the savings plan must result from efficiencies in meeting identified needs of the member.

(1) The savings plan shall identify:

1. The specific goods, services, supports or supplies to be purchased through the savings plan.
2. The amount of the individual budget allocated each month to the savings plan.
3. The amount of the individual budget allocated each month to meet the member's identified service needs.

4. How the member's assessed needs will continue to be met through the individual budget when funds are placed in savings.

(2) With the exception of funds allocated for respite care, the savings plan shall not include funds budgeted for direct services that were not received. The budgeted amount associated with unused direct services other than respite care shall revert to the Medicaid program at the end of each month. Funds from unused respite services may be allocated to the savings plan but shall not be used for anything other than future respite care.

(3) Funds accumulated under a savings plan shall be used only to purchase items that increase independence or substitute for human assistance to the extent that expenditures would otherwise be made for human assistance, including additional goods, supports, services or supplies. The self-directed personal care, individual-directed goods and services, or self-directed community supports and services purchased with funds from a savings plan must:

1. Be used to meet a member's identified need,
2. Be medically necessary, and
3. Be approved by the member's case manager or service worker.

(4) All funds allocated to a savings plan that are not expended by December 31 of each year shall revert to the Medicaid program.

(5) The annual reassessment of a member's needs must take into account the purchases of goods and services that substitute for human assistance. Adjustments shall be made to the services used to determine the individual budget based on the reassessment.

g. Budget authority. The member shall have authority over the individual budget authorized by the department to perform the following tasks:

(1) Contract with entities to provide services and supports as described in this subrule.

(2) Determine the amount to be paid for services. Reimbursement rates shall be consistent with rates paid by others in the community for the same or substantially similar services. Reimbursement rates for the independent support broker and the financial management service are subject to the limits in 441—subrule 79.1(2). The reimbursement rate for a member's legal representative who provides services to the member as allowed by 441—paragraph 79.9(7) "b" 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.

(3) Schedule the provision of services. Whenever a member's legal representative provides services to the member as allowed by 441—paragraph 79.9(7) "b," the legal representative may not be paid for more than 40 hours of service per week and 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.

(4) Authorize payment for optional service components identified in the individual budget.

(5) Reallocate funds among services included in the budget. Every purchase of a good or service must be identified and approved in the individual budget before the purchase is made.

h. Delegation of budget authority. The member may delegate responsibility for the individual budget to a representative in addition to the independent support broker.

(1) The representative must be at least 18 years old.

(2) The representative shall not be a current provider of service to the member.

(3) The member shall sign a consent form that designates who the member has chosen as a representative and what responsibilities the representative shall have.

(4) The representative shall not be paid for this service.

i. Employer authority. The member shall have the authority to be the common-law employer of employees providing services and support under the consumer choices option. A common-law employer has the right to direct and control the performance of the services. The member may perform the following functions:

- (1) Recruit employees.
- (2) Select employees from a worker registry.
- (3) Verify employee qualifications.
- (4) Specify additional employee qualifications.
- (5) Determine employee duties.
- (6) Determine employee wages and benefits.
- (7) Schedule employees.
- (8) Train and supervise employees.

j. Employment agreement. Any person employed by the member to provide services under the consumer choices option shall sign an employment agreement with the member that outlines the employee's and member's responsibilities.

k. Responsibilities of the independent support broker. The independent support broker shall perform the following services as directed by the member or the member's representative:

- (1) Assist the member with developing the member's initial and subsequent individual budgets and with making any changes to the individual budget.
- (2) Have monthly contact with the member for the first four months of implementation of the initial individual budget and have quarterly contact thereafter.
- (3) Complete the required employment packet with the financial management service.
- (4) Assist with interviewing potential employees and entities providing services and supports if requested by the member.
- (5) Assist the member with determining whether a potential employee meets the qualifications necessary to perform the job.
- (6) Assist the member with obtaining a signed consent from a potential employee to conduct background checks if requested by the member.
- (7) Assist the member with negotiating with entities providing services and supports if requested by the member.
- (8) Assist the member with contracts and payment methods for services and supports if requested by the member.
- (9) Assist the member with developing an emergency backup plan. The emergency backup plan shall address any health and safety concerns.
- (10) Review expenditure reports from the financial management service to ensure that services and supports in the individual budget are being provided.
- (11) Document in writing on the independent support broker timecard every contact the broker has with the member. Contact documentation shall include information on the extent to which the member's individual budget has addressed the member's needs and the satisfaction of the member.

l. Responsibilities of the financial management service. The financial management service shall perform all of the following services:

- (1) Receive Medicaid funds in an electronic transfer.
- (2) Process and pay invoices for approved goods and services included in the individual budget.
- (3) Enter the individual budget into the web-based tracking system chosen by the department and enter expenditures as they are paid.
- (4) Provide real-time individual budget account balances for the member, the independent support broker, and the department, available at a minimum during normal business hours (9 a.m. to 5 p.m., Monday through Friday).
- (5) Conduct criminal background checks on potential employees pursuant to 441—Chapter 119.
- (6) Verify for the member an employee's citizenship or alien status.
- (7) Assist the member with fiscal and payroll-related responsibilities including, but not limited to:

1. Verifying that hourly wages comply with federal and state labor rules.
2. Collecting and processing timecards.
3. Withholding, filing, and paying federal, state and local income taxes, Medicare and Social Security (FICA) taxes, and federal (FUTA) and state (SUTA) unemployment and disability insurance taxes, as applicable.
4. Computing and processing other withholdings, as applicable.
5. Processing all judgments, garnishments, tax levies, or other withholding on an employee's pay as may be required by federal, state, or local laws.
6. Preparing and issuing employee payroll checks.
7. Preparing and disbursing IRS Forms W-2 and W-3 annually.
8. Processing federal advance earned income tax credit for eligible employees.
9. Refunding over-collected FICA, when appropriate.
10. Refunding over-collected FUTA, when appropriate.
- (8) Assist the member in completing required federal, state, and local tax and insurance forms.
- (9) Establish and manage documents and files for the member and the member's employees.
- (10) Monitor timecards, receipts, and invoices to ensure that they are consistent with the individual budget. Keep records of all timecards and invoices for each member for a total of five years.
- (11) Provide to the department, the independent support broker, and the member monthly and quarterly status reports that include a summary of expenditures paid and amount of budget unused.
- (12) Establish an accessible customer service system and a method of communication for the member and the independent support broker that includes alternative communication formats.
- (13) Establish a customer services complaint reporting system.
- (14) Develop a policy and procedures manual that is current with state and federal regulations and update as necessary.
- (15) Develop a business continuity plan in the case of emergencies and natural disasters.
- (16) Provide to the department an annual independent audit of the financial management service.
- (17) Assist in implementing the state's quality management strategy related to the financial management service.

78.41(16) General service standards. All intellectual disability waiver services must be provided in accordance with the following standards:

- a. Reimbursement shall not be available under the waiver for any services that the member can obtain as other nonwaiver Medicaid services or through any other funding source.
- b. All services provided under the waiver must be delivered in the least restrictive environment possible and in conformity with the member's service plan.
- c. All rights restrictions must be implemented in accordance with 441—subrule 77.25(4). The member service plan or treatment plan shall include documentation of:
 - (1) Any restrictions on the member's rights, including the rights of privacy, dignity, respect, and freedom from coercion and restraint.
 - (2) The need for the restriction.
 - (3) The less intrusive methods of meeting the need that have been tried but did not work.
 - (4) Either a plan to restore those rights or written documentation that a plan is not necessary or appropriate.
 - (5) Established time limits for periodic reviews to determine if the restriction is still necessary or can be terminated.
 - (6) The informed consent of the member.
 - (7) An assurance that the interventions and supports will cause no harm to the member.
 - (8) A regular collection and review of data to measure the ongoing effectiveness of the restriction.
- d. Services must be billed in whole units.
- e. For all services with a 15-minute unit of service, the following rounding process will apply:
 - (1) Add together the minutes spent on all billable activities during a calendar day for a daily total.
 - (2) For each day, divide the total minutes spent on billable activities by 15 to determine the number of full 15-minute units for that day.

(3) Round the remainder using these guidelines: Round 1 to 7 minutes down to zero units; round 8 to 14 minutes up to one unit.

(4) Add together the number of full units and the number of rounded units to determine the total number of units to bill for that day.

This rule is intended to implement Iowa Code section 249A.4.

[ARC 9045B, IAB 9/8/10, effective 11/1/10; ARC 9403B, IAB 3/9/11, effective 5/1/11 (See Delay note at end of chapter); ARC 9650B, IAB 8/10/11, effective 10/1/11; ARC 9704B, IAB 9/7/11, effective 9/1/11; ARC 9884B, IAB 11/30/11, effective 1/4/12; ARC 0707C, IAB 5/1/13, effective 7/1/13; ARC 0709C, IAB 5/1/13, effective 7/1/13; ARC 0842C, IAB 7/24/13, effective 7/1/13; ARC 1056C, IAB 10/2/13, effective 11/6/13; ARC 1071C, IAB 10/2/13, effective 10/1/13; ARC 1610C, IAB 9/3/14, effective 8/13/14; ARC 2050C, IAB 7/8/15, effective 7/1/15; ARC 2471C, IAB 3/30/16, effective 5/4/16; ARC 2848C, IAB 12/7/16, effective 11/15/16; ARC 2936C, IAB 2/1/17, effective 3/8/17; ARC 3481C, IAB 12/6/17, effective 12/1/17; ARC 3790C, IAB 5/9/18, effective 6/13/18; ARC 3874C, IAB 7/4/18, effective 8/8/18]

441—78.42(249A) Pharmacies administering influenza vaccine to children. Payment will be made to a pharmacy for the administration of influenza vaccine available through the Vaccines for Children (VFC) Program administered by the department of public health if the pharmacy is enrolled in the VFC program. Payment will be made for the vaccine only if the VFC program stock has been depleted.

This rule is intended to implement Iowa Code section 249A.4.

[ARC 9132B, IAB 10/6/10, effective 11/1/10; ARC 9316B, IAB 12/29/10, effective 2/2/11; ARC 0065C, IAB 4/4/12, effective 6/1/12]

441—78.43(249A) HCBS brain injury waiver services. Payment shall be approved for the following services to members eligible for the HCBS brain injury waiver services as established in 441—Chapter 83 and as identified in the member's service plan. Effective March 17, 2022, payment shall only be made for services provided in integrated, community-based settings that support full access of members receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.

78.43(1) Case management services. Individual case management services means services that assist members who reside in a community setting or are transitioning to a community setting in gaining access to needed medical, social, educational, housing, transportation, vocational, and other appropriate services in order to ensure the health, safety, and welfare of the member.

a. Case management services shall be provided as set forth in rules 441—90.5(249A) and 441—90.8(249A).

b. The service shall be delivered in such a way as to enhance the capabilities of consumers and their families to exercise their rights and responsibilities as citizens in the community. The goal is to enhance the ability of the consumer to exercise choice, make decisions, take risks that are a typical part of life, and fully participate as members of the community.

c. The case manager must develop a relationship with the consumer so that the abilities, needs and desires of the consumer can be clearly identified and communicated and the case manager can help to ensure that the system and specific services are responsive to the needs of the individual consumers.

d. Members who are eligible for targeted case management are not eligible for case management as a waiver service.

78.43(2) Supported community living services. Supported community living services are provided by the provider within the member's home and community, according to the individualized member need as identified in the service plan.

a. The basic components of the service may include, but are not limited to, personal and home skills training services, individual advocacy services, community skills training services, personal environment support services, transportation, and treatment services.

(1) Personal and home skills training services are activities which assist a member to develop or maintain skills for self-care, self-directedness, and care of the immediate environment.

(2) Individual advocacy is the act or process of representing the member's rights and interests in order to realize the rights to which the member is entitled and to remove barriers to meeting the member's needs.

(3) Community skills training services are activities which assist a member to develop or maintain skills allowing better participation in the community. Services shall focus on the following areas as they apply to the member being served:

1. Personal management skills training services are activities which assist a member to maintain or develop skills necessary to sustain the member in the physical environment and are essential to the management of the member's personal business and property. This includes self-advocacy skills. Examples of personal management skills are the ability to maintain a household budget, plan and prepare nutritional meals, use community resources such as public transportation and libraries, and select foods at the grocery store.

2. Socialization skills training services are activities which assist a member to develop or maintain skills which include self-awareness and self-control, social responsiveness, community participation, social amenities, and interpersonal skills.

3. Communication skills training services are activities which assist a member to develop or maintain skills including expressive and receptive skills in verbal and nonverbal language and the functional application of acquired reading and writing skills.

(4) Personal and environmental support services are those activities and expenditures provided to or on behalf of a member in the areas of personal needs in order to allow the member to function in the least restrictive environment.

(5) Transportation services are activities and expenditures designed to assist the member to travel from one place to another to obtain services or carry out life's activities. The services exclude transportation provided as nonemergency medical transportation pursuant to rule 441—78.13(249A).

(6) Treatment services are activities designed to assist the member to maintain or improve physiological, emotional and behavioral functioning and to prevent conditions that would present barriers to the member's functioning. Treatment services include physical or physiological treatment and psychotherapeutic treatment.

1. Physiological treatment includes medication regimens designed to prevent, halt, control, relieve, or reverse symptoms or conditions which interfere with the normal functioning of the human body. Physiological treatment shall be provided by or under the direct supervision of a certified or licensed health care professional.

2. Psychotherapeutic treatment means activities provided to assist a member in the identification or modification of beliefs, emotions, attitudes, or behaviors in order to maintain or improve the member's functioning in response to the physical, emotional, and social environment.

b. The supported community living services are intended to provide for the daily living needs of the member and shall be available as needed during any 24-hour period. Activities do not include those associated with vocational services, academics, day care, medical services, Medicaid case management or other case management. Services are individualized supportive services provided in a variety of community-based, integrated settings.

(1) Supported community living services shall be available at a daily rate to members living outside the home of their family, legal representative, or foster family and for whom a provider has primary responsibility for supervision or structure during the month. This service shall provide supervision or structure in identified periods when another resource is not available.

(2) Supported community living services shall be available at a 15-minute rate to members for whom a daily rate is not established.

c. Services may be provided to a child or an adult. Children must first access all other services for which they are eligible and which are appropriate to meet their needs before accessing the HCBS brain injury waiver services. A maximum of four persons may reside in a living unit.

(1) A member may live in the home of the member's family or legal representative or in another typical community living arrangement.

(2) A member living with the member's family or legal representative is not subject to the maximum of four residents in a living unit.

(3) A member may not live in a licensed medical or health care facility or in a setting that is required to be licensed as a medical or health care facility.

d. A member aged 17 or under living in the home of the member's family, legal representative, or foster family shall receive services based on development of adaptive, behavior, or health skills. Duration of services shall be based on age-appropriateness and individual attention span.

e. Provider budgets shall reflect all staff-to-member ratios and shall reflect costs associated with members' specific support needs for travel and transportation, consulting, instruction, and environmental modifications and repairs, as determined necessary by the interdisciplinary team for each member. The specific support needs must be identified in the Medicaid case manager's service plan, the total costs shall not exceed \$1570 per member per year, and the provider must maintain records to support the expenditures. A unit of service is:

(1) One full calendar day when a member residing in the living unit receives on-site staff supervision for eight or more hours per day as an average over a calendar month and the member's service plan identifies and reflects the need for this amount of supervision.

(2) Fifteen minutes when subparagraph 78.43(2)"e"(1) does not apply.

f. The maximum number of units available per member is as follows:

(1) 365 daily units per state fiscal year except a leap year, when 366 daily units are available.

(2) 33,580 15-minute units per state fiscal year except a leap year, when 33,672 15-minute units are available.

g. The service shall be identified in the member's service plan.

h. Supported community living services shall not be simultaneously reimbursed with other residential services or with respite, transportation, personal assistance, nursing, or home health aide services provided through Medicaid or the HCBS brain injury waiver.

78.43(3) Respite care services. Respite care services are services provided to the member that give temporary relief to the usual caregiver and provide all the necessary care that the usual caregiver would provide during that period. The purpose of respite care is to enable the member to remain in the member's current living situation.

a. Services provided outside the member's home shall not be reimbursable if the living unit where respite is provided is reserved for another person on a temporary leave of absence.

b. Member-to-staff ratios shall be appropriate to the individual needs of the member as determined by the member's interdisciplinary team.

c. A unit of service is 15 minutes.

d. Respite care is not to be provided to members during the hours in which the usual caregiver is employed except when the member is attending a 24-hour residential camp. Respite care shall not be used as a substitute for a child's day care. Respite care cannot be provided to a member whose usual caregiver is a consumer-directed attendant care provider for the member.

e. The interdisciplinary team shall determine if the member will receive basic individual respite, specialized respite or group respite as defined in 441—Chapter 83.

f. A maximum of 14 consecutive days of 24-hour respite care may be reimbursed.

g. Respite services provided for a period exceeding 24 consecutive hours to three or more individuals who require nursing care because of a mental or physical condition must be provided by a health care facility licensed as described in Iowa Code chapter 135C.

h. Respite services shall not be provided simultaneously with other residential, supported community living services, nursing, or home health aide services provided through the medical assistance program.

78.43(4) Supported employment services. Supported employment services are service activities provided pursuant to subrule 78.27(10).

78.43(5) Home and vehicle modification. Covered home or vehicle modifications are physical modifications to the member's home or vehicle that directly address the member's medical or remedial need. Covered modifications must be necessary to provide for the health, welfare, or safety of the member and enable the member to function with greater independence in the home or vehicle.

a. Modifications that are necessary or desirable without regard to the member's medical or remedial need and that would be expected to increase the fair market value of the home or vehicle, such as furnaces, fencing, or adding square footage to the residence, are excluded except as specifically

included below. Purchasing or leasing of a motorized vehicle is excluded. Home and vehicle repairs are also excluded.

b. Only the following modifications are covered:

- (1) Kitchen counters, sink space, cabinets, special adaptations to refrigerators, stoves, and ovens.
- (2) Bathtubs and toilets to accommodate transfer, special handles and hoses for shower heads, water faucet controls, and accessible showers and sink areas.
- (3) Grab bars and handrails.
- (4) Turnaround space adaptations.
- (5) Ramps, lifts, and door, hall and window widening.
- (6) Fire safety alarm equipment specific for disability.
- (7) Voice-activated, sound-activated, light-activated, motion-activated, and electronic devices directly related to the member's disability.
- (8) Vehicle lifts, driver-specific adaptations, remote-start systems, including such modifications already installed in a vehicle.
- (9) Keyless entry systems.
- (10) Automatic opening device for home or vehicle door.
- (11) Special door and window locks.
- (12) Specialized doorknobs and handles.
- (13) Plexiglas replacement for glass windows.
- (14) Modification of existing stairs to widen, lower, raise or enclose open stairs.
- (15) Motion detectors.
- (16) Low-pile carpeting or slip-resistant flooring.
- (17) Telecommunications device for the deaf.
- (18) Exterior hard-surface pathways.
- (19) New door opening.
- (20) Pocket doors.
- (21) Installation or relocation of controls, outlets, switches.
- (22) Air conditioning and air filtering if medically necessary.
- (23) Heightening of existing garage door opening to accommodate modified van.
- (24) Bath chairs.

c. A unit of service is the completion of needed modifications or adaptations.

d. All modifications and adaptations shall be provided in accordance with applicable federal, state, and local building and vehicle codes.

e. Services shall be performed following prior department approval of the modification as specified in 441—subrule 79.1(17) and a binding contract between the provider and the member.

f. All contracts for home or vehicle modification shall be awarded through competitive bidding. The contract shall include the scope of work to be performed, the time involved, supplies needed, the cost, diagrams of the project whenever applicable, and an assurance that the provider has liability and workers' compensation coverage and the applicable permit and license.

g. Service payment shall be made to the enrolled home or vehicle modification provider. If applicable, payment will be forwarded to the subcontracting agency by the enrolled home or vehicle modification provider following completion of the approved modifications. Payment of up to \$6,366.64 per year may be made to certified providers upon satisfactory completion of the service.

h. Services shall be included in the member's service plan and shall exceed the Medicaid state plan services.

78.43(6) *Personal emergency response or portable locator system.*

a. A personal emergency response system is an electronic device that transmits a signal to a central monitoring station to summon assistance in the event of an emergency.

- (1) The necessary components of a system are:
 1. An in-home medical communications transceiver.
 2. A remote, portable activator.
 3. A central monitoring station with backup systems staffed by trained attendants at all times.

4. Current data files at the central monitoring station containing response protocols and personal, medical and emergency information for each member.

(2) The service shall be identified in the member's service plan.

(3) A unit is a one-time installation fee or one month of service.

(4) Maximum units per state fiscal year shall be the initial installation and 12 months of service.

b. A portable locator system is an electronic device that transmits a signal to a monitoring device. The system allows a member to access assistance in the event of an emergency and allows law enforcement or the monitoring system provider to locate a member who is unable to request help or to activate a system independently. The member must be unable to access assistance in an emergency situation due to the member's age or disability.

(1) The required components of the portable locator system are:

1. A portable communications transceiver or transmitter to be worn or carried by the member.

2. Monitoring by the provider at a central location with response protocols and personal, medical, and emergency information for each member as applicable.

(2) The service shall be identified in the member's service plan.

(3) Payable units of service are purchase of equipment, an installation or set-up fee, and monthly fees.

(4) Maximum units per state fiscal year shall be one equipment purchase, one installation or set-up fee, and 12 months of service.

78.43(7) *Transportation.* Transportation services may be provided for members to conduct business errands and essential shopping, to travel to and from work or day programs, and to reduce social isolation. A unit of service is one mile of transportation or one one-way trip. Transportation may not be reimbursed simultaneously with HCBS brain injury waiver supported community living service when the transportation costs are included within the supported community living reimbursement rate.

78.43(8) *Specialized medical equipment.*

a. Specialized medical equipment shall include medically necessary items which are for personal use by members with a brain injury and which:

(1) Provide for health and safety of the member,

(2) Are not ordinarily covered by Medicaid,

(3) Are not funded by educational or vocational rehabilitation programs, and

(4) Are not provided by voluntary means.

b. Coverage includes, but is not limited to:

(1) Electronic aids and organizers.

(2) Medicine dispensing devices.

(3) Communication devices.

(4) Bath aids.

(5) Noncovered environmental control units.

(6) Repair and maintenance of items purchased through the waiver.

c. Payment of up to \$6,366.64 per year may be made to enrolled specialized medical equipment providers upon satisfactory receipt of the service. Each month within the 12-month period, the service worker shall encumber an amount within the monthly dollar cap allowed for the member until the amount of the equipment cost is reached.

d. The need for specialized medical equipment shall be:

(1) Documented by a health care professional as necessary for the member's health and safety, and

(2) Identified in the member's service plan.

e. Payment for most items shall be based on a fee schedule. The amount of the fee shall be determined as directed in 441—subrule 79.1(17).

78.43(9) *Adult day care services.* Adult day care services provide an organized program of supportive care in a group environment to persons who need a degree of supervision and assistance on a regular or intermittent basis in a day care center. A unit of service is 15 minutes (up to four units per day), a half day (1.25 to 4 hours per day), a full day (4.25 to 8 hours per day), or an extended day (8.25

to 12 hours per day). Components of the service include health-related care, social services, and other related support services.

78.43(10) *Family counseling and training services.* Family counseling and training services are face-to-face mental health services provided to the consumer and the family with whom the consumer lives, or who routinely provide care to the consumer to increase the consumer's or family members' capabilities to maintain and care for the consumer in the community. Counseling may include helping the consumer or the consumer's family members with crisis, coping strategies, stress reduction, management of depression, alleviation of psychosocial isolation and support in coping with the effects of a brain injury. It may include the use of treatment regimes as specified in the ITP. Periodic training updates may be necessary to safely maintain the consumer in the community.

Family may include spouse, children, friends, or in-laws of the consumer. Family does not include individuals who are employed to care for the consumer.

78.43(11) *Prevocational services.* Prevocational services are service activities provided pursuant to subrule 78.27(9).

78.43(12) *Behavioral programming.* Behavioral programming consists of individually designed strategies to increase the consumer's appropriate behaviors and decrease the consumer's maladaptive behaviors which have interfered with the consumer's ability to remain in the community. Behavioral programming includes:

- a. A complete assessment of both appropriate and maladaptive behaviors.
- b. Development of a structured behavioral intervention plan which should be identified in the ITP.
- c. Implementation of the behavioral intervention plan.
- d. Ongoing training and supervision to caregivers and behavioral aides.
- e. Periodic reassessment of the plan.

Types of appropriate behavioral programming include, but are not limited to, clinical redirection, token economies, reinforcement, extinction, modeling, and over-learning.

78.43(13) *Consumer-directed attendant care service.* Consumer-directed attendant care services are service activities performed by a person to help a member with self-care tasks which the member would typically do independently if the member were otherwise able. Covered service activities are limited to the nonskilled activities listed in paragraph 78.43(13) "f" and the skilled activities listed in paragraph 78.43(13) "g." Covered service activities must be essential to the health, safety, and welfare of the member. Services may be provided in the absence of a parent or guardian if the parent or guardian has given advance direction for the service provision.

a. *Service planning.*

(1) The member, parent, guardian, or attorney in fact under a durable power of attorney for health care shall:

1. Select the individual or agency that will provide the components of the attendant care services.
2. Determine with the selected provider what components of attendant care services the provider shall perform, subject to confirmation by the service worker or case manager that those components are consistent with the assessment and are authorized covered services.

3. Complete, sign, and date Form 470-3372, HCBS Consumer-Directed Attendant Care Agreement, to indicate the frequency, scope, and duration of services (a description of each service component and the time agreed on for that component). The case manager or service worker and provider shall also sign the agreement.

4. Submit the completed agreement to the service worker or case manager. The agreement shall be part of the member's service plan and shall be kept in the member's records, in the provider's records, and in the service worker's or case manager's records. Any service component that is not listed in the agreement shall not be payable.

(2) Whenever a legal representative acts as a provider of consumer-directed attendant care as allowed by 441—paragraph 79.9(7) "b," the following shall apply:

1. The payment rate for the legal representative must be based on the skill level of the legal representative and may not exceed the median statewide reimbursement rate for the service unless the higher rate receives prior approval from the department;

2. The legal representative may not be paid for more than 40 hours of service per week; and
3. A contingency plan must be established in the member's service plan to ensure service delivery in the event the legal representative is unable to provide services due to illness or other unexpected event.

b. Supervision of skilled services. Skilled consumer-directed attendant care services shall be provided under the supervision of a licensed nurse or licensed therapist working under the direction of a physician. The licensed nurse or therapist shall:

- (1) Retain accountability for actions that are delegated.
- (2) Ensure appropriate assessment, planning, implementation, and evaluation.
- (3) Make on-site supervisory visits every two weeks with the service provider present.

c. Service documentation. The consumer-directed attendant care provider must complete Form 470-4389, Consumer-Directed Attendant Care (CDAC) Service Record, for each day of service. Any service component that is not documented in accordance with rule 441—79.3(249A) shall not be payable.

d. Role of guardian or attorney. If the member has a guardian or attorney in fact under a durable power of attorney for health care:

(1) The service worker's or case manager's service plan shall address how consumer-directed attendant care services will be monitored to ensure that the member's needs are being adequately met. If the guardian or attorney in fact is the service provider, the service plan shall address how the service worker or case manager shall oversee service provision.

(2) The guardian or attorney in fact shall sign the claim form in place of the member, indicating that the service has been provided as presented on the claim.

e. Service units and billing. A unit of service is 15 minutes provided by an individual or agency. Each service shall be billed in whole units.

f. Nonskilled services. Covered nonskilled service activities are limited to help with the following activities:

- (1) Dressing.
- (2) Bathing, shampooing, hygiene, and grooming.
- (3) Access to and from bed or a wheelchair, transferring, ambulation, and mobility in general.
- (4) Toileting, including bowel, bladder, and catheter assistance (emptying the catheter bag, collecting a specimen, and cleaning the external area around the catheter).
- (5) Meal preparation, cooking, and assistance with feeding, not including the cost of meals themselves. Meal preparation and cooking shall be provided only in the member's home.
- (6) Housekeeping, laundry, and shopping essential to the member's health care at home.
- (7) Taking medications ordinarily self-administered, including those ordered by a physician or other qualified health care provider.
- (8) Minor wound care.
- (9) Going to or returning from a place of employment and job-related tasks while the member is on the job site. Transportation for the member and assistance with understanding or performing the essential job functions are not included in consumer-directed attendant care services.
- (10) Tasks, such as financial management and scheduling, that require cognitive or physical assistance.
- (11) Communication essential to the health and welfare of the member, through interpreting and reading services and use of assistive devices for communication.
- (12) Using transportation essential to the health and welfare of the member. The cost of the transportation is not included.

g. Skilled services. Covered skilled service activities are limited to help with the following activities:

- (1) Tube feedings of members unable to eat solid foods.
- (2) Intravenous therapy administered by a registered nurse.
- (3) Parenteral injections required more than once a week.
- (4) Catheterizations, continuing care of indwelling catheters with supervision of irrigations, and changing of Foley catheters when required.

(5) Respiratory care including inhalation therapy and tracheotomy care or tracheotomy care and ventilator.

(6) Care of decubiti and other ulcerated areas, noting and reporting to the nurse or therapist.

(7) Rehabilitation services including, but not limited to, bowel and bladder training, range of motion exercises, ambulation training, restorative nursing services, respiratory care and breathing programs, reality orientation, reminiscing therapy, remotivation, behavior modification, and reteaching of the activities of daily living.

(8) Colostomy care.

(9) Care of uncontrolled medical conditions, such as brittle diabetes, and comfort care of terminal conditions.

(10) Postsurgical nursing care.

(11) Monitoring medications requiring close supervision because of fluctuating physical or psychological conditions, e.g., antihypertensives, digitalis preparations, mood-altering or psychotropic drugs, or narcotics.

(12) Preparing and monitoring response to therapeutic diets.

(13) Recording and reporting of changes in vital signs to the nurse or therapist.

h. Excluded services and costs. Services, activities, costs and time that are not covered as consumer-directed attendant care include the following (not an exclusive list):

(1) Any activity related to supervising a member. Only direct services are billable.

(2) Any activity that the member is able to perform.

(3) Costs of food.

(4) Costs for the supervision of skilled services by the nurse or therapist. The supervising nurse or therapist may be paid from private insurance, Medicare, or other third-party payment sources, or may be paid as another Medicaid service, including early and periodic screening, diagnosis and treatment services.

(5) Exercise that does not require skilled services.

(6) Parenting or child care for or on behalf of the member.

(7) Reminders and cueing.

(8) Services provided simultaneously with any other similar service regardless of funding source, including other waiver services and state supplementary assistance in-home health-related care services.

(9) Transportation costs.

(10) Wait times for any activity.

78.43(14) Interim medical monitoring and treatment services. Interim medical monitoring and treatment (IMMT) services are monitoring and treatment of a medical nature for children or adults whose medical needs make alternative care unavailable, inadequate, or insufficient. IMMT services are not intended to provide day care but to supplement available resources. Services must be ordered by a physician.

a. Need for service. The member must be currently receiving home health agency services under rule 441—78.9(249A) and require medical assessment, medical monitoring, and regular medical intervention or intervention in a medical emergency during those services. The service worker or case manager must identify the need for IMMT services after evaluating the member's living environment, family and natural supports, ability to perform activities of daily living, and health care needs. The services must be needed:

(1) To allow the member's usual caregivers to be employed,

(2) During a search for employment by a usual caregiver,

(3) To allow for academic or vocational training of a usual caregiver,

(4) Due to the hospitalization of a usual caregiver for treatment for physical or mental illness, or

(5) Due to the death of a usual caregiver.

b. Service requirements. Interim medical monitoring and treatment services shall:

(1) Provide experiences for each member's social, emotional, intellectual, and physical development;

(2) Include comprehensive developmental care and any special services for a member with special needs; and

(3) Include medical assessment, medical monitoring, and medical intervention as needed on a regular or emergency basis. Medical intervention means the ability to assess the situation and contact the appropriate medical professional, not the direct application of medical care.

c. Interim medical monitoring and treatment services may include supervision while the member is being transported to and from school.

d. Limitations.

(1) A maximum of 12 hours of service is available per day.

(2) Covered services do not include a complete nutritional regimen.

(3) Interim medical monitoring and treatment services may not duplicate any regular Medicaid or waiver services provided under the state plan. Services under the state plan, including home health agency services under rule 441—78.9(249A), must be exhausted before IMMT services are accessed.

(4) Interim medical monitoring and treatment services shall be provided in the following settings that are approved by the department as integrated, community-based settings: the member's home; a registered child development home; a licensed child care center, residential care facility, or adult day care facility; or during the time when the member is being transported to and from school.

(5) The member-to-staff ratio shall not be more than six members to one staff person.

(6) The parent or guardian of the member shall be responsible for the usual and customary nonmedical cost of day care during the time in which the member is receiving IMMT services. Medical care necessary for monitoring and treatment is an allowable IMMT cost. If the cost of care goes above the usual and customary cost of day care services due to the member's medical condition, the costs above the usual and customary cost shall be covered as IMMT services.

e. A unit of service is 15 minutes.

78.43(15) Consumer choices option. The consumer choices option provides a member with a flexible monthly individual budget that is based on the member's service needs. With the individual budget, the member shall have the authority to purchase goods and services to meet the member's assessed needs and may choose to employ providers of services and supports. The services, supports, and items that are purchased with an individual budget must be directly related to a member's assessed need or goal established in the member's service plan. Components of this service are set forth below.

a. *Agreement.* As a condition of participating in the consumer choices option, a member shall sign Form 470-4289, HCBS Consumer Choices Informed Consent and Risk Agreement, to document that the member has been informed of the responsibilities and risks of electing the consumer choices option.

b. *Individual budget amount.* A monthly individual budget amount shall be established for each member based on the assessed needs of the member and based on the services and supports authorized in the member's service plan. The member shall be informed of the individual budget amount during the development of the service plan.

(1) Services that may be included in determining the individual budget amount for a member in the HCBS brain injury waiver are:

1. Consumer-directed attendant care (unskilled).

2. Day habilitation.

3. Home and vehicle modification.

4. Prevocational services.

5. Basic individual respite care.

6. Specialized medical equipment.

7. Supported community living.

8. Supported employment.

9. Transportation.

(2) The department shall determine an average unit cost for each service listed in subparagraph 78.43(15) "b"(1) based on actual unit costs from the previous fiscal year plus a cost-of-living adjustment.

(3) In aggregate, costs for individual budget services shall not exceed the current costs of waiver program services. In order to maintain cost neutrality, the department shall apply a utilization adjustment

factor to the amount of service authorized in the member's service plan before calculating the value of that service to be included in the individual budget amount.

(4) The department shall compute the utilization adjustment factor for each service by dividing the net costs of all claims paid for the service by the total of the authorized costs for that service, using at least 12 consecutive months of aggregate service data. The utilization adjustment factor shall be no lower than 60 percent. The department shall analyze and adjust the utilization adjustment factor at least annually in order to maintain cost neutrality.

(5) Individual budgets for respite services shall be computed based on the average cost for services identified in subparagraph 78.43(15) "b"(2). Respite services are not subject to the utilization adjustment factor in subparagraph 78.43(15) "b"(3).

(6) Anticipated costs for home and vehicle modification, specialized medical equipment, and supported employment services to obtain a job are not subject to the average cost in subparagraph 78.43(15) "b"(2) or the utilization adjustment factor in subparagraph 78.43(15) "b"(3). Anticipated costs for these services shall not include the costs of the financial management services or the independent support broker. Before becoming part of the individual budget, all home and vehicle modifications, specialized medical equipment, and supported employment services to obtain a job shall be identified in the member's service plan and approved by the case manager or service worker. Costs for these services may be paid to the financial management services provider in a one-time payment.

(7) The individual budget amount may be changed only at the first of the month and shall remain fixed for the entire month.

c. Required service components. To participate in the consumer choices option, a member must hire an independent support broker and must work with a financial management service that is enrolled as a Medicaid provider. Before hiring the independent support broker, the member shall receive the results of the background check conducted pursuant to 441—Chapter 119.

d. Optional service components. A member who elects the consumer choices option may purchase the following goods, services and supports, which shall be provided in the member's home or at an integrated community setting:

(1) Self-directed personal care services. Self-directed personal care services are services or goods that provide a range of assistance in activities of daily living and incidental activities of daily living that help the member remain in the home and community. These services must be identified in the member's service plan developed by the member's case manager or service worker.

(2) Self-directed community supports and employment. Self-directed community supports and employment are services that support the member in developing and maintaining independence and community integration. These services must be identified in the member's service plan developed by the member's case manager or service worker.

(3) Individual-directed goods and services. Individual-directed goods and services are services, equipment, or supplies not otherwise provided through the Medicaid program that address an assessed need or goal identified in the member's service plan. The item or service shall meet the following requirements:

1. Promote opportunities for community living and inclusion.
2. Increase independence or substitute for human assistance, to the extent the expenditures would otherwise be made for that human assistance.
3. Be accommodated within the member's budget without compromising the member's health and safety.
4. Be provided to the member or directed exclusively toward the benefit of the member.
5. Be the least costly to meet the member's needs.
6. Not be available through another source.

e. Development of the individual budget. The independent support broker shall assist the member in developing and implementing the member's individual budget. The individual budget shall include:

- (1) The costs of the financial management service.
- (2) The costs of the independent support broker. The independent support broker may be compensated for up to 6 hours of service for assisting with the implementation of the initial individual

budget. The independent support broker shall not be paid for more than 30 hours of service for an individual member during a 12-month period without prior approval by the department.

(3) The costs of any optional service component chosen by the member as described in paragraph 78.43(15)“d.” Costs of the following items and services shall not be covered by the individual budget:

1. Child care services.
2. Clothing not related to an assessed medical need.
3. Conference, meeting or similar venue expenses other than the costs of approved services the member needs while attending the conference, meeting or similar venue.
4. Costs associated with shipping items to the member.
5. Experimental and non-FDA-approved medications, therapies, or treatments.
6. Goods or services covered by other Medicaid programs.
7. Home furnishings.
8. Home repairs or home maintenance.
9. Homeopathic treatments.
10. Insurance premiums or copayments.
11. Items purchased on installment payments.
12. Motorized vehicles.
13. Nutritional supplements.
14. Personal entertainment items.
15. Repairs and maintenance of motor vehicles.
16. Room and board, including rent or mortgage payments.
17. School tuition.
18. Service animals.
19. Services covered by third parties or services that are the responsibility of a non-Medicaid program.
20. Sheltered workshop services.
21. Social or recreational purchases not related to an assessed need or goal identified in the member’s service plan.
22. Vacation expenses, other than the costs of approved services the member needs while on vacation.

(4) The costs of any approved home or vehicle modification or specialized medical equipment. When authorized, the budget may include an amount allocated for a home or vehicle modification or specialized medical equipment. Before becoming part of the individual budget, all home and vehicle modifications and specialized medical equipment shall be identified in the member’s service plan and approved by the case manager or service worker. The authorized amount shall not be used for anything other than the specific modification or equipment.

(5) Any amount set aside in a savings plan to reserve funds for the future purchase of self-directed personal care, individual-directed goods and services, or self-directed community supports and services as defined in paragraph 78.43(15)“d.” The savings plan shall meet the requirements in paragraph 78.43(15)“f.”

f. Savings plan. A member savings plan must be in writing and be approved by the department before the start of the savings plan. Amounts allocated to the savings plan must result from efficiencies in meeting identified needs of the member.

- (1) The savings plan shall identify:
 1. The specific goods, services, supports or supplies to be purchased through the savings plan.
 2. The amount of the individual budget allocated each month to the savings plan.
 3. The amount of the individual budget allocated each month to meet the member’s identified service needs.
 4. How the member’s assessed needs will continue to be met through the individual budget when funds are placed in savings.
- (2) With the exception of funds allocated for respite care, the savings plan shall not include funds budgeted for direct services that were not received. The budgeted amount associated with unused direct

services other than respite care shall revert to the Medicaid program at the end of each month. Funds from unused respite services may be allocated to the savings plan but shall not be used for anything other than future respite care.

(3) Funds accumulated under a savings plan shall be used only to purchase items that increase independence or substitute for human assistance to the extent that expenditures would otherwise be made for human assistance, including additional goods, supports, services or supplies. The self-directed personal care, individual-directed goods and services, or self-directed community supports and services purchased with funds from a savings plan must:

1. Be used to meet a member's identified need,
2. Be medically necessary, and
3. Be approved by the member's case manager or service worker.

(4) All funds allocated to a savings plan that are not expended by December 31 of each year shall revert to the Medicaid program.

(5) The annual reassessment of a member's needs must take into account the purchases of goods and services that substitute for human assistance. Adjustments shall be made to the services used to determine the individual budget based on the reassessment.

g. Budget authority. The member shall have authority over the individual budget authorized by the department to perform the following tasks:

(1) Contract with entities to provide services and supports as described in this subrule.

(2) Determine the amount to be paid for services. Reimbursement rates shall be consistent with rates paid by others in the community for the same or substantially similar services. Reimbursement rates for the independent support broker and the financial management service are subject to the limits in 441—subrule 79.1(2). The reimbursement rate for a member's legal representative who provides services to the member as allowed by 441—paragraph 79.9(7) "b" 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.

(3) Schedule the provision of services. Whenever a member's legal representative provides services to the member as allowed by 441—paragraph 79.9(7) "b," the legal representative may not be paid for more than 40 hours of service per week and 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.

(4) Authorize payment for optional service components identified in the individual budget.

(5) Reallocate funds among services included in the budget. Every purchase of a good or service must be identified and approved in the individual budget before the purchase is made.

h. Delegation of budget authority. The member may delegate responsibility for the individual budget to a representative in addition to the independent support broker.

(1) The representative must be at least 18 years old.

(2) The representative shall not be a current provider of service to the member.

(3) The member shall sign a consent form that designates who the member has chosen as a representative and what responsibilities the representative shall have.

(4) The representative shall not be paid for this service.

i. Employer authority. The member shall have the authority to be the common-law employer of employees providing services and support under the consumer choices option. A common-law employer has the right to direct and control the performance of the services. The member may perform the following functions:

(1) Recruit employees.

(2) Select employees from a worker registry.

(3) Verify employee qualifications.

(4) Specify additional employee qualifications.

(5) Determine employee duties.

(6) Determine employee wages and benefits.

(7) Schedule employees.

(8) Train and supervise employees.

j. Employment agreement. Any person employed by the member to provide services under the consumer choices option shall sign an employment agreement with the member that outlines the employee's and member's responsibilities.

k. Responsibilities of the independent support broker. The independent support broker shall perform the following services as directed by the member or the member's representative:

(1) Assist the member with developing the member's initial and subsequent individual budgets and with making any changes to the individual budget.

(2) Have monthly contact with the member for the first four months of implementation of the initial individual budget and have quarterly contact thereafter.

(3) Complete the required employment packet with the financial management service.

(4) Assist with interviewing potential employees and entities providing services and supports if requested by the member.

(5) Assist the member with determining whether a potential employee meets the qualifications necessary to perform the job.

(6) Assist the member with obtaining a signed consent from a potential employee to conduct background checks if requested by the member.

(7) Assist the member with negotiating with entities providing services and supports if requested by the member.

(8) Assist the member with contracts and payment methods for services and supports if requested by the member.

(9) Assist the member with developing an emergency backup plan. The emergency backup plan shall address any health and safety concerns.

(10) Review expenditure reports from the financial management service to ensure that services and supports in the individual budget are being provided.

(11) Document in writing on the independent support broker timecard every contact the broker has with the member. Contact documentation shall include information on the extent to which the member's individual budget has addressed the member's needs and the satisfaction of the member.

l. Responsibilities of the financial management service. The financial management service shall perform all of the following services:

(1) Receive Medicaid funds in an electronic transfer.

(2) Process and pay invoices for approved goods and services included in the individual budget.

(3) Enter the individual budget into the web-based tracking system chosen by the department and enter expenditures as they are paid.

(4) Provide real-time individual budget account balances for the member, the independent support broker, and the department, available at a minimum during normal business hours (9 a.m. to 5 p.m., Monday through Friday).

(5) Conduct criminal background checks on potential employees pursuant to 441—Chapter 119.

(6) Verify for the member an employee's citizenship or alien status.

(7) Assist the member with fiscal and payroll-related responsibilities including, but not limited to:

1. Verifying that hourly wages comply with federal and state labor rules.

2. Collecting and processing timecards.

3. Withholding, filing, and paying federal, state and local income taxes, Medicare and Social Security (FICA) taxes, and federal (FUTA) and state (SUTA) unemployment and disability insurance taxes, as applicable.

4. Computing and processing other withholdings, as applicable.

5. Processing all judgments, garnishments, tax levies, or other withholding on an employee's pay as may be required by federal, state, or local laws.

6. Preparing and issuing employee payroll checks.

7. Preparing and disbursing IRS Forms W-2 and W-3 annually.

8. Processing federal advance earned income tax credit for eligible employees.

9. Refunding over-collected FICA, when appropriate.

10. Refunding over-collected FUTA, when appropriate.
- (8) Assist the member in completing required federal, state, and local tax and insurance forms.
- (9) Establish and manage documents and files for the member and the member's employees.
- (10) Monitor timecards, receipts, and invoices to ensure that they are consistent with the individual budget. Keep records of all timecards and invoices for each member for a total of five years.
- (11) Provide to the department, the independent support broker, and the member monthly and quarterly status reports that include a summary of expenditures paid and amount of budget unused.
- (12) Establish an accessible customer service system and a method of communication for the member and the independent support broker that includes alternative communication formats.
- (13) Establish a customer services complaint reporting system.
- (14) Develop a policy and procedures manual that is current with state and federal regulations and update as necessary.
- (15) Develop a business continuity plan in the case of emergencies and natural disasters.
- (16) Provide to the department an annual independent audit of the financial management service.
- (17) Assist in implementing the state's quality management strategy related to the financial management service.

78.43(16) General service standards. All brain injury waiver services must be provided in accordance with the following standards:

- a. Reimbursement shall not be available under the waiver for any services that the member can obtain as other nonwaiver Medicaid services or through any other funding source.
- b. All services provided under the waiver must be delivered in the least restrictive environment possible and in conformity with the member's service plan.
- c. All rights restrictions must be implemented in accordance with 441—subrule 77.25(4). The member service plan or treatment plan shall include documentation of:
 - (1) Any restrictions on the member's rights, including the rights of privacy, dignity, respect, and freedom from coercion and restraint.
 - (2) The need for the restriction.
 - (3) The less intrusive methods of meeting the need that have been tried but did not work.
 - (4) Either a plan to restore those rights or written documentation that a plan is not necessary or appropriate.
 - (5) Established time limits for periodic reviews to determine if the restriction is still necessary or can be terminated.
 - (6) The informed consent of the member.
 - (7) An assurance that the interventions and supports will cause no harm to the member.
 - (8) A regular collection and review of data to measure the ongoing effectiveness of the restriction.
- d. Services must be billed in whole units.
- e. For all services with a 15-minute unit of service, the following rounding process will apply:
 - (1) Add together the minutes spent on all billable activities during a calendar day for a daily total.
 - (2) For each day, divide the total minutes spent on billable activities by 15 to determine the number of full 15-minute units for that day.
 - (3) Round the remainder using these guidelines: Round 1 to 7 minutes down to zero units; round 8 to 14 minutes up to one unit.
 - (4) Add together the number of full units and the number of rounded units to determine the total number of units to bill for that day.

This rule is intended to implement Iowa Code section 249A.4.

[**ARC 7957B**, IAB 7/15/09, effective 7/1/09; **ARC 9045B**, IAB 9/8/10, effective 11/1/10; **ARC 9403B**, IAB 3/9/11, effective 5/1/11 (See Delay note at end of chapter); **ARC 9704B**, IAB 9/7/11, effective 9/1/11; **ARC 9884B**, IAB 11/30/11, effective 1/4/12; **ARC 0191C**, IAB 7/11/12, effective 7/1/12; **ARC 0359C**, IAB 10/3/12, effective 12/1/12; **ARC 0707C**, IAB 5/1/13, effective 7/1/13; **ARC 0709C**, IAB 5/1/13, effective 7/1/13; **ARC 0842C**, IAB 7/24/13, effective 7/1/13; **ARC 1056C**, IAB 10/2/13, effective 11/6/13; **ARC 1071C**, IAB 10/2/13, effective 10/1/13; **ARC 1610C**, IAB 9/3/14, effective 8/13/14; **ARC 2050C**, IAB 7/8/15, effective 7/1/15; **ARC 2471C**, IAB 3/30/16, effective 5/4/16; **ARC 2848C**, IAB 12/7/16, effective 11/15/16; **ARC 2936C**, IAB 2/1/17, effective 3/8/17; **ARC 3874C**, IAB 7/4/18, effective 8/8/18]

441—78.44(249A) Lead inspection services. Payment shall be approved for lead inspection services. This service shall be provided for children who have had two venous blood lead levels of 15 to 19 micrograms per deciliter or one venous level greater than or equal to 20 micrograms per deciliter. This service includes, but is not limited to, X-ray fluorescence analyzer (XRF) readings, visual examination of paint, preventive education of the resident and homeowner, health education about lead poisoning, and a written report to the family, homeowner, medical provider, and local childhood lead poisoning prevention program.

This rule is intended to implement Iowa Code section 249A.4.

441—78.45(249A) Assertive community treatment. Assertive community treatment (ACT) services are comprehensive, integrated, and intensive outpatient services provided by a multidisciplinary team under the supervision of a psychiatrist. ACT services are directed toward the rehabilitation of behavioral, social, or emotional deficits or the amelioration of symptoms of a mental disorder. Most services are delivered in the member's home or another community setting.

78.45(1) Applicability. ACT services may be provided only to a member who meets all of the following criteria:

a. The member is at least 17 years old.
b. The member has a severe and persistent mental illness or complex mental health symptomatology. A severe and persistent mental illness is a psychiatric disorder that causes symptoms and impairments in basic mental and behavioral processes that produce distress and major functional disability in adult role functioning (such as social, personal, family, educational or vocational roles). Specifically, the member has a degree of impairment arising from a psychiatric disorder such that:

(1) The member does not have the resources or skills necessary to maintain an adequate level of functioning in the home or community environment without assistance or support;

(2) The member's judgment, impulse control, or cognitive perceptual abilities are compromised; and

(3) The member exhibits significant impairment in social, interpersonal, or familial functioning.

c. The member has a validated principal mental health diagnosis consistent with a severe and persistent mental illness. For this purpose, a mental health diagnosis means a disorder, dysfunction, or dysphoria diagnosed pursuant to the current version of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association, excluding neurodevelopmental disorders, substance-related disorders, personality disorders, medication-induced movement disorders and other adverse effects of medication, and other conditions that may be a focus of clinical attention. Members with a primary diagnosis of substance-related disorder, developmental disability, or organic disorder are not eligible for ACT services.

d. The member needs a consistent team of professionals and multiple mental health and support services to maintain the member in the community and reduce hospitalizations, as evidenced by:

(1) A pattern of repeated treatment failures with at least two hospitalizations within the previous 24 months, or

(2) A need for multiple or combined mental health and basic living supports to prevent the need for a more intrusive level of care.

e. The member presents a reasonable likelihood that ACT services will lead to specific, observable improvements in the member's functioning and assist the member in achieving or maintaining community tenure. Specifically, the member:

(1) Is medically stable;

(2) Does not require a level of care that includes more intensive medical monitoring;

(3) Presents a low risk to self, others, or property, with treatment and support; and

(4) Lives independently in the community or demonstrates a capacity to live independently and move from a dependent residential setting to independent living.

f. At the time of admission, the member has a comprehensive assessment that includes psychiatric history, medical history, work and educational history, substance use, problems with activities of daily living, social interests, and family relationships.

g. The member has a written treatment plan containing a work evaluation and the necessary psychiatric rehabilitation treatment and support services. The plan shall identify:

- (1) Treatment objectives and outcomes,
- (2) The expected frequency and duration of each service,
- (3) The location where the services will be provided,
- (4) A crisis plan, and
- (5) The schedule for updates of the treatment plan.

78.45(2) Services. The ACT team shall participate in all mental health services provided to the member and shall provide 24-hour service for the psychiatric needs of the member. Available ACT services are:

a. *Evaluation and medication management.*

(1) The evaluation portion of ACT services consists of a comprehensive mental health evaluation and assessment of the member by a psychiatrist, advanced registered nurse practitioner, or physician assistant.

(2) Medication management consists of the prescription and management of medication by a psychiatrist, advanced registered nurse practitioner, or physician assistant to respond to the member's complaints and symptoms. A psychiatric registered nurse assists in this management by contact with the member regarding medications and their effect on the member's complaints and symptoms.

b. *Integrated therapy and counseling for mental health and substance abuse.* This service consists of direct counseling for treatment of mental health and substance abuse symptoms by a psychiatrist, licensed mental health professional, advanced registered nurse practitioner, physician assistant, or substance abuse specialist. Individual counseling is provided by other team members under the supervision of a psychiatrist or licensed mental health practitioner.

c. *Skill teaching.* Skill teaching consists of side-by-side demonstration and observation of daily living activities by a registered nurse, licensed mental health professional, psychologist, substance abuse counselor, peer specialist, community support specialist, advanced registered nurse practitioner, or physician assistant.

d. *Community support.* Community support is provided by a licensed mental health professional, psychologist, substance abuse counselor, peer specialist, community support specialist, advanced registered nurse practitioner, or physician assistant. Community support consists of the following activities focused on recovery and rehabilitation:

(1) Personal and home skills training to assist the member to develop and maintain skills for self-direction and coping with the living situation.

(2) Community skills training to assist the member in maintaining a positive level of participation in the community through development of socialization skills and personal coping skills.

e. *Medication monitoring.* Medication monitoring services are provided by a psychiatric nurse and other team members under the supervision of a psychiatrist or psychiatric nurse and consist of:

(1) Monitoring the member's day-to-day functioning, medication compliance, and access to medications; and

(2) Ensuring that the member keeps appointments.

f. *Case management for treatment and service plan coordination.* Case management consists of the development by the ACT team of an individualized treatment and service plan, including personalized goals and outcomes, to address the member's medical symptoms and remedial functional impairments.

(1) Case management includes:

1. Assessments, referrals, follow-up, and monitoring.

2. Assisting the member in gaining access to necessary medical, social, educational, and other services.

3. Assessing the member to determine service needs by collecting relevant historical information through member records and other information from relevant professionals and natural supports.

(2) The team shall:

1. Develop a specific care plan based on the assessment of needs, including goals and actions to address the needed medical, social, educational, and other necessary services.

2. Make referrals to services and related activities to assist the member with the assessed needs.

3. Monitor and perform follow-up activities necessary to ensure that the plan is carried out and that the member has access to necessary services. Activities may include monitoring contacts with providers, family members, natural supports, and others.

4. Hold daily team meetings to facilitate ACT services and coordinate the member's care with other members of the team.

g. Crisis response. Crisis response consists of direct assessment and treatment of the member's urgent or crisis symptoms in the community by a registered nurse, licensed mental health professional, psychologist, substance abuse counselor, community support specialist, case manager, advanced registered nurse practitioner, or physician assistant, as appropriate.

h. Work-related services. Work-related services may be provided by a registered nurse, licensed mental health professional, psychologist, substance abuse counselor, community support specialist, case manager, advanced registered nurse practitioner, or physician assistant. Services consist of assisting the member in managing mental health symptoms as they relate to job performance. Services may include:

(1) Collaborating with the member to look for job situations that may cause symptoms to increase and creating strategies to manage these situations.

(2) Assisting the member to develop or enhance skills to obtain a work placement, such as individual work-related behavioral management.

(3) Providing supports to maintain employment, such as crisis intervention related to employment.

(4) Teaching communication, problem solving, and safety skills.

(5) Teaching personal skills such as time management and appropriate grooming for employment.

This rule is intended to implement Iowa Code section 249A.4.

[ARC 9440B, IAB 4/6/11, effective 4/1/11; ARC 1850C, IAB 2/4/15, effective 4/1/15; ARC 2164C, IAB 9/30/15, effective 10/1/15]

441—78.46(249A) Physical disability waiver service. Payment shall be approved for the following services to members eligible for the HCBS physical disability waiver as established in 441—Chapter 83 and as identified in the member's service plan. Effective March 17, 2022, payment shall only be made for services provided in integrated, community-based settings that support full access of members receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.

78.46(1) Consumer-directed attendant care service. Consumer-directed attendant care services are service activities performed by a person to help a member with self-care tasks which the member would typically do independently if the member were otherwise able. Covered service activities are limited to the nonskilled activities listed in paragraph 78.46(1) "f" and the skilled activities listed in paragraph 78.46(1) "g." Covered service activities must be essential to the health, safety, and welfare of the member. Services may be provided in the absence of a parent or guardian if the parent or guardian has given advance direction for the service provision.

a. Service planning.

(1) The member, parent, guardian, or attorney in fact under a durable power of attorney for health care shall:

1. Select the individual or agency that will provide the components of the attendant care services.

2. Determine with the selected provider what components of attendant care services the provider shall perform, subject to confirmation by the service worker or case manager that those components are consistent with the assessment and are authorized covered services.

3. Complete, sign, and date Form 470-3372, HCBS Consumer-Directed Attendant Care Agreement, to indicate the frequency, scope, and duration of services (a description of each service component and the time agreed on for that component). The case manager or service worker and provider shall also sign the agreement.

4. Submit the completed agreement to the service worker or case manager. The agreement shall be part of the member's service plan and shall be kept in the member's records, in the provider's records,

and in the service worker's or case manager's records. Any service component that is not listed in the agreement shall not be payable.

(2) Whenever a legal representative acts as a provider of consumer-directed attendant care as allowed by 441—paragraph 79.9(7) "b," the following shall apply:

1. The payment rate for the legal representative must be based on the skill level of the legal representative and may not exceed the median statewide reimbursement rate for the service unless the higher rate receives prior approval from the department;

2. The legal representative may not be paid for more than 40 hours of service per week; and

3. A contingency plan must be established in the member's service plan to ensure service delivery in the event the legal representative is unable to provide services due to illness or other unexpected event.

b. Supervision of skilled services. Skilled consumer-directed attendant care services shall be provided under the supervision of a licensed nurse or licensed therapist working under the direction of a physician. The licensed nurse or therapist shall:

(1) Retain accountability for actions that are delegated.

(2) Ensure appropriate assessment, planning, implementation, and evaluation.

(3) Make on-site supervisory visits every two weeks with the service provider present.

c. Service documentation. The consumer-directed attendant care provider must complete Form 470-4389, Consumer-Directed Attendant Care (CDAC) Service Record, for each day of service. Any service component that is not documented in accordance with rule 441—79.3(249A) shall not be payable.

d. Role of guardian or attorney. If the member has a guardian or attorney in fact under a durable power of attorney for health care:

(1) The service worker's or case manager's service plan shall address how consumer-directed attendant care services will be monitored to ensure that the member's needs are being adequately met. If the guardian or attorney in fact is the service provider, the service plan shall address how the service worker or case manager shall oversee service provision.

(2) The guardian or attorney in fact shall sign the claim form in place of the member, indicating that the service has been provided as presented on the claim.

e. Service units and billing. A unit of service is 15 minutes provided by an individual or agency. Each service shall be billed in whole units.

f. Nonskilled services. Covered nonskilled service activities are limited to help with the following activities:

(1) Dressing.

(2) Bathing, shampooing, hygiene, and grooming.

(3) Access to and from bed or a wheelchair, transferring, ambulation, and mobility in general.

(4) Toileting, including bowel, bladder, and catheter assistance (emptying the catheter bag, collecting a specimen, and cleaning the external area around the catheter).

(5) Meal preparation, cooking, and assistance with feeding, not including the cost of meals themselves. Meal preparation and cooking shall be provided only in the member's home.

(6) Housekeeping, laundry, and shopping essential to the member's health care at home.

(7) Taking medications ordinarily self-administered, including those ordered by a physician or other qualified health care provider.

(8) Minor wound care.

(9) Going to or returning from a place of employment and job-related tasks while the member is on the job site. Transportation for the member and assistance with understanding or performing the essential job functions are not included in consumer-directed attendant care services.

(10) Tasks, such as financial management and scheduling, that require cognitive or physical assistance.

(11) Communication essential to the health and welfare of the member, through interpreting and reading services and use of assistive devices for communication.

(12) Using transportation essential to the health and welfare of the member. The cost of the transportation is not included.

g. Skilled services. Covered skilled service activities are limited to help with the following activities:

- (1) Tube feedings of members unable to eat solid foods.
- (2) Intravenous therapy administered by a registered nurse.
- (3) Parenteral injections required more than once a week.
- (4) Catheterizations, continuing care of indwelling catheters with supervision of irrigations, and changing of Foley catheters when required.
- (5) Respiratory care including inhalation therapy and tracheotomy care or tracheotomy care and ventilator.
- (6) Care of decubiti and other ulcerated areas, noting and reporting to the nurse or therapist.
- (7) Rehabilitation services including, but not limited to, bowel and bladder training, range of motion exercises, ambulation training, restorative nursing services, respiratory care and breathing programs, reality orientation, reminiscing therapy, remotivation, behavior modification, and reteaching of the activities of daily living.
- (8) Colostomy care.
- (9) Care of uncontrolled medical conditions, such as brittle diabetes, and comfort care of terminal conditions.
- (10) Postsurgical nursing care.
- (11) Monitoring medications requiring close supervision because of fluctuating physical or psychological conditions, e.g., antihypertensives, digitalis preparations, mood-altering or psychotropic drugs, or narcotics.
- (12) Preparing and monitoring response to therapeutic diets.
- (13) Recording and reporting of changes in vital signs to the nurse or therapist.

h. Excluded services and costs. Services, activities, costs and time that are not covered as consumer-directed attendant care include the following (not an exclusive list):

- (1) Any activity related to supervising a member. Only direct services are billable.
- (2) Any activity that the member is able to perform.
- (3) Costs of food.
- (4) Costs for the supervision of skilled services by the nurse or therapist. The supervising nurse or therapist may be paid from private insurance, Medicare, or other third-party payment sources, or may be paid as another Medicaid service, including early and periodic screening, diagnosis and treatment services.
- (5) Exercise that does not require skilled services.
- (6) Parenting or child care for or on behalf of the member.
- (7) Reminders and cueing.
- (8) Services provided simultaneously with any other similar service regardless of funding source, including other waiver services and state supplementary assistance in-home health-related care services.
- (9) Transportation costs.
- (10) Wait times for any activity.

78.46(2) Home and vehicle modification. Covered home or vehicle modifications are physical modifications to the member's home or vehicle that directly address the member's medical or remedial need. Covered modifications must be necessary to provide for the health, welfare, or safety of the member and enable the member to function with greater independence in the home or vehicle.

a. Modifications that are necessary or desirable without regard to the member's medical or remedial need and that would be expected to increase the fair market value of the home or vehicle, such as furnaces, fencing, or adding square footage to the residence, are excluded except as specifically included below. Purchasing or leasing of a motorized vehicle is excluded. Home and vehicle repairs are also excluded.

b. Only the following modifications are covered:

- (1) Kitchen counters, sink space, cabinets, special adaptations to refrigerators, stoves, and ovens.
- (2) Bathtubs and toilets to accommodate transfer, special handles and hoses for shower heads, water faucet controls, and accessible showers and sink areas.

- (3) Grab bars and handrails.
- (4) Turnaround space adaptations.
- (5) Ramps, lifts, and door, hall and window widening.
- (6) Fire safety alarm equipment specific for disability.
- (7) Voice-activated, sound-activated, light-activated, motion-activated, and electronic devices directly related to the member's disability.
- (8) Vehicle lifts, driver-specific adaptations, remote-start systems, including such modifications already installed in a vehicle.
- (9) Keyless entry systems.
- (10) Automatic opening device for home or vehicle door.
- (11) Special door and window locks.
- (12) Specialized doorknobs and handles.
- (13) Plexiglas replacement for glass windows.
- (14) Modification of existing stairs to widen, lower, raise or enclose open stairs.
- (15) Motion detectors.
- (16) Low-pile carpeting or slip-resistant flooring.
- (17) Telecommunications device for the deaf.
- (18) Exterior hard-surface pathways.
- (19) New door opening.
- (20) Pocket doors.
- (21) Installation or relocation of controls, outlets, switches.
- (22) Air conditioning and air filtering if medically necessary.
- (23) Heightening of existing garage door opening to accommodate modified van.
- (24) Bath chairs.
- c. A unit of service is the completion of needed modifications or adaptations.
- d. All modifications and adaptations shall be provided in accordance with applicable federal, state, and local building and vehicle codes.
- e. Services shall be performed following prior department approval of the modification as specified in 441—subrule 79.1(17) and a binding contract between the provider and the member.
- f. All contracts for home or vehicle modification shall be awarded through competitive bidding. The contract shall include the scope of work to be performed, the time involved, supplies needed, the cost, diagrams of the project whenever applicable, and an assurance that the provider has liability and workers' compensation coverage and the applicable permit and license.
- g. Service payment shall be made to the enrolled home or vehicle modification provider. If applicable, payment will be forwarded to the subcontracting agency by the enrolled home or vehicle modification provider following completion of the approved modifications. Payment of up to \$6,366.64 per year may be made to certified providers upon satisfactory completion of the service.
- h. Services shall be included in the member's service plan and shall exceed the Medicaid state plan services.

78.46(3) *Personal emergency response or portable locator system.*

- a. A personal emergency response system is an electronic device that transmits a signal to a central monitoring station to summon assistance in the event of an emergency.
 - (1) The necessary components of a system are:
 - 1. An in-home medical communications transceiver.
 - 2. A remote, portable activator.
 - 3. A central monitoring station with backup systems staffed by trained attendants at all times.
 - 4. Current data files at the central monitoring station containing response protocols and personal, medical, and emergency information for each member.
 - (2) The service shall be identified in the member's service plan.
 - (3) A unit of service is a one-time installation fee or one month of service.
 - (4) Maximum units per state fiscal year shall be the initial installation and 12 months of service.

b. A portable locator system is an electronic device that transmits a signal to a monitoring device. The system allows a member to access assistance in the event of an emergency and allows law enforcement or the monitoring system provider to locate a member who is unable to request help or to activate a system independently. The member must be unable to access assistance in an emergency situation due to the member's age or disability.

(1) The required components of the portable locator system are:

1. A portable communications transceiver or transmitter to be worn or carried by the member.
2. Monitoring by the provider at a central location with response protocols and personal, medical, and emergency information for each member as applicable.

(2) The service shall be identified in the member's service plan.

(3) Payable units of service are purchase of equipment, an installation or set-up fee, and monthly fees.

(4) Maximum units per state fiscal year shall be one equipment purchase, one installation or set-up fee, and 12 months of service.

78.46(4) Specialized medical equipment.

a. Specialized medical equipment shall include medically necessary items which are for personal use by members with a physical disability and which:

(1) Provide for the health and safety of the member,

(2) Are not ordinarily covered by Medicaid,

(3) Are not funded by educational or vocational rehabilitation programs, and

(4) Are not provided by voluntary means.

b. Coverage includes, but is not limited to:

(1) Electronic aids and organizers.

(2) Medicine dispensing devices.

(3) Communication devices.

(4) Bath aids.

(5) Noncovered environmental control units.

(6) Repair and maintenance of items purchased through the waiver.

c. Payment of up to \$6,366.64 per year may be made to enrolled specialized medical equipment providers upon satisfactory receipt of the service.

d. The need for specialized medical equipment shall be:

(1) Documented by a health care professional as necessary for the member's health and safety, and

(2) Identified in the member's service plan.

e. Payment for most items shall be based on a fee schedule. The amount of the fee shall be determined as directed in 441—subrule 79.1(17).

78.46(5) Transportation. Transportation services may be provided for members to conduct business errands and essential shopping, to travel to and from work or day programs, and to reduce social isolation. A unit of service is one mile of transportation or one one-way trip.

78.46(6) Consumer choices option. The consumer choices option provides a member with a flexible monthly individual budget that is based on the member's service needs. With the individual budget, the member shall have the authority to purchase goods and services to meet the member's assessed needs and may choose to employ providers of services and supports. The services, supports, and items that are purchased with an individual budget must be directly related to a member's assessed need or goal established in the member's service plan. Components of this service are set forth below.

a. *Agreement.* As a condition of participating in the consumer choices option, a member shall sign Form 470-4289, HCBS Consumer Choices Informed Consent and Risk Agreement, to document that the member has been informed of the responsibilities and risks of electing the consumer choices option.

b. *Individual budget amount.* A monthly individual budget amount shall be established for each member based on the assessed needs of the member and on the services and supports authorized in the member's service plan. The member shall be informed of the individual budget amount during the development of the service plan.

(1) Services that may be included in determining the individual budget amount for a member in the HCBS physical disability waiver are:

1. Consumer-directed attendant care (unskilled).
2. Home and vehicle modification.
3. Specialized medical equipment.
4. Transportation.

(2) The department shall determine an average unit cost for each service listed in subparagraph 78.46(6)“b”(1) based on actual unit costs from the previous fiscal year plus a cost-of-living adjustment.

(3) In aggregate, costs for individual budget services shall not exceed the current costs of waiver program services. In order to maintain cost neutrality, the department shall apply a utilization adjustment factor to the amount of service authorized in the member’s service plan before calculating the value of that service to be included in the individual budget amount.

(4) The department shall compute the utilization adjustment factor for each service by dividing the net costs of all claims paid for the service by the total of the authorized costs for that service, using at least 12 consecutive months of aggregate service data. The utilization adjustment factor shall be no lower than 60 percent. The department shall analyze and adjust the utilization adjustment factor at least annually in order to maintain cost neutrality.

(5) Individual budgets for respite services shall be computed based on the average cost for services identified in subparagraph 78.46(6)“b”(2). Respite services are not subject to the utilization adjustment factor in subparagraph 78.46(6)“b”(3).

(6) Anticipated costs for home and vehicle modification and specialized medical equipment are not subject to the average cost in subparagraph 78.46(6)“b”(2) or the utilization adjustment factor in subparagraph 78.46(6)“b”(3). Anticipated costs for home and vehicle modification and specialized medical equipment shall not include the costs of the financial management services or the independent support broker. Before becoming part of the individual budget, all home and vehicle modifications and specialized medical equipment shall be identified in the member’s service plan and approved by the case manager or service worker. Costs for home and vehicle modification and specialized medical equipment may be paid to the financial management services provider in a one-time payment.

(7) The individual budget amount may be changed only at the first of the month and shall remain fixed for the entire month.

c. Required service components. To participate in the consumer choices option, a member must hire an independent support broker and must work with a financial management service that is enrolled as a Medicaid provider. Before hiring the independent support broker, the member shall receive the results of the background check conducted pursuant to 441—Chapter 119.

d. Optional service components. A member who elects the consumer choices option may purchase the following goods, services and supports, which shall be provided in the member’s home or at an integrated community setting:

(1) Self-directed personal care services. Self-directed personal care services are services or goods that provide a range of assistance in activities of daily living and incidental activities of daily living that help the member remain in the home and community. These services must be identified in the member’s service plan developed by the member’s case manager or service worker.

(2) Self-directed community supports and employment. Self-directed community supports and employment are services that support the member in developing and maintaining independence and community integration. These services must be identified in the member’s service plan developed by the member’s case manager or service worker.

(3) Individual-directed goods and services. Individual-directed goods and services are services, equipment, or supplies not otherwise provided through the Medicaid program that address an assessed need or goal identified in the member’s service plan. The item or service shall meet the following requirements:

1. Promote opportunities for community living and inclusion.
2. Increase independence or substitute for human assistance, to the extent the expenditures would otherwise be made for that human assistance.

3. Be accommodated within the member's budget without compromising the member's health and safety.

4. Be provided to the member or directed exclusively toward the benefit of the member.

5. Be the least costly to meet the member's needs.

6. Not be available through another source.

e. Development of the individual budget. The independent support broker shall assist the member in developing and implementing the member's individual budget. The individual budget shall include:

(1) The costs of the financial management service.

(2) The costs of the independent support broker. The independent support broker may be compensated for up to 6 hours of service for assisting with the implementation of the initial individual budget. The independent support broker shall not be paid for more than 30 hours of service for an individual member during a 12-month period without prior approval by the department.

(3) The costs of any optional service component chosen by the member as described in paragraph 78.46(6) "d." Costs of the following items and services shall not be covered by the individual budget:

1. Child care services.

2. Clothing not related to an assessed medical need.

3. Conference, meeting or similar venue expenses other than the costs of approved services the member needs while attending the conference, meeting or similar venue.

4. Costs associated with shipping items to the member.

5. Experimental and non-FDA-approved medications, therapies, or treatments.

6. Goods or services covered by other Medicaid programs.

7. Home furnishings.

8. Home repairs or home maintenance.

9. Homeopathic treatments.

10. Insurance premiums or copayments.

11. Items purchased on installment payments.

12. Motorized vehicles.

13. Nutritional supplements.

14. Personal entertainment items.

15. Repairs and maintenance of motor vehicles.

16. Room and board, including rent or mortgage payments.

17. School tuition.

18. Service animals.

19. Services covered by third parties or services that are the responsibility of a non-Medicaid program.

20. Sheltered workshop services.

21. Social or recreational purchases not related to an assessed need or goal identified in the member's service plan.

22. Vacation expenses, other than the costs of approved services the member needs while on vacation.

(4) The costs of any approved home or vehicle modification or specialized medical equipment. When authorized, the budget may include an amount allocated for a home or vehicle modification or specialized medical equipment. Before becoming part of the individual budget, all home and vehicle modifications and specialized medical equipment shall be identified in the member's service plan and approved by the case manager or service worker. The authorized amount shall not be used for anything other than the specific modification or equipment.

(5) Any amount set aside in a savings plan to reserve funds for the future purchase of self-directed personal care, individual-directed goods and services, or self-directed community supports and services as defined in paragraph 78.46(6) "d." The savings plan shall meet the requirements in paragraph 78.46(6) "f."

f. Savings plan. A member savings plan must be in writing and be approved by the department before the start of the savings plan. Amounts allocated to the savings plan must result from efficiencies in meeting identified needs of the member.

(1) The savings plan shall identify:

1. The specific goods, services, supports or supplies to be purchased through the savings plan.
2. The amount of the individual budget allocated each month to the savings plan.
3. The amount of the individual budget allocated each month to meet the member's identified service needs.

4. How the member's assessed needs will continue to be met through the individual budget when funds are placed in savings.

(2) With the exception of funds allocated for respite care, the savings plan shall not include funds budgeted for direct services that were not received. The budgeted amount associated with unused direct services other than respite care shall revert to the Medicaid program at the end of each month. Funds from unused respite services may be allocated to the savings plan but shall not be used for anything other than future respite care.

(3) Funds accumulated under a savings plan shall be used only to purchase items that increase independence or substitute for human assistance to the extent that expenditures would otherwise be made for human assistance, including additional goods, supports, services or supplies. The self-directed personal care, individual-directed goods and services, or self-directed community supports and services purchased with funds from a savings plan must:

1. Be used to meet a member's identified need,
2. Be medically necessary, and
3. Be approved by the member's case manager or service worker.

(4) All funds allocated to a savings plan that are not expended by December 31 of each year shall revert to the Medicaid program.

(5) The annual reassessment of a member's needs must take into account the purchases of goods and services that substitute for human assistance. Adjustments shall be made to the services used to determine the individual budget based on the reassessment.

g. Budget authority. The member shall have authority over the individual budget authorized by the department to perform the following tasks:

(1) Contract with entities to provide services and supports as described in this subrule.

(2) Determine the amount to be paid for services. Reimbursement rates shall be consistent with rates paid by others in the community for the same or substantially similar services. Reimbursement rates for the independent support broker and the financial management service are subject to the limits in 441—subrule 79.1(2). The reimbursement rate for a member's legal representative who provides services to the member as allowed by 441—paragraph 79.9(7) "b" 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.

(3) Schedule the provision of services. Whenever a member's legal representative provides services to the member as allowed by 441—paragraph 79.9(7) "b," the legal representative may not be paid for more than 40 hours of service per week and 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.

(4) Authorize payment for waiver goods and services optional service components identified in the individual budget.

(5) Reallocate funds among services included in the budget. Every purchase of a good or service must be identified and approved in the individual budget before the purchase is made.

h. Delegation of budget authority. The member may delegate responsibility for the individual budget to a representative in addition to the independent support broker.

(1) The representative must be at least 18 years old.

(2) The representative shall not be a current provider of service to the member.

(3) The member shall sign a consent form that designates who the member has chosen as a representative and what responsibilities the representative shall have.

(4) The representative shall not be paid for this service.

i. Employer authority. The member shall have the authority to be the common-law employer of employees providing services and support under the consumer choices option. A common-law employer has the right to direct and control the performance of the services. The member may perform the following functions:

- (1) Recruit employees.
- (2) Select employees from a worker registry.
- (3) Verify employee qualifications.
- (4) Specify additional employee qualifications.
- (5) Determine employee duties.
- (6) Determine employee wages and benefits.
- (7) Schedule employees.
- (8) Train and supervise employees.

j. Employment agreement. Any person employed by the member to provide services under the consumer choices option shall sign an employment agreement with the member that outlines the employee's and member's responsibilities.

k. Responsibilities of the independent support broker. The independent support broker shall perform the following services as directed by the member or the member's representative:

(1) Assist the member with developing the member's initial and subsequent individual budgets and with making any changes to the individual budget.

(2) Have monthly contact with the member for the first four months of implementation of the initial individual budget and have quarterly contact thereafter.

(3) Complete the required employment packet with the financial management service.

(4) Assist with interviewing potential employees and entities providing services and supports if requested by the member.

(5) Assist the member with determining whether a potential employee meets the qualifications necessary to perform the job.

(6) Assist the member with obtaining a signed consent from a potential employee to conduct background checks if requested by the member.

(7) Assist the member with negotiating with entities providing services and supports if requested by the member.

(8) Assist the member with contracts and payment methods for services and supports if requested by the member.

(9) Assist the member with developing an emergency backup plan. The emergency backup plan shall address any health and safety concerns.

(10) Review expenditure reports from the financial management service to ensure that services and supports in the individual budget are being provided.

(11) Document in writing on the independent support broker timecard every contact the broker has with the member. Contact documentation shall include information on the extent to which the member's individual budget has addressed the member's needs and the satisfaction of the member.

l. Responsibilities of the financial management service. The financial management service shall perform all of the following services:

(1) Receive Medicaid funds in an electronic transfer.

(2) Process and pay invoices for approved goods and services included in the individual budget.

(3) Enter the individual budget into the web-based tracking system chosen by the department and enter expenditures as they are paid.

(4) Provide real-time individual budget account balances for the member, the independent support broker, and the department, available at a minimum during normal business hours (9 a.m. to 5 p.m., Monday through Friday).

(5) Conduct criminal background checks on potential employees pursuant to 441—Chapter 119.

- (6) Verify for the member an employee's citizenship or alien status.
- (7) Assist the member with fiscal and payroll-related responsibilities including, but not limited to:
 1. Verifying that hourly wages comply with federal and state labor rules.
 2. Collecting and processing timecards.
 3. Withholding, filing, and paying federal, state and local income taxes, Medicare and Social Security (FICA) taxes, and federal (FUTA) and state (SUTA) unemployment and disability insurance taxes, as applicable.
 4. Computing and processing other withholdings, as applicable.
 5. Processing all judgments, garnishments, tax levies, or other withholding on an employee's pay as may be required by federal, state, or local laws.
 6. Preparing and issuing employee payroll checks.
 7. Preparing and disbursing IRS Forms W-2 and W-3 annually.
 8. Processing federal advance earned income tax credit for eligible employees.
 9. Refunding over-collected FICA, when appropriate.
 10. Refunding over-collected FUTA, when appropriate.
- (8) Assist the member in completing required federal, state, and local tax and insurance forms.
- (9) Establish and manage documents and files for the member and the member's employees.
- (10) Monitor timecards, receipts, and invoices to ensure that they are consistent with the individual budget. Keep records of all timecards and invoices for each member for a total of five years.
- (11) Provide to the department, the independent support broker, and the member monthly and quarterly status reports that include a summary of expenditures paid and amount of budget unused.
- (12) Establish an accessible customer service system and a method of communication for the member and the independent support broker that includes alternative communication formats.
- (13) Establish a customer services complaint reporting system.
- (14) Develop a policy and procedures manual that is current with state and federal regulations and update as necessary.
- (15) Develop a business continuity plan in the case of emergencies and natural disasters.
- (16) Provide to the department an annual independent audit of the financial management service.
- (17) Assist in implementing the state's quality management strategy related to the financial management service.

78.46(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]

441—78.47(249A) Pharmaceutical case management services. Payment will be approved for pharmaceutical case management services provided by an eligible physician and pharmacist for Medicaid recipients determined to be at high risk for medication-related problems. These services are designed to identify, prevent, and resolve medication-related problems and improve drug therapy outcomes.

78.47(1) Medicaid recipient eligibility. Patients are eligible for pharmaceutical case management services if they have active prescriptions for four or more regularly scheduled nontopical medications, are ambulatory, do not reside in a nursing facility, and have at least one of the eligible disease states of congestive heart disease, ischemic heart disease, diabetes mellitus, hypertension, hyperlipidemia, asthma, depression, atrial fibrillation, osteoarthritis, gastroesophageal reflux, or chronic obstructive pulmonary disease.

78.47(2) Provider eligibility. Physicians and pharmacists shall meet the following criteria to provide pharmaceutical case management services.

a. Physicians and pharmacists must be enrolled in the Iowa Medicaid program, have an Iowa Medicaid provider number, and receive training under the direction of the department regarding the provision of pharmaceutical case management services under the Iowa Medicaid program.

A copy of pharmaceutical case management records, including documentation of services provided, shall be maintained on file in each provider's facility and be made available for audit by the department on request.

b. Physicians shall be licensed to practice medicine.

c. Pharmacists shall present to the department evidence of competency including state licensure, submit five acceptable patient care plans, and have successfully completed professional training on patient-oriented, medication-related problem prevention and resolution. Pharmacists shall also maintain problem-oriented patient records, provide a private patient consultation area, and submit a statement indicating that the submitted patient care plans are representative of the pharmacists' usual patient care plans.

Acceptable professional training programs are:

(1) A doctor of pharmacy degree program.

(2) The Iowa Center for Pharmaceutical Care (ICPC) training program, which is a cooperative training initiative of the University of Iowa College of Pharmacy, Drake University College of Pharmacy and Health Sciences, and the Iowa Pharmacy Foundation.

(3) Other programs containing similar coursework and supplemental practice site evaluation and reengineering, approved by the department with input from a peer review advisory committee.

78.47(3) Services. Eligible patients may choose whether to receive the services. If patients elect to receive the services, they must receive the services from any eligible physician and pharmacist acting as a pharmaceutical case management (PCM) team. Usually the eligible physician and pharmacist will be the patient's primary physician and pharmacist. Pharmaceutical case management services are to be value-added services complementary to the basic medical services provided by the primary physician and pharmacist.

The PCM team shall provide the following services:

- a. Initial assessment.* The initial assessment shall consist of:
- (1) A patient evaluation by the pharmacist, including:
 1. Medication history;
 2. Assessment of indications, effectiveness, safety, and compliance of medication therapy;
 3. Assessment for the presence of untreated illness; and
 4. Identification of medication-related problems such as unnecessary medication therapy, suboptimal medication selection, inappropriate compliance, adverse drug reactions, and need for additional medication therapy.
 - (2) A written report and recommendation from the pharmacist to the physician.
 - (3) A patient care action plan developed by the PCM team with the patient's agreement and implemented by the PCM team. Specific components of the action plan will vary based on patient needs and conditions but may include changes in medication regimen, focused patient or caregiver education, periodic assessment for changes in the patient's condition, periodic monitoring of the effectiveness of medication therapy, self-management training, provision of patient-specific educational and informational materials, compliance enhancement, and reinforcement of healthy lifestyles. An action plan must be completed for each initial assessment.
- b. New problem assessments.* These assessments are initiated when a new medication-related problem is identified. The action plan is modified and new components are implemented to address the new problem. This assessment may occur in the interim between scheduled follow-up assessments.
- c. Problem follow-up assessments.* These assessments are based on patient need and a problem identified by a prior assessment. The patient's status is evaluated at an appropriate interval. The effectiveness of the implemented action plan is determined and modifications are made as needed.
- d. Preventive follow-up assessments.* These assessments occur approximately every six months when no current medication-related problems have been identified in prior assessments. The patient is reassessed for newly developed medication-related problems and the action plan is reviewed.

This rule is intended to implement Iowa Code section 249A.4 and 2000 Iowa Acts, chapter 1228, section 9.

441—78.48(249A) Public health agencies. Payments will be made to local public health agencies on a fee schedule basis for providing vaccine and vaccine administration and testing for communicable disease. In order to be paid for the administration of a vaccine covered under the Vaccines for Children (VFC) Program, a public health agency must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

This rule is intended to implement Iowa Code section 249A.4.
[ARC 0358C, IAB 10/3/12, effective 11/7/12]

441—78.49(249A) Infant and toddler program services. Subject to the following subrules, payment shall be made for medical services provided to Medicaid eligible children by infant and toddler program providers under the infants and toddlers with disabilities program administered by the Iowa Child Health Specialty Clinics and the departments of education, public health, and human services.

78.49(1) Covered services. Covered services include, but are not limited to, audiology, psychological evaluation and counseling, health and nursing services, nutrition services, occupational therapy services, physical therapy services, developmental services, speech-language services, vision services, case management, and medical transportation.

78.49(2) Case management services. Payment shall also be approved for infant and toddler case management services subject to the following requirements:

a. Definition. "Case management" means services that will assist eligible children in gaining access to needed medical, social, educational, and other services. Case management is intended to address the complexities of coordinated service delivery for children with medical needs. The case manager should be the focus for coordinating and overseeing the effectiveness of all providers and programs in responding to the assessed need. Case management does not include the direct delivery of

an underlying medical, educational, social, or other service to which an eligible child has been referred or any activities that are an integral part or an extension of the direct services.

b. Choice of provider. Children who also are eligible to receive targeted case management services under 441—Chapter 90 must choose whether to receive case management through the infant and toddler program or through 441—Chapter 90. The chosen provider must meet the requirements of this subrule.

(1) When a child resides in a medical institution, the institution is responsible for case management. The child is not eligible for any other case management services. However, noninstitutional case management services may be provided during the last 14 days before the child's planned discharge if the child's stay in the institution has been less than 180 consecutive days. If the child has been in the institution 180 consecutive days or longer, the child may receive noninstitutional case management services during the last 60 days before the child's planned discharge.

(2) If the case management agency also provides direct services, the case management unit must be designed so that conflict of interest is addressed and does not result in self-referrals.

(3) If the costs of any part of case management services are reimbursable under another program, the costs must be allocated between those programs and Medicaid in accordance with OMB Circular No. A-87 or any related or successor guidance or regulations regarding allocation of costs.

(4) The case manager must complete a competency-based training program with content related to knowledge and understanding of eligible children, Early ACCESS rules, the nature and scope of services in Early ACCESS, and the system of payments for services, as well as case management responsibilities and strategies. The department of education or its designee shall determine whether a person has successfully completed the training.

c. Assessment. The case manager shall conduct a comprehensive assessment and periodic reassessment of an eligible child to identify all of the child's service needs, including the need for any medical, educational, social, or other services. Assessment activities are defined to include the following:

- (1) Taking the child's history;
- (2) Identifying the needs of the child;
- (3) Gathering information from other sources, such as family members, medical providers, social workers, and educators, if necessary, to form a complete assessment of the child;
- (4) Completing documentation of the information gathered and the assessment results; and
- (5) Repeating the assessment every six months to determine whether the child's needs or preferences have changed.

d. Plan of care. The case manager shall develop a plan of care based on the information collected through the assessment or reassessment. The plan of care shall:

- (1) Include the child's strengths and preferences;
- (2) Consider the child's physical and social environment;
- (3) Specify goals of providing services to the child; and
- (4) Specify actions to address the child's medical, social, educational, and other service needs. These actions may include activities such as ensuring the active participation of the child and working with the child or the child's authorized health care decision maker and others to develop goals and identify a course of action to respond to the assessed needs of the child.

e. Other service components. Case management must include the following components:

(1) Contacts with the child and family. The case manager shall have face-to-face contact with the child and family within the first 30 days of service and every three months thereafter. In months in which there is no face-to-face contact, a telephone contact between the service coordinator and the family is required.

(2) Referral and related activities to help a child obtain needed services. The case manager shall help to link the child with medical, social, or educational providers or other programs and services that are capable of providing needed services. Referral activities do not include provision of the direct services, program, or activity to which the child has been linked. Referral activities include:

1. Assisting the family in gaining access to the infant and toddler program services and other services identified in the child's plan of care.

2. Assisting the family in identifying available service providers and funding resources and documenting unmet needs and gaps in services.

3. Making referrals to providers for needed services.
4. Scheduling appointments for the child.
5. Facilitating the timely delivery of services.
6. Arranging payment for medical transportation.

(3) Monitoring and follow-up activities. Monitoring activities shall take place at least once annually for the duration of the child's eligibility, but may be conducted as frequently as necessary to ensure that the plan of care is effectively implemented and adequately addresses the needs of the child. Monitoring and follow-up activities may be with the child, family members, providers, or other entities. The purpose of these activities is to help determine:

1. Whether services are being furnished in accordance with the child's plan of care.
2. Whether the services in the plan of care are adequate to meet the needs of the child.
3. Whether there are changes in the needs or status of the child. If there are changes in the child's needs or status, follow-up activities shall include making necessary adjustments to the plan of care and to service arrangements with providers.

(4) Keeping records, including preparing reports, updating the plan of care, making notes about plan activities in the child's record, and preparing and responding to correspondence with the family and others.

f. Documentation of case management. For each child receiving case management, case records must document:

- (1) The name of the child;
- (2) The dates of case management services;
- (3) The agency chosen by the family to provide the case management services;
- (4) The nature, content, and units of case management services received;
- (5) Whether the goals specified in the care plan have been achieved;
- (6) Whether the family has declined services in the care plan;
- (7) Time lines for providing services and reassessment; and
- (8) The need for and occurrences of coordination with case managers of other programs.

78.49(3) *Child's eligibility.* Payable services must be provided to a child under the age of 36 months who is experiencing developmental delay or who has a condition that is known to have a high probability of resulting in developmental delay at a later date.

78.49(4) *Delivery of services.* Services must be delivered directly by the infant and toddler program provider or by a practitioner under contract with the infant and toddler program provider.

78.49(5) *Remission of nonfederal share of costs.* Payment for services shall be made only when the following conditions are met:

- a.* Rescinded IAB 5/10/06, effective 7/1/06.
- b.* The infant and toddler program provider has executed an agreement to remit the nonfederal share of the cost to the department.
- c.* The infant and toddler program provider shall sign and return Form 470-3816, Medicaid Billing Remittance, along with the funds remitted for the nonfederal share of the costs of the services specified on the form.

This rule is intended to implement Iowa Code section 249A.4.

441—78.50(249A) Local education agency services. Subject to the following subrules, payment shall be made for medical services provided by local education agency services providers to Medicaid members under the age of 21.

78.50(1) *Covered services.* Covered services include, but are not limited to, audiology services, behavior services, consultation services, medical transportation, nursing services, nutrition services, occupational therapy services, personal assistance, physical therapy services, psychologist services, speech-language services, social work services, vision services, and school-based clinic visit services.

a. In order to be paid for the administration of a vaccine covered under the Vaccines for Children (VFC) Program, a local education agency must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

b. Payment for supplies shall be approved when the supplies are incidental to the patient's care, e.g., syringes for injections, and do not exceed \$25 per month. Durable medical equipment and other supplies are not covered as local education agency services.

c. To the extent that federal funding is not available under Title XIX of the Social Security Act, payment for transportation between home and school is not a covered service.

78.50(2) *Coordination services.* Rescinded IAB 12/3/08, effective 2/1/09.

78.50(3) *Delivery of services.* Services must be delivered directly by the local education agency services providers or by a practitioner under contract with the local education agency services provider.

78.50(4) *Remission of nonfederal share of costs.* Payment for services shall be made only when the following conditions are met:

a. Rescinded IAB 5/10/06, effective 7/1/06.

b. The local education agency services provider has executed an agreement to remit the nonfederal share of the cost to the department.

c. The local education agency provider shall sign and return Form 470-3816, Medicaid Billing Remittance, along with the funds remitted for the nonfederal share of the costs of the services as specified on the form.

This rule is intended to implement Iowa Code section 249A.4.
[ARC 0065C, IAB 4/4/12, effective 6/1/12]

441—78.51(249A) Indian health service 638 facility services. Payment shall be made for all medically necessary services and supplies provided by a licensed practitioner at an Indian health service 638 facility, as defined at rule 441—77.45(249A), within the practitioner's scope of practice and subject to the limitations and exclusions set forth in subrule 78.1(1).

This rule is intended to implement Iowa Code section 249A.4.

441—78.52(249A) HCBS children's mental health waiver services. Payment will be approved for the following services to members eligible for the HCBS children's mental health waiver as established in 441—Chapter 83 and as identified in the member's service plan. Effective March 17, 2022, payment shall only be made for services provided in integrated, community-based settings that support full access of members receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.

78.52(1) *General service standards.* All children's mental health waiver services must be provided in accordance with the following standards:

a. Reimbursement shall not be available under the waiver for any services that the member can obtain as other nonwaiver Medicaid services or through any other funding source.

b. All services provided under the waiver must be delivered in the least restrictive environment possible and in conformity with the member's service plan.

c. All rights restrictions must be implemented in accordance with 441—subrule 77.25(4). The member service plan or treatment plan shall include documentation of:

(1) Any restrictions on the member's rights, including the rights of privacy, dignity, respect, and freedom from coercion and restraint.

(2) The need for the restriction.

(3) The less intrusive methods of meeting the need that have been tried but did not work.

(4) Either a plan to restore those rights or written documentation that a plan is not necessary or appropriate.

(5) Established time limits for periodic reviews to determine if the restriction is still necessary or can be terminated.

- (6) The informed consent of the member.
- (7) An assurance that the interventions and supports will cause no harm to the member.
- (8) A regular collection and review of data to measure the ongoing effectiveness of the restriction.
- d. Services must be billed in whole units.
- e. For all services with a 15-minute unit of service, the following rounding process will apply:
 - (1) Add together the minutes spent on all billable activities during a calendar day for a daily total.
 - (2) For each day, divide the total minutes spent on billable activities by 15 to determine the number of full 15-minute units for that day.
 - (3) Round the remainder using these guidelines: Round 1 to 7 minutes down to zero units; round 8 to 14 minutes up to one unit.
 - (4) Add together the number of full units and the number of rounded units to determine the total number of units to bill for that day.

78.52(2) *Environmental modifications and adaptive devices.*

a. Environmental modifications and adaptive devices include medically necessary items installed or used within the member's home that are used by the member to address specific, documented health, mental health, or safety concerns. The following items are excluded under this service:

- (1) Items ordinarily covered by Medicaid.
- (2) Items funded by educational or vocational rehabilitation programs.
- (3) Items provided by voluntary means.
- (4) Repair and maintenance of items purchased through the waiver.
- (5) Fencing.

b. A unit of service is one modification or device.

c. For each unit of service provided, the case manager shall maintain in the member's case file a signed statement from a mental health professional on the member's interdisciplinary team that the service has a direct relationship to the member's diagnosis of serious emotional disturbance.

d. Payment for most items shall be based on a fee schedule. The amount of the fee shall be determined as directed in 441—subrule 79.1(17).

78.52(3) *Family and community support services.* Family and community support services shall support the member and the member's family by the development and implementation of strategies and interventions that will result in the reduction of stress and depression and will increase the member's and the family's social and emotional strength.

a. Dependent on the needs of the member and the member's family members individually or collectively, family and community support services may be provided to the member, to the member's family members, or to the member and the family members as a family unit.

b. Family and community support services shall be provided under the recommendation and direction of a mental health professional who is a member of the member's interdisciplinary team pursuant to 441—Chapter 83.

c. Family and community support services shall incorporate recommended support interventions and activities, which may include the following:

- (1) Developing and maintaining a crisis support network for the member and for the member's family.
- (2) Modeling and coaching effective coping strategies for the member's family members.
- (3) Building resilience to the stigma of serious emotional disturbance for the member and the family.
- (4) Reducing the stigma of serious emotional disturbance by the development of relationships with peers and community members.

(5) Modeling and coaching the strategies and interventions identified in the member's crisis intervention plan as defined in 441—24.1(225C) for life situations with the member's family and in the community.

(6) Developing medication management skills.

(7) Developing personal hygiene and grooming skills that contribute to the member's positive self-image.

(8) Developing positive socialization and citizenship skills.

d. Family and community support services may include an amount not to exceed \$1500 per member per year for transportation within the community and purchase of therapeutic resources. Therapeutic resources may include books, training materials, and visual or audio media.

(1) The interdisciplinary team must have identified the transportation or therapeutic resource as a support need and included that need in the case manager's plan.

(2) The annual amount available for transportation and therapeutic resources must be listed in the member's service plan.

(3) The member's parent or legal guardian shall submit a signed statement that the transportation or therapeutic resource cannot be provided by the member or the member's family or legal guardian.

(4) The member's Medicaid case manager shall maintain a signed statement that potential community resources are unavailable and shall list the community resources contacted to fund the transportation or therapeutic resource.

(5) The transportation or therapeutic resource must not be otherwise eligible for Medicaid reimbursement.

e. The following components are specifically excluded from family and community support services:

(1) Vocational services.

(2) Prevocational services.

(3) Supported employment services.

(4) Room and board.

(5) Academic services.

(6) General supervision and care.

f. A unit of family and community support services is 15 minutes.

78.52(4) *In-home family therapy.* In-home family therapy provides skilled therapeutic services to the member and family that will increase their ability to cope with the effects of serious emotional disturbance on the family unit and the familial relationships. The service must support the family by the development of coping strategies that will enable the member to continue living within the family environment.

a. The goal of in-home family therapy is to maintain a cohesive family unit.

b. In-home family therapy is exclusive of and cannot serve as a substitute for individual therapy, family therapy, or other mental health therapy that may be obtained through the Iowa Plan or other funding sources.

c. A unit of in-home family therapy service is 15 minutes.

78.52(5) *Respite care services.* Respite care services are services provided to the member that give temporary relief to the usual caregiver and provide all the necessary care that the usual caregiver would provide during that period. The purpose of respite care is to enable the member to remain in the member's current living situation.

a. Respite services provided outside the member's home shall not be reimbursable if the living unit where respite care is provided is reserved for another person on a temporary leave of absence.

b. Member-to-staff ratios shall be appropriate to the individual needs of the member as determined by the member's interdisciplinary team.

c. A unit of service is 15 minutes.

d. Respite care is not to be provided to members during the hours in which the usual caregiver is employed except when the member is attending a 24-hour residential camp. Respite care shall not be used as a substitute for a child's day care.

e. The interdisciplinary team shall determine if the member will receive basic individual respite, specialized respite or group respite as defined in 441—Chapter 83.

f. A maximum of 14 consecutive days of 24-hour respite care may be reimbursed.

g. Respite services provided for a period exceeding 24 consecutive hours to three or more members who require nursing care because of a mental or physical condition must be provided by a health care facility licensed under Iowa Code chapter 135C.

h. Respite services shall not be provided simultaneously with other residential, nursing, or home health aide services provided through the medical assistance program.

This rule is intended to implement Iowa Code section 249A.4 and 2005 Iowa Acts, chapter 167, section 13, and chapter 117, section 3.

[ARC 9403B, IAB 3/9/11, effective 5/1/11 (See Delay note at end of chapter); ARC 9704B, IAB 9/7/11, effective 9/1/11; ARC 9884B, IAB 11/30/11, effective 1/4/12; ARC 0707C, IAB 5/1/13, effective 7/1/13; ARC 0709C, IAB 5/1/13, effective 7/1/13; ARC 3874C, IAB 7/4/18, effective 8/8/18]

441—78.53(249A) Health home services. Subject to federal approval in the Medicaid state plan, payment shall be made for health home services as described in subrule 78.53(1) provided to an eligible Medicaid member as described in subrule 78.53(2) who has selected a health home services provider as provided in subrule 78.53(3).

78.53(1) Covered services. Health home services consist of the following services provided in a comprehensive, timely, and high-quality manner using health information technology to link services, as feasible and appropriate:

a. Comprehensive care management, which means:

- (1) Providing for all the member's health care needs or taking responsibility for arranging care with other qualified professionals;
- (2) Developing and maintaining for each member a continuity of care document that details all important aspects of the member's medical needs, treatment plan, and medication list; and
- (3) Implementing a formal screening tool to assess behavioral health treatment needs and physical health care needs.

b. Care coordination, which means assisting members with:

- (1) Medication adherence;
- (2) Chronic disease management;
- (3) Appointments, referral scheduling, and reminders; and
- (4) Understanding health insurance coverage.

c. Health promotion, which means coordinating or providing behavior modification interventions aimed at:

- (1) Supporting health management;
- (2) Improving disease control; and
- (3) Enhancing safety, disease prevention, and an overall healthy lifestyle.

d. Comprehensive transitional care following a member's move from an inpatient setting to another setting. Comprehensive transitional care includes:

- (1) Updates of the member's continuity of care document and case plan to reflect the member's short-term and long-term care coordination needs; and
- (2) Personal follow-up with the member regarding all needed follow-up after the transition.

e. Member and family support (including authorized representatives). This support may include:

- (1) Communicating with and advocating for the member or family for the assessment of care decisions;
- (2) Assisting with obtaining and adhering to medications and other prescribed treatments;
- (3) Increasing health literacy and self-management skills; and
- (4) Assessing the member's physical and social environment so that the plan of care incorporates needs, strengths, preferences, and risk factors.

f. Referral to community and social support services available in the community.

78.53(2) Members eligible for health home services.

a. Subject to the authority of the Secretary of the United States Department of Health and Human Services pursuant to 42 U.S.C. §1396w-4(h)(1)(B) to establish higher levels for the number or severity of chronic or mental health conditions for purposes of determining eligibility for receipt of health home services, payment shall be made only for health home services provided to a Medicaid member who:

- (1) Has at least two chronic conditions;
- (2) Has one chronic condition and is at risk of having a second chronic condition;
- (3) Has a serious mental illness; or

- (4) Has a serious emotional disturbance.
- b. For purposes of this rule, the term “chronic condition” means:
 - (1) A mental health disorder.
 - (2) A substance use disorder.
 - (3) Asthma.
 - (4) Diabetes.
 - (5) Heart disease.
 - (6) Being overweight, as evidenced by:
 - 1. Having a body mass index (BMI) over 25 for an adult, or
 - 2. Weighing over the 85th percentile for the pediatric population.
 - (7) Hypertension.
- c. For purposes of this rule, the term “serious mental illness” means:
 - (1) A psychotic disorder;
 - (2) Schizophrenia;
 - (3) Schizoaffective disorder;
 - (4) Major depression;
 - (5) Bipolar disorder;
 - (6) Delusional disorder; or
 - (7) Obsessive-compulsive disorder.

d. For purposes of this rule, the term “serious emotional disturbance” means a diagnosable mental, behavioral, or emotional disorder (not including substance use disorders, learning disorders, or intellectual disorders) that is of sufficient duration to meet diagnostic criteria specified in the most current Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association and that results in a functional impairment. For this purpose, the term “functional impairment” means episodic, recurrent, or continuous difficulties that substantially interfere with or limit a person from achieving or maintaining one or more developmentally appropriate social, behavioral, cognitive, communicative, or adaptive skills and that substantially interfere with or limit the person’s role or functioning in family, school, or community activities, not including difficulties resulting from temporary and expected responses to stressful events in a person’s environment.

78.53(3) Selection of health home services provider. As a condition of payment for health home services, the eligible member receiving the services must have selected the billing provider as the member’s health home, as reported by the provider. A member must select a provider located in the member’s county of residence or in a contiguous county.

This rule is intended to implement Iowa Code section 249A.4 and 2011 Iowa Acts, chapter 129, section 10.

[ARC 0198C, IAB 7/11/12, effective 7/1/12; ARC 0838C, IAB 7/24/13, effective 7/1/13]

441—78.54(249A) Speech-language pathology services. Payment will be approved for the same services provided by a speech-language pathologist that are payable under Title XVIII of the Social Security Act (Medicare).

This rule is intended to implement Iowa Code section 249A.4 and 2012 Iowa Acts, Senate File 2158. [ARC 0360C, IAB 10/3/12, effective 12/1/12]

441—78.55(249A) Services rendered via telehealth. An in-person contact between a health care professional and a patient is not required as a prerequisite for payment for otherwise-covered services appropriately provided through telehealth in accordance with generally accepted health care practices and standards prevailing in the applicable professional community at the time the services are provided, as well as being in accordance with provisions under rule 653—13.11(147,148,272C). Health care services provided through in-person consultations or through telehealth shall be treated as equivalent services for the purposes of reimbursement.

This rule is intended to implement Iowa Code section 249A.4 and 2015 Iowa Acts, Senate File 505, division V, section 12(23).

[ARC 2166C, IAB 9/30/15, effective 11/4/15]

441—78.56(249A) Community-based neurobehavioral rehabilitation services. Payment will be made for community-based neurobehavioral rehabilitation services that do not duplicate other services covered in this chapter.

78.56(1) Definitions.

“Assessment” means the review of the current functioning of the member using the service in regard to the member’s situation, needs, strengths, abilities, desires, and goals.

“Brain injury” means a diagnosis in accordance with rule 441—83.81(249A).

“Health care” means the services provided by trained and licensed health care professionals to restore or maintain the member’s health.

“Intermittent community-based neurobehavioral rehabilitation services” are provided to a Medicaid member on an as-needed basis to support the member and the member’s family or caregivers to assist the member to increase adaptive behaviors, decrease maladaptive behaviors, and adapt and accommodate to challenging behaviors to support the member to remain in the member’s own home and community.

“Member” means a person who has been determined to be eligible for Medicaid under 441—Chapter 75.

“Neurobehavioral rehabilitation” refers to a specialized category of neurorehabilitation provided by a multidisciplinary team that has been trained in, and delivers, services individually designed to address cognitive, medical, behavioral and psychosocial challenges, as well as the physical manifestations of acquired brain injury. Services concurrently work to optimize functioning at personal, family and community levels, by supporting the increase of adaptive behaviors, decrease of maladaptive behaviors and adaptation and accommodation to challenging behaviors to support a member to maximize the member’s independence in activities of daily living and ability to live in the member’s home and community.

“Program” means a set of related resources and services directed to the accomplishment of a fixed set of goals for eligible members.

“Standardized assessment” means a valid, reliable, and comprehensive functional assessment tool(s) or process, or both, approved by the department for use in the assessment of a member’s individual needs.

78.56(2) Member eligibility. To be eligible to receive community-based neurobehavioral rehabilitation services, a member shall meet the following criteria:

a. *Brain injury diagnosis.* To be eligible for community-based neurobehavioral rehabilitation services, the member must have a brain injury diagnosis as set forth in rule 441—83.81(249A).

b. *Risk factors.* The member has the following post-brain injury risk factors:

(1) The member is exhibiting neurobehavioral symptoms in such frequency or severity that the member has undergone or is currently undergoing treatment more intensive than outpatient care and is currently hospitalized, institutionalized, incarcerated or homeless or is at risk of hospitalization, institutionalization, incarceration or homelessness; or

(2) The member has a history of presenting with neurobehavioral or psychiatric symptoms resulting in at least one episode that required professional supportive care more intensive than outpatient care more than once in a lifetime (e.g., emergency services, alternative home care, partial hospitalization, or inpatient hospitalization).

c. *Need for assistance.* The member exhibits neurobehavioral symptoms in such frequency, severity or intensity that community-based neurobehavioral rehabilitation is required.

d. *Needs assessment.* The member shall have a standardized comprehensive functional neurobehavioral assessment reviewed or completed by a licensed neuropsychologist, neurologist, M.D., or D.O. The neurobehavioral assessment shall document the member’s need for community-based neurobehavioral rehabilitation, and the medical services unit of the Iowa Medicaid enterprise has determined that the member is in need of specialty neurobehavioral rehabilitation services.

e. *Standards for assessment.* Each member will have had a department-approved, standardized comprehensive functional neurobehavioral assessment completed within the 90 days prior to admission. Each needs assessment will include the assessment of a member’s individual physical, emotional, cognitive, medical and psychosocial residuals related to the member’s brain injury, which must include the following:

(1) Identification of the neurobehavioral needs that put the member at risk, including but not limited to verbal aggression, physical aggression, self-harm, unwanted sexual behavior, cognitive and or behavioral perseveration, wandering or elopement, lack of motivation, lack of initiation or other unwanted social behaviors not otherwise specified.

(2) Identification of triggers of unwanted behaviors and the member's ability to self-manage the member's symptoms.

(3) The member's rehabilitation and medical care history to include medication history and status.

(4) The member's employment history and the member's barriers to employment.

(5) The member's dietary and nutritional needs.

(6) The member's community accessibility and safety.

(7) The member's access to transportation.

(8) The member's history of substance abuse.

(9) The member's vulnerability to exploitation and history of risk of exploitation.

(10) The member's history and status of relationships, natural supports and socialization.

f. Emergency admission. In the event that emergency admission is required, the assessment shall be completed within ten calendar days of admission.

78.56(3) Covered services.

a. Service setting.

(1) Community-based neurobehavioral residential rehabilitation services are provided to a member living in a three-to-five-bed residential care facility with a specialized license designation issued by the department of inspections and appeals; or

(2) Community-based neurobehavioral intermittent rehabilitation services are provided to a member living in the member's own residence in the community.

No payment shall be made for community-based neurobehavioral rehabilitation when provided in a medical institution such as an intermediate care facility for persons with intellectual disabilities, nursing facility or skilled nursing facility.

b. Community-based neurobehavioral rehabilitation residential services identified in the treatment plan may include:

(1) Prescriptive programming to maintain and advance progress made in rehabilitation;

(2) Modifying or adapting the member's environment to improve overall functioning;

(3) Assistance in obtaining preventative, appropriate and timely medical and dental care;

(4) Compensatory strategies to assist in managing ADLS (activities of daily living);

(5) Assistance with coordinating and obtaining physical, oral, or mental health care and any other professional services necessary to the member's health and well-being;

(6) Behavioral and cognitive programming and supports;

(7) Medication management and consultation with pharmacy;

(8) Health and wellness management including dietary and nutritional programming;

(9) Progressive physical strengthening, fitness and retraining;

(10) Assistance with obtaining and use of assistive technology;

(11) Sobriety support development;

(12) Assistance with the self-identification of antecedent triggers;

(13) Assistance with preparation for transition to less intensive services including accessing the community;

(14) Flexibility in programming to meet individual needs;

(15) Assistance with re-learning coping and compensatory strategies;

(16) Support and assistance in seeking substance abuse and co-occurring disorders services;

(17) Support and assistance with obtaining legal consultation and services;

(18) Assistance with community accessibility and safety;

(19) Assistance with re-learning household maintenance;

(20) Assistance with recreational and leisure skill development;

(21) Assistance with the development and application of self-advocacy skills to navigate the service system;

- (22) Opportunities to learn about brain injury and individual needs following brain injury;
- (23) Support for carrying out the member's individual goals in the rehabilitation treatment plan;
- (24) Assistance with pursuit of education and employment goals;
- (25) Protective oversight in the residential setting and community;
- (26) Assistance and education to family, providers and other support system interests that are supporting the member receiving neurobehavioral rehabilitation services;
- (27) Transitional support and training;
- (28) Transportation essential to the attainment of the member's individual goals in the rehabilitation treatment plan;
- (29) Promotion of a program structure and support for members served so they can relearn or regain skills for maximum independence, community access, and integration.

c. Community-based neurobehavioral rehabilitation intermittent services identified in the treatment plan may occur in the member's own home with or on behalf of the member and may include:

- (1) Promotion of a program structure and support for members served so they can re-learn or regain skills for maximum community inclusion and access;
- (2) Modifying or adapting the member's environment to improve overall functioning;
- (3) Compensatory strategies to assist in managing ADLS (activities of daily living);
- (4) Behavioral supports;
- (5) Assistance with obtaining and use of assistive technology;
- (6) Assistance with the self-identification of antecedent triggers;
- (7) Flexibility in programming to meet the member's individual needs;
- (8) Assistance with re-learning coping and compensatory strategies;
- (9) Assistance with the development and application of self-advocacy skills to navigate the service system;
- (10) Support for carrying out the member's individual goals in the rehabilitation treatment plan;
- (11) Assistance and education to family, providers and other support system interests that are supporting the member receiving community-based neurobehavioral rehabilitation services;
- (12) Transitional support and training;
- (13) Transportation essential to the attainment of the member's individual goals in the rehabilitation treatment plan.

d. Approval of treatment plan. The community-based neurobehavioral services provider shall submit the proposed plan of care, the results of the member's formal assessment, and medical documentation supporting a brain injury diagnosis to the Iowa Medicaid enterprise (IME) medical services unit for approval before providing the services.

e. Initial treatment plan. Within 30 days of admission, the provider shall submit the member's treatment plan to the IME medical services unit.

- (1) The IME medical services unit will approve the provider's treatment plan if:
 1. The treatment plan conforms to the medical necessity requirements in subrule 78.55(4);
 2. The treatment plan is consistent with the written diagnosis and treatment recommendations made by a licensed medical professional that is a licensed neuropsychologist or neurologist, M.D., or D.O.;
 3. The treatment plan is sufficient in amount, duration, and scope to reasonably achieve its purpose;
 4. The provider can demonstrate that the provider possesses the skills and resources necessary to implement the plan; and
 5. The treatment plan does not exceed 180 days in duration.

(2) A treatment summary detailing the member's response to treatment during the previous approval period must be submitted when approval for subsequent plans is requested.

f. Subsequent plans. The IME medical services unit may approve a subsequent neurobehavioral rehabilitation treatment plan that conforms to the conditions of medical necessity pursuant to subrule 78.56(4) and to the conditions pursuant to subrule 78.56(3).

g. Quality review. The IME medical services unit may perform the quality review to evaluate:

- (1) The time elapsed from referral to rehabilitation treatment plan development;
- (2) The continuity of treatment;
- (3) The length of stay per member;
- (4) The affiliation of the medical professional recommending services with the neurobehavioral rehabilitation services provider;
- (5) Gaps in service;
- (6) The results achieved;
- (7) Member and stakeholder satisfaction;
- (8) The provider's compliance with standards listed in rule 441—77.54(249A).

78.56(4) *Medical necessity.* Nothing in this rule shall be deemed to exempt coverage of community-based neurobehavioral rehabilitation services from the requirement that services be medically necessary. “Medically necessary” means that the service is:

- a. Consistent with the diagnosis and treatment of the member's condition;
- b. Required to meet the medical needs of the member and is needed for reasons other than the convenience of the member or the member's caregiver;
- c. The least costly type of service that can reasonably meet the medical needs of the member; and
- d. In accordance with the standards of good medical practice. The standards of good practice for each field of medical and remedial care covered by the Iowa Medicaid program are those standards of good practice identified by:
 - (1) Knowledgeable Iowa clinicians practicing or teaching in the field; and
 - (2) The professional literature regarding best practices in the field.

78.56(5) *Documentation standards.* Community-based neurobehavioral rehabilitation service providers shall maintain service provision records, financial records, and clinical records in accordance with the provisions of rule 441—79.3(249A).

[ARC 2341C, IAB 1/6/16, effective 2/10/16]

441—78.57(249A) *Child care medical services.* Payments will be made to licensed child care centers that provide medical services in addition to child care. Medically necessary services are provided under a plan of care that is developed by licensed professionals within their scope of practice and authorized by the member's physician. The services include and implement a comprehensive protocol of care that is developed in conjunction with the parent or guardian and specifies the medical, nursing, personal care, psychosocial and developmental therapies required by the medically dependent or technologically dependent child served.

78.57(1) Nursing services are services which are provided by a registered nurse or a licensed practical nurse under the direction of the member's physician to a member in a licensed child care center. Nursing services shall be provided according to a written plan of care authorized by a physician. Payment for nursing services may be approved if the services are determined to be medically necessary as defined in subrule 78.57(5). Nursing services include activities that require the expertise of a nurse, such as physical assessment, tracheostomy care, medication administration, and tube feedings.

78.57(2) Personal care services are those services which are provided by an aide but are delegated and supervised by a registered nurse under the direction of the member's physician. Payment for personal care services may be approved if the services are determined to be medically necessary as defined in subrule 78.57(5). Personal care services shall be in accordance with the member's plan of care and authorized by a physician. Personal care services include the activities of daily living, oral hygiene, grooming, toileting, feeding, range of motion and positioning, and training the member in necessary self-help skills, including teaching prosocial skills and reinforcing positive interactions.

78.57(3) Psychosocial services are those services that focus at decreasing or eliminating maladaptive behaviors. Payment for psychosocial services may be approved if the services are determined to be medically necessary as defined in subrule 78.57(5). Psychosocial services shall be in accordance with the member's plan of care and authorized by a physician. Psychosocial services include implementing a plan using clinically accepted techniques for decreasing or eliminating maladaptive behaviors. Psychosocial intervention plans must be developed and reviewed by licensed mental health providers.

78.57(4) Developmental therapies are those services which are provided by an aide but are delegated and supervised by a licensed therapist under the direction of the member's physician. Payment for developmental therapies may be approved if the services are determined to be medically necessary as defined in subrule 78.57(5). Developmental therapies shall be in accordance with the member's plan of care and authorized by a physician. Developmental therapies include activities based on the individual's needs such as fine motor, gross motor, and receptive expressive language.

78.57(5) "Medically necessary" means the service is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent the worsening of conditions that endanger life, cause pain, result in illness or infirmity, or threaten to cause or aggravate a disability or chronic illness and is an effective course of treatment for the member requesting a service.

78.57(6) Requirements.

a. Nursing, psychosocial, developmental therapies and personal care services shall be ordered in writing.

b. Nursing, psychosocial, developmental therapies and personal care services shall be authorized by the department or the department's designated review agent prior to payment.

c. Prior authorization shall be requested at the time of initial submission of the plan of care or at any time the plan of care is substantially amended and shall be renewed with the department or the department's designated review agent. Initial request for and request for renewal of prior authorization shall be submitted to the department's designated review agent. The provider of the service is responsible for requesting prior authorization and for obtaining renewal of prior authorization. The request for prior authorization shall include a nursing assessment, the plan of care, and supporting documentation. A treatment plan shall be completed prior to the start of care and at a minimum reviewed every 180 days thereafter. The plan of care shall support the medical necessity and intensity of services to be provided by reflecting the following information:

- (1) Place of service.
- (2) Type of service to be rendered and the treatment modalities being used.
- (3) Frequency of the services.
- (4) Assistance devices to be used.
- (5) Date on which services were initiated.
- (6) Progress of member in response to treatment.
- (7) Medical supplies to be furnished.
- (8) Member's medical condition as reflected by the following information, if applicable:
 1. Dates of prior hospitalization.
 2. Dates of prior surgery.
 3. Date last seen by a primary care provider.
 4. Diagnoses and dates of onset of diagnoses for which treatment is being rendered.
 5. Prognosis.
 6. Functional limitations.
 7. Vital signs reading.
 8. Date of last episode of acute recurrence of illness or symptoms.
 9. Medications.
- (9) Discipline of the person providing the service.
- (10) Certification period.

(11) Physician's signature and date. The treatment plan must be signed and dated by the physician before the claim for service is submitted for reimbursement.

(12) Forms 470-4815 and 470-4816 are utilized during the prior authorization review.

78.57(7) Nursing, personal care, and psychosocial services do not include:

a. Services provided to members aged 21 and older.

b. Services that require prior authorizations that are provided without regard to the prior authorization process.

c. Nursing services provided simultaneously with other Medicaid services (e.g., home health aide, physical, occupational, or speech therapy services, etc.).

d. Services that exceed the services that are approvable under the private duty nursing and personal care program pursuant to subrule 78.9(10).

e. Transportation services.

f. Services provided to a member while the member is in institutional care.

This rule is intended to implement Iowa Code chapter 249A.

[ARC 2361C, IAB 1/6/16, effective 1/1/16]

441—78.58(249A) Qualified Medicare beneficiary (QMB) provider services.

78.58(1) Payment. Payment will be made to QMB providers for a QMB-eligible member's coinsurance, copayment, and deductible for Medicare-covered services. The eligible member may be responsible for copayments pursuant to 441—subrule 79.1(13).

78.58(2) Definitions.

“*Coinsurance*” means a percentage of costs of a covered health care service that has to be paid.

“*Copayment*” means a fixed amount a member pays for a covered health care service.

“*Deductible*” means the amount paid for covered health care services before the insurance plan will effect payment.

“*Medicare cost sharing*” means the Medicare member's responsibility for a Medicare-covered service. “*Medicare cost sharing*” includes coinsurance, copayments, and deductibles.

“*Qualified Medicare beneficiary*” or “*QMB*” means an individual who has been determined eligible for the QMB program pursuant to 441—subrule 75.1(29). Under the QMB program, Medicaid pays the individual's Medicare Part A and B premiums; coinsurance; copayment; and deductible (except for Part D).

This rule is intended to implement Iowa Code section 249A.4.

[ARC 3494C, IAB 12/6/17, effective 1/10/18]

441—78.59(249A) Health insurance premium payment (HIPP) provider services.

78.59(1) Reimbursement. A HIPP provider may bill the department for the HIPP-eligible member's out-of-pocket cost-sharing obligations. Reimbursement of claims is limited to in-network coinsurance, copayments, and deductibles of the HIPP-eligible member's health insurance, paid for through the HIPP program. The HIPP-eligible member may be responsible for a copayment pursuant to 441—subrule 79.1(13).

78.59(2) Definitions.

“*Coinsurance*” means a percentage of costs of a covered health care service that has to be paid.

“*Copayment*” means a fixed amount a member pays for a covered health care service.

“*Cost sharing*” means the member's health insurance in-network responsibility for a covered service. “*Cost sharing*” includes coinsurance, copayments, and deductibles.

“*Deductible*” means the amount paid for covered health care services before the insurance plan will effect payment.

“*Eligible member*” means an individual eligible for Medicaid pursuant to rule 441—75.1(249A) et seq. and who qualifies for and is participating in the department's HIPP program prescribed under rule 441—75.21(249A).

“*Health insurance premium payment (HIPP) program*” or “*HIPP program*” has the same meaning as provided in rule 441—75.21(249A).

This rule is intended to implement Iowa Code section 249A.4.

[ARC 3494C, IAB 12/6/17, effective 1/10/18]

441—78.60(249A) Crisis response services. Payment will be made to providers (eligible pursuant to rule 441—77.55(249A)) of crisis response services, crisis stabilization community-based services, and crisis stabilization residential services delivered as set forth in 441—Chapter 24, Division II.

This rule is intended to implement Iowa Code section 249A.4.

[ARC 3551C, IAB 1/3/18, effective 2/7/18]

441—78.61(249A) Subacute mental health services. Payment will be made to providers (eligible pursuant to rule 441—77.56(249A)) for the provision of subacute mental health care facility services that meet the standards outlined in 481—Chapter 71.

This rule is intended to implement Iowa Code section 249A.4.
[ARC 3551C, IAB 1/3/18, effective 2/7/18]

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- ¹ Two ARCs
- ² Effective date of 78.3 and 78.31 delayed 70 days by the Administrative Rules Review Committee at its January 1, 1988 meeting.
- ³ Effective date of 4/1/90 delayed 70 days by the Administrative Rules Review Committee at its March 12, 1990, meeting.
- ⁴ Effective date of 4/1/91 delayed until adjournment of the 1991 session of the General Assembly by the Administrative Rules Review Committee at its meeting held February 12, 1991.
- ⁵ Effective date of 3/1/92 delayed until adjournment of the 1992 General Assembly by the Administrative Rules Review Committee at its meeting held February 3, 1992.
- ⁶ Two ARCs
- ⁷ Two ARCs
- ⁸ At a special meeting held January 24, 2002, the Administrative Rules Review Committee voted to delay until adjournment of the 2002 Session of the General Assembly the effective date of amendments published in the February 6, 2002, Iowa Administrative Bulletin as **ARC 1365B**.
- ⁹ Effective date of 12/15/02 delayed 70 days by the Administrative Rules Review Committee at its December 10, 2002, meeting.
- ¹⁰ Two or more ARCs
- ¹¹ July 1, 2009, effective date of amendments to 78.27(2)“d” delayed 70 days by the Administrative Rules Review Committee at a special meeting held June 25, 2009.
- ¹² May 11, 2011, effective date of 78.34(5)“d,” 78.38(5)“h,” 78.41(2)“g,” 78.43(3)“d,” and 78.52(5)“a” delayed 70 days by the Administrative Rules Review Committee at its meeting held April 11, 2011.

CHAPTER 83
MEDICAID WAIVER SERVICES

PREAMBLE

Medicaid waiver services are services provided to maintain persons in their own homes or communities who would otherwise require care in a medical institution, including support for persons to seek and maintain employment in the community. Provision of these services must be cost-effective. Services are limited to certain targeted client groups for whom a federal waiver has been requested and approved. Services provided through the waivers are not available to other Medicaid recipients as the services are beyond the scope of the Medicaid state plan.

[ARC 2471C, IAB 3/30/16, effective 5/4/16]

DIVISION I—HCBS HEALTH AND DISABILITY WAIVER SERVICES

441—83.1(249A) Definitions.

“Attorney in fact under a durable power of attorney for health care” means an individual who is designated by a durable power of attorney for health care, pursuant to Iowa Code chapter 144B, as an agent to make health care decisions on behalf of an individual and who has consented to act in that capacity.

“Basic individual respite” means respite provided on a staff-to-consumer ratio of one to one or higher to individuals without specialized needs requiring the care of a licensed registered nurse or licensed practical nurse.

“Blind individual” means an individual who has a central visual acuity of 20/200 or less in the better eye with the use of corrective lens or visual field restriction to 20 degrees or less.

“Client participation” means the amount of the recipient income that the person must contribute to the cost of health and disability waiver services exclusive of medical vendor payments before Medicaid will participate.

“Deeming” means the specified amount of parental or spousal income and resources considered in determining eligibility for a child or spouse according to current supplemental security income guidelines.

“Disabled person” means an individual who is unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which has lasted or is expected to last for a continuous period of not less than 12 months. A child under the age of 18 is considered disabled if the child suffers a medically determinable physical or mental impairment of comparable severity.

“Financial participation” means client participation and medical payments from a third party including veterans’ aid and attendance.

“Group respite” is respite provided on a staff-to-consumer ratio of less than one to one.

“Guardian” means a guardian appointed in probate court.

“Intermediate care facility for persons with an intellectual disability level of care” means that the individual has a diagnosis of intellectual disability made in accordance with the criteria provided in the current version of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association; or has a related condition as defined in 42 CFR 435.1009; and needs assistance in at least three of the following major life areas: mobility, musculoskeletal skills, activities of daily living, domestic skills, toileting, eating skills, vision, hearing or speech or both, gross/fine motor skills, sensory-taste, smell, tactile, academic skills, vocational skills, social/community skills, behavior, and health care.

“Intermittent homemaker service” means homemaker service provided from one to three hours a day for not more than four days per week.

“Intermittent respite service” means respite service provided from one to three times a week.

“Managed care organization” means an entity that (1) is under contract with the department to provide services to Medicaid recipients and (2) meets the definition of “health maintenance organization” as defined in Iowa Code section 514B.1.

“Medical assessment” means a visual and physical inspection of the consumer, noting deviations from the norm, and a statement of the consumer’s mental and physical condition that can be amendable to or resolved by appropriate actions of the provider.

“Medical institution” means a nursing facility or an intermediate care facility for persons with an intellectual disability which has been approved as a Medicaid vendor.

“Medical intervention” means consumer care in the areas of hygiene, mental and physical comfort, assistance in feeding and elimination, and control of the consumer’s care and treatment to meet the physical and mental needs of the consumer in compliance with the plan of care in areas of health, prevention, restoration, and maintenance.

“Medical monitoring” means observation for the purpose of assessing, preventing, maintaining, and treating disease or illness based on the consumer’s plan of care.

“Nursing facility level of care” means that the following conditions are met:

1. The presence of a physical or mental impairment which restricts the member’s daily ability to perform the essential activities of daily living, bathing, dressing, and personal hygiene, and impedes the member’s capacity to live independently.
2. The member’s physical or mental impairment is such that self-execution of required nursing care is improbable or impossible.

“Service plan” means a person-centered, outcome-based plan of services which is written by the member’s case manager with input and direction from the member and which addresses all relevant services and supports being provided. The service plan is developed by the interdisciplinary team, which includes the member and, if appropriate, the member’s legal representative, member’s family, service providers, and others directly involved with the member.

“Skilled nursing facility level of care” means that the following conditions are met:

1. The member’s medical condition requires skilled nursing services or skilled rehabilitation services as defined in 42 CFR 409.31(a), 409.32, and 409.34.
2. Services are provided in accordance with the general provisions for all Medicaid providers and services as described in rule 441—79.9(249A).
3. Documentation submitted for review indicates that the member has:
 - a. A physician order for all skilled services.
 - b. Services that require the skills of medical personnel, including registered nurses, licensed practical nurses, physical therapists, occupational therapists, speech pathologists, or audiologists.
 - c. An individualized care plan that identifies support needs.
 - d. Confirmation that skilled services are provided to the member.
 - e. Skilled services that are provided by, or under the supervision of, medical personnel as described above.
 - f. Skilled nursing services that are needed and provided seven days a week or skilled rehabilitation services that are needed and provided at least five days a week.

“Specialized respite” means respite provided on a staff-to-consumer ratio of one to one or higher to individuals with specialized medical needs requiring the care, monitoring or supervision of a licensed registered nurse or licensed practical nurse.

“Substantial gainful activity” means productive activities which add to the economic wealth, or produce goods or services to which the public attaches a monetary value.

“Third-party payments” means payments from an attorney, individual, institution, corporation, or public or private agency which is liable to pay part or all of the medical costs incurred as a result of injury, disease or disability by or on behalf of an applicant or a past or present recipient of medical assistance.

“Usual caregiver” means a person or persons who reside with the consumer and are available on a 24-hour-per-day basis to assume responsibility for the care of the consumer.

[ARC 0306C, IAB 9/5/12, effective 11/1/12; ARC 0757C, IAB 5/29/13, effective 8/1/13; ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 3874C, IAB 7/4/18, effective 8/8/18]

441—83.2(249A) Eligibility. To be eligible for health and disability waiver services, a person must meet certain eligibility criteria and be determined to need a service(s) allowable under the program.

83.2(1) Eligibility criteria.

a. The person must be under the age of 65 and blind or disabled as determined by the receipt of social security disability benefits or by a disability determination made through the department. Disability determinations are made according to supplemental security income guidelines under Title XVI of the Social Security Act.

b. The person must be ineligible for Supplemental Security Income (SSI) if the person is 21 years of age or older, except that persons who are receiving health and disability waiver services upon reaching the age of 21 may continue to be eligible regardless of SSI eligibility until they reach the age of 25.

c. Persons shall meet the eligibility requirements of the supplemental security income program except for the following:

(1) The person is under 18 years of age, unmarried and not the head of a household and is ineligible for supplemental security income because of the deeming of the parent's(s') income.

(2) The person is married and is ineligible for supplemental security income because of the deeming of the spouse's income or resources.

(3) The person is ineligible for supplemental security income due to excess income and the person's income does not exceed 300 percent of the maximum monthly payment for one person under supplemental security income.

(4) The person is under 18 years of age and is ineligible for supplemental security income because of excess resources.

d. The person must be certified as being in need of nursing facility or skilled nursing facility level of care or as being in need of care in an intermediate care facility for persons with an intellectual disability, based on information submitted on a completed information submission tool Form 470-4694 for children aged 3 and under, the interRAI - Pediatric Home Care (PEDS-HC) for those aged 4 to 20, or the interRAI - Home Care (HC) for those aged 21 to 64 and other supporting documentation as relevant. Form 470-4694, the interRAI - Pediatric Home Care (PEDS-HC) and the interRAI - Home Care (HC) are available upon request from the IME medical services unit. Copies of the completed information submission tool for an individual are available to that individual from the individual's case manager or managed care organization.

(1) The member's designated case manager shall use the completed assessment to develop the comprehensive service plan as specified in rule 441—90.5(249A).

(2) The IME medical services unit shall be responsible for the initial determination of the member's level of care certification. The IME medical services unit or the member's managed care organization shall be responsible for annual redetermination of the level of care.

(3) Health and disability waiver services will not be provided when the person is an inpatient in a medical institution.

(4) The managed care organization must submit documentation to the IME medical services unit for all reassessments, performed at least annually, which indicate a change in the member's level of care. The IME medical services unit shall make a final determination for any reassessments which indicate a change in the level of care. If the level of care reassessment indicates no change in level of care, the member is approved to continue at the already established level of care.

e. To be eligible for interim medical monitoring and treatment services the consumer must be:

(1) Under the age of 21;

(2) Currently receiving home health agency services under rule 441—78.9(249A) and require medical assessment, medical monitoring, and regular medical intervention or intervention in a medical emergency during those services. (The home health aide services for which the consumer is eligible must be maximized before the consumer accesses interim medical monitoring and treatment.);

(3) Residing in the consumer's family home or foster family home; and

(4) In need of interim medical monitoring and treatment as ordered by a physician or a physician assistant.

f. The person must meet income and resource guidelines for Medicaid as if in a medical institution pursuant to 441—Chapter 75. When a husband and wife who are living together both apply for the

waiver, income and resource guidelines as specified at 441—paragraphs 75.5(2) “b” and 75.5(4) “c” shall be applied.

g. The person must have service needs that can be met by this waiver program. At a minimum a person must receive one billable unit of service under the waiver per calendar quarter.

h. To be eligible for the consumer choices option as set forth in 441—subrule 78.34(13), a person cannot be living in a residential care facility.

83.2(2) Need for services.

a. The member shall have a service plan approved by the department which is developed by the designated case manager. This service plan must be completed prior to services provision and annually thereafter.

The designated case manager shall establish the interdisciplinary team for the member and, with the team, identify the member’s need for service based on the member’s needs and desires as well as the availability and appropriateness of services, using the following criteria:

(1) This service plan shall be based, in part, on information in the completed information submission tool listed in paragraph 83.2(1) “d” and other supporting documentation as relevant. The designated case manager shall have a face-to-face visit with the member at least quarterly.

(2) Service plans for persons aged 20 or under shall be developed to reflect use of all appropriate nonwaiver Medicaid services and so as not to replace or duplicate those services. The designated case manager shall list all nonwaiver Medicaid services in the service plan.

(3) Service plans for persons aged 20 or under that include home health or nursing services shall not be approved until a home health agency has made a request to cover the member’s service needs through nonwaiver Medicaid services.

b. Except as provided below, the total monthly cost of the health and disability waiver services, excluding the cost of home and vehicle modification services, shall not exceed the established aggregate monthly cost for level of care as follows:

<u>Skilled level of care</u>	<u>Nursing level of care</u>	<u>ICF/ID</u>
\$2,792.65	\$959.50	\$3,742.93

For members eligible for SSI who remain eligible for health and disability waiver services until the age of 25 because they are receiving health and disability waiver services upon reaching the age of 21, these amounts shall be increased by the cost of services for which the member would be eligible under 441—subrule 78.9(10) if still under 21 years of age.

c. Interim medical monitoring and treatment services must be needed because all usual caregivers are unavailable to provide care due to one of the following circumstances:

(1) Employment. Interim medical monitoring and treatment services are to be received only during hours of employment.

(2) Academic or vocational training. Interim medical monitoring and treatment services provided while a usual caregiver participates in postsecondary education or vocational training shall be limited to 24 periods of no more than 30 days each per caregiver as documented by the service worker or targeted case manager. Time spent in high school completion, adult basic education, GED, or English as a second language does not count toward the limit.

(3) Absence from the home due to hospitalization, treatment for physical or mental illness, or death of the usual caregiver. Interim medical monitoring and treatment services under this subparagraph are limited to a maximum of 30 days.

(4) Search for employment.

1. Care during job search shall be limited to only those hours the usual caregiver is actually looking for employment, including travel time.

2. Interim medical monitoring and treatment services may be provided under this paragraph only during the execution of one job search plan of up to 30 working days in a 12-month period, approved by the department service worker or targeted case manager pursuant to 441—subparagraph 170.2(2) “b”(5).

3. Documentation of job search contacts shall be furnished to the department service worker or targeted case manager.

[ARC 0306C, IAB 9/5/12, effective 11/1/12; ARC 0548C, IAB 1/9/13, effective 1/1/13; ARC 0665C, IAB 4/3/13, effective 6/1/13; ARC 0757C, IAB 5/29/13, effective 8/1/13; ARC 0842C, IAB 7/24/13, effective 7/1/13; ARC 1056C, IAB 10/2/13, effective 11/6/13; ARC 1445C, IAB 4/30/14, effective 7/1/14; ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 2848C, IAB 12/7/16, effective 11/15/16; ARC 2936C, IAB 2/1/17, effective 3/8/17; ARC 3184C, IAB 7/5/17, effective 8/9/17]

441—83.3(249A) Application.

83.3(1) *Application for HCBS health and disability waiver services.* The application process as specified in rules 441—76.1(249A) to 441—76.6(249A) shall be followed.

83.3(2) *Application and services program limit.* The number of persons who may be approved for the HCBS health and disability waiver shall be subject to the number of members to be served as set forth in the federally approved HCBS health and disability waiver. The number of members to be served is set forth at the time of each five-year renewal of the waiver or in amendments to the waiver approved by the Centers for Medicare and Medicaid Services (CMS). When the number of applicants exceeds the number of members specified in the approved waiver, the applicant's name shall be placed on a waiting list maintained by the bureau of long-term care.

a. The county department office shall enter all waiver applications into the individualized services information system (ISIS) to determine if a payment slot is available.

(1) For applicants not currently receiving Medicaid, the county department office shall make the entry by the end of the fifth working day after receipt of a completed Form 470-2927 or 470-2927(S), Health Services Application, or within five working days after receipt of disability determination, whichever is later.

(2) For current Medicaid members, the county department office shall make the entry by the end of the fifth working day after receipt of a written request signed and dated by the applicant.

(3) A payment slot shall be assigned to the applicant upon confirmation of an available slot.

(4) Once a payment slot is assigned, the county department office shall give written notice to the applicant. The department shall hold the payment slot for the applicant as long as reasonable efforts are being made to arrange services and the applicant has not been determined to be ineligible for the program. If services have not been initiated and reasonable efforts are no longer being made to arrange services, the slot shall revert for use by the next person on the waiting list, if applicable. The applicant originally assigned the slot must reapply for a new slot.

b. If no payment slot is available, the department shall enter persons on a waiting list according to the following:

(1) Applicants not currently eligible for Medicaid shall be entered on the waiting list on the basis of the date a completed Form 470-2927 or 470-2927(S), Health Services Application, is received by the department or upon receipt of disability determination, whichever is later.

(2) Applicants currently eligible for Medicaid shall be added to the waiting list on the basis of the date a request as specified in 83.3(2)“a”(2) is received by the department.

(3) In the event that more than one application is received at one time, persons shall be entered on the waiting list on the basis of the month of birth, January being month one and the lowest number.

(4) Applicants who do not fall within the available slots shall have their application rejected, and their names shall be maintained on the waiting list. They shall be contacted to reapply as slots become available based on their order on the waiting list so that the number of approved persons on the program is maintained. The bureau of long-term care shall contact the county department office when a slot becomes available.

(5) Once a payment slot is assigned, the county department office shall give written notice to the person within five working days. The department shall hold the payment slot for 30 days for the person to file a new application. If an application has not been filed within 30 days, the slot shall revert for use by the next person on the waiting list, if applicable. The person originally assigned the slot must reapply for a new slot.

c. The county department office shall notify the bureau of long-term care within five working days of the receipt of an application and of any action on or withdrawal of an application.

83.3(3) Approval of application.

a. Applications for the HCBS health and disability waiver program shall be processed in 30 days unless one or more of the following conditions exist:

- (1) An application has been filed and is pending for federal supplemental security income benefits.
- (2) The application is pending because the department has not received information which is beyond the control of the client or the department.
- (3) The application is pending due to the disability determination process performed through the department.
- (4) The application is pending because a level of care determination has not been made although the required assessment has been submitted to the IME medical services unit.
- (5) The application is pending because the required assessment has not been completed. When a determination is not completed 90 days from the date of application due to the lack of a completed assessment, the application shall be denied.

b. Decisions shall be mailed or given to the applicant on the date when income maintenance eligibility and level of care determinations are completed.

c. An applicant must be given the choice between HCBS health and disability waiver services and institutional care. The applicant, parent, guardian, or attorney in fact under a durable power of attorney for health care shall sign the assessment and indicate that the applicant has elected home- and community-based services.

d. Waiver services provided prior to approval of eligibility for the waiver cannot be paid.

e. A member may be enrolled in only one waiver program at a time. Costs for waiver services are not reimbursable while the member is in a medical institution (hospital or nursing facility) or residential facility. Services may not be simultaneously reimbursed for the same time period as Medicaid or other Medicaid waiver services.

83.3(4) Effective date of eligibility.

a. Deeming of parental or spousal income and resources ceases and eligibility shall be effective on the date the income and resource eligibility and level of care determinations are completed but shall not be earlier than the first of the month following the date of application.

b. The effective date of eligibility for the health and disability waiver for persons who qualify for Medicaid due to eligibility for the waiver services and to whom paragraphs 83.3(4) "a" and "c" do not apply is the date on which the income eligibility and level of care determinations are completed.

c. Eligibility for persons covered under subparagraph 83.2(1) "c"(3) shall exist on the date the income and resource eligibility and level of care determinations are completed but shall not be earlier than the first of the month following the date of application.

d. Eligibility continues until the member has been in a medical institution for 120 consecutive days for other than respite care. Members who are inpatients in a medical institution for 120 or more consecutive days for other than respite care shall be terminated from health and disability waiver services and reviewed for eligibility for other Medicaid coverage groups. The member will be notified of that decision through Form 470-0602, Notice of Decision. If the member returns home before the effective date of the notice of decision and the member's condition has not substantially changed, the denial may be rescinded and eligibility may continue.

83.3(5) Attribution of resources. For the purposes of attributing resources as provided in rule 441—75.5(249A), the date on which the waiver applicant met the level of care criteria in a medical institution as established by the peer review organization shall be used as the date of entry to the medical institution. Only one attribution of resources shall be completed per person. Attributions completed for prior institutionalizations shall be applied to the waiver application.

[ARC 0306C, IAB 9/5/12, effective 11/1/12; ARC 0757C, IAB 5/29/13, effective 8/1/13; ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 3184C, IAB 7/5/17, effective 8/9/17; ARC 3234C, IAB 8/2/17, effective 9/6/17]

441—83.4(249A) Financial participation. Persons must contribute their predetermined financial participation to the cost of health and disability waiver services or other Medicaid services, as applicable.

83.4(1) Maintenance needs of the individual. The maintenance needs of the individual shall be computed by deducting an amount which is 300 percent of the maximum monthly payment for one person under supplemental security income (SSI) from the client's total income.

83.4(2) Limitation on payment. If the sum of the third-party payment and client participation equals or exceeds the reimbursement established by the service worker or targeted case manager for health and disability waiver services, Medicaid shall make no payments to health and disability waiver service providers. However, Medicaid shall make payments to other medical vendors, as applicable.

83.4(3) Maintenance needs of spouse and other dependents. Rescinded IAB 4/9/97, effective 6/1/97. [ARC 0757C, IAB 5/29/13, effective 8/1/13]

441—83.5(249A) Redetermination. A complete redetermination of eligibility for the health and disability waiver shall be completed at least once every 12 months or when there is significant change in the person's situation or condition.

A redetermination of continuing eligibility factors shall be made in accordance with rules 441—76.7(249A) and 441—83.2(249A). A redetermination shall include verification of the existence of a current service plan meeting the requirements listed in rule 441—83.7(249A).

83.5(1) The IME medical services unit or the member's managed care organization shall be responsible for annual redetermination of the level of care.

83.5(2) The managed care organization must submit documentation to the IME medical services unit for all reassessments, performed at least annually, which indicate a change in the member's level of care. The IME medical services unit shall make a final determination for any reassessments which indicate a change in the level of care. If the level of care reassessment indicates no change in level of care, the member is approved to continue at the already established level of care.

[ARC 0757C, IAB 5/29/13, effective 8/1/13; ARC 2361C, IAB 1/6/16, effective 1/1/16]

441—83.6(249A) Allowable services. Services allowable under the health and disability waiver are homemaker, home health, adult day care, respite care, nursing, counseling, consumer-directed attendant care, interim medical monitoring and treatment, home and vehicle modification, personal emergency response system, home-delivered meals, nutritional counseling, financial management, independent support brokerage, self-directed personal care, self-directed community supports and employment, and individual-directed goods and services as set forth in rule 441—78.34(249A).

[ARC 0757C, IAB 5/29/13, effective 8/1/13]

441—83.7(249A) Service plan. A service plan shall be prepared for health and disability waiver members in accordance with 441—paragraph 90.5(1) "b." Service plans for both children and adults shall be completed every 12 months or when there is significant change in the person's situation or condition.

83.7(1) The service plan shall include the frequency of the health and disability waiver services and the types of providers who will deliver the services.

83.7(2) The service plan shall indicate whether the member has elected the consumer choices option. If the member has elected the consumer choices option, the service plan shall identify:

- a. The independent support broker selected by the member; and
- b. The financial management service selected by the member.

83.7(3) The service plan shall also list all nonwaiver Medicaid services.

83.7(4) The service plan shall identify a plan for emergencies and the supports available to the member in an emergency.

[ARC 0757C, IAB 5/29/13, effective 8/1/13; ARC 2361C, IAB 1/6/16, effective 1/1/16]

441—83.8(249A) Adverse service actions.

83.8(1) Denial. An application for services shall be denied when it is determined by the department that:

- a. The client is not eligible for or in need of services.
- b. Needed services are not available or received from qualified providers.

c. Service needs exceed the aggregate monthly costs established in 83.2(2) “*b*,” or are not met by the services provided.

d. Needed services are not available or received from qualifying providers.

83.8(2) Termination. A particular service may be terminated when the department determines that:

a. The provisions of 441—paragraph 130.5(2) “*a*,” “*b*,” “*c*,” “*g*,” or “*h*” apply.

b. The costs of the health and disability waiver service for the person exceed the aggregate monthly costs established in 83.2(2) “*b*.”

c. The member receives care in a hospital, nursing facility, or intermediate care facility for persons with an intellectual disability for 120 days in any one stay for purposes other than respite care.

d. The member receives health and disability waiver services and the physical or mental condition of the member requires more care than can be provided in the member’s own home as determined by the designated case manager.

e. Service providers are not available.

83.8(3) Reduction of services shall apply as in 441—subrule 130.5(3), paragraphs “*a*” and “*b*.”

[ARC 0306C, IAB 9/5/12, effective 11/1/12; ARC 0757C, IAB 5/29/13, effective 8/1/13; ARC 3184C, IAB 7/5/17, effective 8/9/17; ARC 3234C, IAB 8/2/17, effective 9/6/17]

441—83.9(249A) Appeal rights. Notice of adverse action and right to appeal shall be given in accordance with 441—Chapter 7 and rule 441—130.5(234). The applicant or recipient is entitled to have a review of the level of care determination by the IME medical services unit by sending a letter requesting a review to the IME medical services unit. If dissatisfied with that decision, the applicant or recipient may file an appeal with the department.

441—83.10(249A) County reimbursement. Rescinded IAB 4/9/97, effective 6/1/97.

441—83.11(249A) Conversion to the X-PERT system. Rescinded IAB 8/7/02, effective 10/1/02.

These rules are intended to implement Iowa Code sections 249A.3 and 249A.4.

441—83.12 to 83.20 Reserved.

DIVISION II—HCBS ELDERLY WAIVER SERVICES

441—83.21(249A) Definitions.

“*Attorney in fact under a durable power of attorney for health care*” means an individual who is designated by a durable power of attorney for health care, pursuant to Iowa Code chapter 144B, as an agent to make health care decisions on behalf of an individual and who has consented to act in that capacity.

“*Basic individual respite*” means respite provided on a staff-to-consumer ratio of one to one or higher to individuals without specialized needs requiring the care of a licensed registered nurse or licensed practical nurse.

“*Client participation*” means the amount of the recipient income that the person must contribute to the cost of elderly waiver services exclusive of medical vendor payments before Medicaid will participate.

“*Group respite*” is respite provided on a staff-to-consumer ratio of less than one to one.

“*Guardian*” means a guardian appointed in probate court.

“*Interdisciplinary team*” means a collection of persons with varied professional backgrounds who develop one plan of care to meet a client’s need for services.

“*Managed care organization*” means an entity that (1) is under contract with the department to provide services to Medicaid recipients and (2) meets the definition of “health maintenance organization” as defined in Iowa Code section 514B.1.

“*Medical institution*” means a nursing facility which has been approved as a Medicaid vendor.

“*Nursing facility level of care*” means that the following conditions are met:

1. The presence of a physical or mental impairment which restricts the member's daily ability to perform the essential activities of daily living, bathing, dressing, and personal hygiene, and impedes the member's capacity to live independently.

2. The member's physical or mental impairment is such that self-execution of required nursing care is improbable or impossible.

"*Service plan*" means a person-centered, outcome-based plan of services which is written by the member's case manager with input and direction from the member and which addresses all relevant services and supports being provided. The service plan is developed by the interdisciplinary team, which includes the member and, if appropriate, the member's legal representative, member's family, service providers, and others directly involved with the member.

"*Skilled nursing facility level of care*" means that the following conditions are met:

1. The member's medical condition requires skilled nursing services or skilled rehabilitation services as defined in 42 CFR 409.31(a), 409.32, and 409.34.

2. Services are provided in accordance with the general provisions for all Medicaid providers and services as described in rule 441—79.9(249A).

3. Documentation submitted for review indicates that the member has:

a. A physician order for all skilled services.

b. Services that require the skills of medical personnel, including registered nurses, licensed practical nurses, physical therapists, occupational therapists, speech pathologists, or audiologists.

c. An individualized care plan that identifies support needs.

d. Confirmation that skilled services are provided to the member.

e. Skilled services that are provided by, or under the supervision of, medical personnel as described above.

f. Skilled nursing services that are needed and provided seven days a week or skilled rehabilitation services that are needed and provided at least five days a week.

"*Specialized respite*" means respite provided on a staff-to-consumer ratio of one to one or higher to individuals with specialized medical needs requiring the care, monitoring or supervision of a licensed registered nurse or licensed practical nurse.

"*Third-party payments*" means payments from an individual, institution, corporation, or public or private agency which is liable to pay part or all of the medical costs incurred as a result of injury, disease or disability by or on behalf of an applicant or a past or present recipient of medical assistance.

"*Usual caregiver*" means a person or persons who reside with the consumer and are available on a 24-hour-per-day basis to assume responsibility for the care of the consumer.

[ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 3874C, IAB 7/4/18, effective 8/8/18]

441—83.22(249A) Eligibility. To be eligible for elderly waiver services a person must meet certain eligibility criteria and be determined to need a service(s) allowable under the program.

83.22(1) Eligibility criteria. All of the following criteria must be met. The person must be:

a. Sixty-five years of age or older.

b. A resident of the state of Iowa.

c. Eligible for Medicaid as if in a medical institution pursuant to 441—Chapter 75. When a husband and wife who are living together both apply for the waiver, income and resource guidelines as specified at 441—paragraphs 75.5(2) "b" and 75.5(4) "c" shall be applied.

d. Certified as being in need of the intermediate or skilled level of care based, in part, on information submitted on the interRAI - Home Care (HC). The interRAI - Home Care (HC) is available on request from IME medical services unit and other supporting documentation as relevant. Copies of the completed interRAI - Home Care (HC) for an individual are available to that individual from the individual's case manager or managed care organization.

(1) The assessment shall be completed when the person applies for waiver services, upon request to report a significant change in the person's condition, and annually for reassessment of the person's level of care. The IME medical services unit shall be responsible for determination of the initial level of care.

(2) The IME medical services unit or the member's managed care organization shall be responsible for annual redetermination of the level of care.

(3) Elderly waiver services will not be provided when the person is an inpatient in a medical institution.

(4) The managed care organization must submit documentation to the IME medical services unit for all reassessments, performed at least annually, which indicate a change in the member's level of care. The IME medical services unit shall make a final determination for any reassessments which indicate a change in the level of care. If the level of care reassessment indicates no change in level of care, the member is approved to continue at the already established level of care.

e. Determined to need services as described in subrule 83.22(2).

f. Rescinded IAB 10/11/06, effective 10/1/06.

g. For the consumer choices option as set forth in rule 441—subrule 78.37(16), residing in a living arrangement other than a residential care facility.

83.22(2) Need for services, service plan, and cost.

a. Case management. Consumers under the elderly waiver shall receive case management services from a provider qualified pursuant to rule 441—77.29(249A). Case management services shall be provided as set forth in rules 441—90.5(249A) and 441—90.8(249A).

b. Interdisciplinary team. The case manager shall establish an interdisciplinary team for the consumer.

(1) *Composition.* The interdisciplinary team shall include the case manager and the consumer and, if appropriate, the consumer's legal representative, family, service providers, and others directly involved in the consumer's care.

(2) *Role.* The team shall identify:

1. The consumer's need for services based on the consumer's needs and desires.

2. Available and appropriate services to meet the consumer's needs.

3. Health and safety issues for the consumer that indicate the need for an emergency plan, based on a risk assessment conducted before the team meeting.

4. Emergency backup support and a crisis response system to address problems or issues arising when support services are interrupted or delayed or when the consumer's needs change.

c. Service plan. An applicant for elderly waiver services shall have a service plan developed by a qualified provider of case management services under the elderly waiver.

(1) Services included in the service plan shall be appropriate to the problems and specific needs or disabilities of the consumer.

(2) Services must be the least costly available to meet the service needs of the member. The total monthly cost of the elderly waiver services exclusive of case management services shall not exceed the established monthly cost of the level of care. Aggregate monthly costs, excluding the cost of case management and home and vehicle modifications, are limited as follows:

Skilled level of care

\$2,792.65

Nursing level of care

\$1,365.78

(3) The service plan must be completed before services are provided.

(4) The service plan must be reviewed at least annually and when there is any significant change in the consumer's needs.

d. Content of service plan. The service plan shall include the following information based on the consumer's current assessment and service needs:

(1) Observable or measurable individual goals.

(2) Interventions and supports needed to meet those goals.

(3) Incremental action steps, as appropriate.

(4) The names of staff, people, businesses, or organizations responsible for carrying out the interventions or supports.

(5) The desired individual outcomes.

(6) The identified activities to encourage the consumer to make choices, to experience a sense of achievement, and to modify or continue participation in the service plan.

(7) Description of any restrictions on the consumer's rights, including the need for the restriction and a plan to restore the rights. For this purpose, rights include maintenance of personal funds and self-administration of medications.

(8) A list of all Medicaid and non-Medicaid services that the consumer received at the time of waiver program enrollment that includes:

1. The name of the service provider responsible for providing the service.
2. The funding source for the service.
3. The amount of service that the consumer is to receive.

(9) Indication of whether the consumer has elected the consumer choice option and, if so, the independent support broker and the financial management service that the consumer has selected.

(10) The determination that the services authorized in the service plan are the least costly.

(11) A plan for emergencies that identifies the supports available to the consumer in situations for which no approved service plan exists and which, if not addressed, may result in injury or harm to the consumer or other persons or in significant amounts of property damage. Emergency plans shall include:

1. The consumer's risk assessment and the health and safety issues identified by the consumer's interdisciplinary team.
2. The emergency backup support and crisis response system identified by the interdisciplinary team.
3. Emergency, backup staff designated by providers for applicable services.

83.22(3) Providers—standards. Rescinded IAB 10/11/06, effective 10/1/06.

[ARC 7957B, IAB 7/15/09, effective 7/1/09; ARC 0191C, IAB 7/11/12, effective 7/1/12; ARC 0306C, IAB 9/5/12, effective 11/1/12; ARC 0359C, IAB 10/3/12, effective 12/1/12; ARC 0548C, IAB 1/9/13, effective 1/1/13; ARC 0665C, IAB 4/3/13, effective 6/1/13; ARC 0842C, IAB 7/24/13, effective 7/1/13; ARC 1056C, IAB 10/2/13, effective 11/6/13; ARC 1445C, IAB 4/30/14, effective 7/1/14; ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 2848C, IAB 12/7/16, effective 11/15/16; ARC 2936C, IAB 2/1/17, effective 3/8/17; ARC 3184C, IAB 7/5/17, effective 8/9/17]

441—83.23(249A) Application.

83.23(1) Application for HCBS elderly waiver. The application process as specified in rules 441—76.1(249A) to 441—76.6(249A) shall be followed.

83.23(2) Application for services. Rescinded IAB 12/6/95, effective 2/1/96.

83.23(3) Approval of application.

a. Applications for the elderly waiver program shall be processed in 30 days unless the worker can document difficulty in locating and arranging services or circumstances beyond the worker's control. In these cases a decision shall be made as soon as possible.

b. Decisions shall be mailed or given to the applicant on the date when both service and income maintenance eligibility determinations are completed.

c. An applicant must be given the choice between elderly waiver services and institutional care. The applicant, guardian, or attorney in fact under a durable power of attorney for health care shall sign the information submission tool specified in 83.22(1) "d," indicating that the applicant has elected waiver services.

d. Waiver services provided prior to approval of eligibility for the waiver cannot be paid.

83.23(4) Effective date of eligibility.

a. The effective date of eligibility is the date on which the income eligibility and level of care determinations are completed.

b. Eligibility for persons whose income exceeds supplemental security income guidelines shall not exist until the persons require care in a medical institution for a period of 30 consecutive days and shall be effective no earlier than the first day of the month in which the 30-day period begins.

c. Eligibility continues until the consumer has been in a medical institution for 120 consecutive days for other than respite care or fails to meet eligibility criteria listed in rule 441—83.22(249A). Consumers who are inpatients in a medical institution for 120 or more consecutive days for other than respite care shall be terminated from elderly waiver services and reviewed for eligibility for other

Medicaid coverage groups. The consumer will be notified of that decision through Form 470-0602, Notice of Decision. If the consumer returns home before the effective date of the notice of decision and the consumer's condition has not substantially changed, the denial may be rescinded and eligibility may continue.

83.23(5) Attribution of resources. For the purposes of attributing resources as provided in rule 441—75.5(249A), the date on which the waiver applicant met the level of care criteria in a medical institution as established by the peer review organization shall be used as the date of entry to the medical institution. Only one attribution of resources shall be completed per person. Attributions completed for prior institutionalizations shall be applied to the waiver application.

[ARC 0306C, IAB 9/5/12, effective 11/1/12; ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 3184C, IAB 7/5/17, effective 8/9/17; ARC 3234C, IAB 8/2/17, effective 9/6/17]

441—83.24(249A) Client participation. Persons must contribute their predetermined client participation to the cost of elderly waiver services.

83.24(1) Computation of client participation. Client participation shall be computed by deducting an amount for the maintenance needs of the individual which is 300 percent of the maximum SSI grant for an individual from the client's total income.

83.24(2) Limitation on payment. If the sum of the third-party payment and client participation equals or exceeds the reimbursement established by the service worker, Medicaid will make no payments for elderly waiver service providers. However, Medicaid will make payments to other medical vendors.

441—83.25(249A) Redetermination. A complete redetermination of eligibility for elderly waiver services shall be done at least once every 12 months.

A redetermination of continuing eligibility factors shall be made when a change in circumstances occurs that affects eligibility in accordance with rule 441—83.22(249A). A redetermination shall contain the components listed in rule 441—83.27(249A).

83.25(1) The IME medical services unit or the member's managed care organization shall be responsible for annual redetermination of the level of care.

83.25(2) The managed care organization must submit documentation to the IME medical services unit for all reassessments, performed at least annually, which indicate a change in the member's level of care. The IME medical services unit shall make a final determination for any reassessments which indicate a change in the level of care. If the level of care reassessment indicates no change in level of care, the member is approved to continue at the already established level of care.

[ARC 2361C, IAB 1/6/16, effective 1/1/16]

441—83.26(249A) Allowable services. Services allowable under the elderly waiver are case management, adult day care, emergency response system, homemaker, home health aide, nursing, respite care, chore, home-delivered meals, home and vehicle modification, mental health outreach, transportation, nutritional counseling, assistive devices, senior companions, consumer-directed attendant care, financial management, independent support brokerage, self-directed personal care, self-directed community supports and employment, and individual-directed goods and services as set forth in rule 441—78.37(249A).

441—83.27(249A) Service plan. The service plan shall be completed jointly by the consumer, the elderly waiver case manager, and any other person identified by the consumer.

83.27(1) The service plan shall indicate whether the consumer has elected the consumer choices option. If the consumer has elected the consumer choices option, the service plan shall identify:

- a. The independent support broker selected by the consumer; and
- b. The financial management service selected by the consumer.

83.27(2) The service plan shall identify a plan for emergencies and the supports available to the consumer in an emergency.

441—83.28(249A) Adverse service actions.

83.28(1) Denial. An application for services shall be denied when it is determined by the department that:

- a. The client is not eligible for or in need of services.
- b. Except for respite care, the elderly waiver services are not needed on a regular basis.
- c. Service needs exceed the aggregate monthly costs established in 83.22(2) “b,” or are not met by services provided.
- d. Needed services are not available or received from qualifying providers.
- e. Rescinded IAB 3/2/94, effective 3/1/94.

83.28(2) Termination. A particular service may be terminated when the department determines that:

- a. The provisions of 441—subrule 130.5(2), paragraph “a,” “b,” “c,” “d,” “g,” or “h” apply.
- b. The costs of the elderly waiver services for the person exceed the aggregate monthly costs established in 83.22(2) “b.”
- c. The client receives care in a hospital or nursing facility for 120 days in any one stay for purposes other than respite care.
- d. The client receives elderly waiver services and the physical or mental condition of the client requires more care than can be provided in the client’s own home as determined by the case manager and the interdisciplinary team.
- e. Service providers are not available.

83.28(3) Reduction of services shall apply as in 441—subrule 130.5(3), paragraphs “a” and “b.” [ARC 3234C, IAB 8/2/17, effective 9/6/17]

441—83.29(249A) Appeal rights. Notice of adverse action and right to appeal shall be given in accordance with 441—Chapter 7 and rule 441—130.5(234).

[ARC 0306C, IAB 9/5/12, effective 11/1/12]

441—83.30(249A) Enhanced services. When a household has one person receiving service in accordance with rules set forth in 441—Chapter 24 and another receiving elderly waiver services, the persons providing case management shall cooperate to make the best plan for both clients. When a person is eligible for services as set forth in 441—Chapter 24 and eligible for services under the elderly waiver, the person’s primary diagnosis will determine which services shall be used.

441—83.31(249A) Conversion to the X-PERT system. Rescinded IAB 8/7/02, effective 10/1/02.

These rules are intended to implement Iowa Code sections 249A.3 and 249A.4.

441—83.32 to 83.40 Reserved.

DIVISION III—HCBS AIDS/HIV WAIVER SERVICES

441—83.41(249A) Definitions.

“*AIDS*” means a medical diagnosis of acquired immunodeficiency syndrome based on the Centers for Disease Control “Revision of the CDC Surveillance Case Definition for Acquired Immunodeficiency Syndrome,” August 14, 1987, Vol. 36, No. 1S issue of “Morbidity and Mortality Weekly Report.”

“*Attorney in fact under a durable power of attorney for health care*” means an individual who is designated by a durable power of attorney for health care, pursuant to Iowa Code chapter 144B, as an agent to make health care decisions on behalf of an individual and who has consented to act in that capacity.

“*Basic individual respite*” means respite provided on a staff-to-consumer ratio of one to one or higher to individuals without specialized needs requiring the care of a licensed registered nurse or licensed practical nurse.

“*Client participation*” means the amount of the recipient’s income that the person must contribute to the cost of AIDS/HIV waiver services exclusive of medical vendor payments before Medicaid will participate.

“*Deeming*” means the specified amount of parental or spousal income and resources considered in determining eligibility for a child or spouse according to current supplemental security income guidelines.

“*Financial participation*” means client participation and medical payments from a third party including veterans’ aid and attendance.

“*Group respite*” is respite provided on a staff-to-consumer ratio of less than one to one.

“*Guardian*” means a guardian appointed in probate court.

“*HIV*” means a medical diagnosis of human immunodeficiency virus infection based on a positive HIV-related test.

“*Managed care organization*” means an entity that (1) is under contract with the department to provide services to Medicaid recipients and (2) meets the definition of “health maintenance organization” as defined in Iowa Code section 514B.1.

“*Medical institution*” means a nursing facility or hospital which has been approved as a Medicaid vendor.

“*Nursing facility level of care*” means that the following conditions are met:

1. The presence of a physical or mental impairment which restricts the member’s daily ability to perform the essential activities of daily living, bathing, dressing, and personal hygiene, and impedes the member’s capacity to live independently.

2. The member’s physical or mental impairment is such that self-execution of required nursing care is improbable or impossible.

“*Service plan*” means a person-centered, outcome-based plan of services which is written by the member’s case manager with input and direction from the member and which addresses all relevant services and supports being provided. The service plan is developed by the interdisciplinary team, which includes the member and, if appropriate, the member’s legal representative, member’s family, service providers, and others directly involved with the member.

“*Skilled nursing facility level of care*” means that the following conditions are met:

1. The member’s medical condition requires skilled nursing services or skilled rehabilitation services as defined in 42 CFR 409.31(a), 409.32, and 409.34.

2. Services are provided in accordance with the general provisions for all Medicaid providers and services as described in rule 441—79.9(249A).

3. Documentation submitted for review indicates that the member has:

a. A physician order for all skilled services.

b. Services that require the skills of medical personnel, including registered nurses, licensed practical nurses, physical therapists, occupational therapists, speech pathologists, or audiologists.

c. An individualized care plan that identifies support needs.

d. Confirmation that skilled services are provided to the member.

e. Skilled services that are provided by, or under the supervision of, medical personnel as described above.

f. Skilled nursing services that are needed and provided seven days a week or skilled rehabilitation services that are needed and provided at least five days a week.

“*Specialized respite*” means respite provided on a staff-to-consumer ratio of one to one or higher to individuals with specialized medical needs requiring the care, monitoring or supervision of a licensed registered nurse or licensed practical nurse.

“*Third-party payments*” means payments from an attorney, individual, institution, corporation, or public or private agency which is liable to pay part or all of the medical costs incurred as a result of injury, disease or disability by or on behalf of an applicant or a past or present recipient of medical assistance.

“*Usual caregiver*” means a person or persons who reside with the consumer and are available on a 24-hour-per-day basis to assume responsibility for the care of the consumer.

[ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 3874C, IAB 7/4/18, effective 8/8/18]

441—83.42(249A) Eligibility. To be eligible for AIDS/HIV waiver services a person must meet certain eligibility criteria and be determined to need a service(s) allowable under the program.

83.42(1) Eligibility criteria. All of the following criteria must be met. The person must:

a. Be diagnosed by a physician as having AIDS or HIV infection.

b. Be certified in need of the level of care that, but for the waiver, would otherwise be provided in a nursing facility or hospital based, in part, on information submitted on a completed Form 470-4694 for children aged 3 and under, the interRAI - Pediatric Home Care (PEDS-HC) for those aged 4 to 20, or the interRAI - Home Care (HC) for those aged 21 and over and other supporting documentation as relevant. Form 470-4694, the interRAI - Pediatric Home Care (PEDS-HC), and the interRAI - Home Care (HC) are available on request from the IME medical services unit. Copies of the completed information submission tool for an individual are available to that individual from the individual's case manager or managed care organization.

(1) The assessment as listed in 83.42(1)“*b*” shall be completed when the person applies for waiver services, upon request to report a significant change in the person's condition, and annually for reassessment of the person's level of care.

(2) The IME medical services unit shall be responsible for approval of the certification of the level of care, and the IME medical services unit or a managed care organization will be responsible for annual redeterminations.

(3) AIDS/HIV waiver services shall not be provided when the person is an inpatient in a medical institution.

c. Be eligible for medical assistance under SSI, SSI-related, FMAP, or FMAP-related coverage groups; medically needy at hospital level of care; or a special income level (300 percent group); or become eligible through application of the institutional deeming rules.

d. Require, and use at least quarterly, one service available under the waiver as determined through an evaluation of need described in subrule 83.42(2).

e. Have service needs such that the costs of the waiver services are not likely to exceed the costs of care that would otherwise be provided in a medical institution.

f. Have income which does not exceed 300 percent of the maximum monthly payment for one person under supplemental security income.

g. For the consumer choices option as set forth in 441—subrule 78.38(9), not be living in a residential care facility.

83.42(2) Need for services.

a. The designated case manager shall review the assessment of the person's need for waiver services and determine the availability and appropriateness of services. This review shall be based, in part, on information in the completed information submission tool designated in 83.42(1)“*b*” and other supporting documentation as relevant.

b. The total monthly cost of the AIDS/HIV waiver services shall not exceed the established aggregate monthly cost for level of care. The monthly cost of AIDS/HIV waiver services cannot exceed the established limit of \$1,876.80.

[ARC 0306C, IAB 9/5/12, effective 11/1/12; ARC 0548C, IAB 1/9/13, effective 1/1/13; ARC 0665C, IAB 4/3/13, effective 6/1/13; ARC 0842C, IAB 7/24/13, effective 7/1/13; ARC 1056C, IAB 10/2/13, effective 11/6/13; ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 2848C, IAB 12/7/16, effective 11/15/16; ARC 2936C, IAB 2/1/17, effective 3/8/17; ARC 3184C, IAB 7/5/17, effective 8/9/17]

441—83.43(249A) Application.

83.43(1) Application for HCBS AIDS/HIV waiver services. The application process as specified in rules 441—76.1(249A) to 441—76.6(249A) shall be followed.

83.43(2) Application for services. Rescinded IAB 12/6/95, effective 2/1/96.

83.43(3) Approval of application.

a. Applications for the HCBS AIDS/HIV waiver program shall be processed in 30 days unless one or more of the following conditions exist:

(1) The application is pending because the department has not received information, which is beyond the control of the client or the department.

(2) The application is pending because a level of care determination has not been made although the completed assessment has been submitted to the IME medical services unit.

(3) Rescinded IAB 3/7/01, effective 5/1/01.

b. Decisions shall be mailed or given to the applicant on the date when income maintenance eligibility and level of care determinations and the consumer service plan are completed.

c. An applicant must be given the choice between HCBS AIDS/HIV waiver services and institutional care. The applicant, parent, guardian, or attorney in fact under a durable power of attorney for health care shall sign the assessment and indicate that the applicant has elected home- and community-based services.

d. Waiver services provided prior to approval of eligibility for the waiver cannot be paid.

83.43(4) Effective date of eligibility.

a. The effective date of eligibility for the AIDS/HIV waiver for persons who are already determined eligible for Medicaid is the date on which the income and resource eligibility and level of care determinations are completed.

b. The effective date of eligibility for the AIDS/HIV waiver for persons who qualify for Medicaid due to eligibility for the waiver services and to whom 441—subrule 75.1(7) and rule 441—75.5(249A) do not apply is the date on which income and resource eligibility and level of care determinations are completed.

c. Eligibility for the waiver continues until the recipient has been in a medical institution for 120 consecutive days for other than respite care or fails to meet eligibility criteria listed in rule 441—83.42(249A). Recipients who are inpatients in a medical institution for 120 or more consecutive days for other than respite care shall be reviewed for eligibility for other Medicaid coverage groups and terminated from AIDS/HIV waiver services if found eligible under another coverage group. The recipient will be notified of that decision through Form 470-0602, Notice of Decision. If the consumer returns home before the effective date of the notice of decision and the person's condition has not substantially changed, the denial may be rescinded and eligibility may continue.

d. The effective date of eligibility for the AIDS/HIV waiver for persons who qualify for Medicaid due to eligibility for the waiver services and to whom the eligibility factors set forth in 441—subrule 75.1(7) and, for married persons, in rule 441—75.5(249A) have been satisfied is the date on which the income eligibility and level of care determinations are completed but shall not be earlier than the first of the month following the date of application.

83.43(5) Attribution of resources. For the purposes of attributing resources as provided in rule 441—75.5(249A), the date on which the waiver applicant met the level of care criteria in a medical institution as established by the peer review organization shall be used as the date of entry to the medical institution. Only one attribution of resources shall be completed per person. Attributions completed for prior institutionalizations shall be applied to the waiver application.

[ARC 0306C, IAB 9/5/12, effective 11/1/12; ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 3184C, IAB 7/5/17, effective 8/9/17; ARC 3234C, IAB 8/2/17, effective 9/6/17]

441—83.44(249A) Financial participation. Persons must contribute their predetermined financial participation to the cost of AIDS/HIV waiver services or other Medicaid services, as applicable.

83.44(1) Maintenance needs of the individual. The maintenance needs of the individual shall be computed by deducting an amount which is 300 percent of the maximum monthly payment for one person under supplemental security income (SSI) from the client's total income.

83.44(2) Limitation on payment. If the amount of the financial participation equals or exceeds the reimbursement established by the service worker for AIDS/HIV services, Medicaid will make no payments to AIDS/HIV waiver service providers. Medicaid will, however, make payments to other medical vendors.

83.44(3) Maintenance needs of spouse and other dependents. Rescinded IAB 4/9/97, effective 6/1/97.

441—83.45(249A) Redetermination. A complete redetermination of eligibility for AIDS/HIV waiver services shall be completed at least once every 12 months or when there is significant change in the person's situation or condition. A redetermination of continuing eligibility factors shall be made in accordance with rules 441—76.7(249A) and 441—83.42(249A). A redetermination shall include the components listed in rule 441—83.47(249A).

83.45(1) The IME medical services unit or the member's managed care organization shall be responsible for annual redetermination of the level of care.

83.45(2) The managed care organization must submit documentation to the IME medical services unit for all reassessments, performed at least annually, which indicate a change in the member's level of care. The IME medical services unit shall make a final determination for any reassessments which indicate a change in the level of care. If the level of care reassessment indicates no change in level of care, the member is approved to continue at the already established level of care.
[ARC 2361C, IAB 1/6/16, effective 1/1/16]

441—83.46(249A) Allowable services. Services allowable under the AIDS/HIV waiver are counseling, home health aide, homemaker, nursing care, respite care, home-delivered meals, adult day care, consumer-directed attendant care, financial management, independent support brokerage, self-directed personal care, self-directed community supports and employment, and individual-directed goods and services as set forth in rule 441—78.38(249A).

441—83.47(249A) Service plan. A service plan shall be prepared for AIDS/HIV waiver consumers in accordance with rule 441—130.7(234) except that service plans for both children and adults shall be completed every 12 months or when there is significant change in the person's situation or condition.

83.47(1) The service plan shall include the frequency of the AIDS/HIV waiver services and the types of providers who will deliver the services.

83.47(2) The service plan shall indicate whether the consumer has elected the consumer choices option. If the consumer has elected the consumer choices option, the service plan shall identify:

- a. The independent support broker selected by the consumer; and
- b. The financial management service selected by the consumer.

83.47(3) Service plans for consumers aged 20 or under must be developed to reflect use of all appropriate nonwaiver Medicaid services so as not to replace or duplicate those services.

83.47(4) The service plan shall identify a plan for emergencies and the supports available to the consumer in an emergency.

441—83.48(249A) Adverse service actions.

83.48(1) Denial. An application for services shall be denied when it is determined by the department that:

- a. The client is not eligible for or in need of services.
- b. Except for respite care, the AIDS/HIV waiver services are not needed on a regular basis.
- c. Service needs exceed the aggregate monthly costs established in 83.42(2) "b" or cannot be met by the services provided under the waiver.
- d. Needed services are not available from qualified providers.

83.48(2) Termination. Participation in the AIDS/HIV waiver program may be terminated when the department determines that:

- a. The provisions of 441—subrule 130.5(2), paragraph "a," "b," "c," "d," "g," or "h" apply.
- b. The costs of the AIDS/HIV waiver services for the person exceed the aggregate monthly costs established in 83.42(2) "b."
- c. The client receives care in a hospital or nursing facility for 120 days or more in any one stay for purposes other than respite care.
- d. The client receives AIDS/HIV waiver services and the physical or mental condition of the client requires more care than can be provided in the client's own home as determined by the service worker.
- e. Service providers are not available.

83.48(3) Reduction of services shall apply as in 441—subrule 130.5(3), paragraphs "a" and "b."
[ARC 3234C, IAB 8/2/17, effective 9/6/17]

441—83.49(249A) Appeal rights. Notice of adverse action and right to appeal shall be given in accordance with 441—Chapter 7 and rule 441—130.5(234).

[ARC 0306C, IAB 9/5/12, effective 11/1/12]

441—83.50(249A) Conversion to the X-PERT system. Rescinded IAB 8/7/02, effective 10/1/02.

These rules are intended to implement Iowa Code section 249A.4.

441—83.51 to 83.59 Reserved.

DIVISION IV—HCBS INTELLECTUAL DISABILITY WAIVER SERVICES

441—83.60(249A) Definitions.

“Adaptive” means age-appropriate skills related to taking care of one’s self and one’s ability to relate to others in daily living situations. These skills include limitations that occur in the areas of communication, self-care, home-living, social skills, community use, self-direction, safety, functional activities of daily living, leisure or work.

“Adult” means a person with an intellectual disability aged 18 or over.

“Appropriate” means that the services or supports or activities provided or undertaken by the organization are relevant to the consumer’s needs, situation, problems, or desires.

“Attorney in fact under a durable power of attorney for health care” means an individual who is designated by a durable power of attorney for health care, pursuant to Iowa Code chapter 144B, as an agent to make health care decisions on behalf of an individual and who has consented to act in that capacity.

“Basic individual respite” means respite provided on a staff-to-consumer ratio of one to one or higher to individuals without specialized needs requiring the care of a licensed registered nurse or licensed practical nurse.

“Behavior” means skills related to regulating one’s own behavior including coping with demands from others, making choices, controlling impulses, conforming conduct to laws, and displaying appropriate sociosexual behavior.

“Case management services” means those services established pursuant to Iowa Code chapter 225C.

“Child” means a person with an intellectual disability aged 17 or under.

“Client participation” means the posteligibility amount of the consumer’s income that persons eligible through a special income level must contribute to the cost of the home and community-based waiver service.

“Counseling” means face-to-face mental health services provided to the consumer and caregiver by a qualified intellectual disability professional (QIDP) to facilitate home management of the consumer and prevent institutionalization.

“Deemed status” means acceptance of certification or licensure of a program or service by another certifying body in place of certification based on review and evaluation.

“Department” means the Iowa department of human services.

“Direct service” means services involving face-to-face assistance to a consumer such as transporting a consumer or providing therapy.

“Fiscal accountability” means the development and maintenance of budgets and independent fiscal review.

“Group respite” is respite provided on a staff-to-consumer ratio of less than one to one.

“Guardian” means a guardian appointed in probate court.

“Health” means skills related to the maintenance of one’s health including eating; illness identification, treatment and prevention; basic first aid; physical fitness; regular physical checkups and personal habits.

“Immediate jeopardy” means circumstances where the life, health, or safety of a person will be severely jeopardized if the circumstances are not immediately corrected.

“Intellectual disability” means a diagnosis of intellectual disability (intellectual developmental disorder), global developmental delay, or unspecified intellectual disability (intellectual developmental disorder) which shall be made only when the onset of the person’s condition was during the developmental period and shall be based on an assessment of the person’s intellectual functioning and level of adaptive skills. The diagnosis shall be made by a person who is a licensed psychologist

or psychiatrist who is professionally trained to administer the tests required to assess intellectual functioning and to evaluate a person's adaptive skills. The diagnosis shall be made in accordance with the criteria provided in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5), published by the American Psychiatric Association.

"Intermediate care facility for persons with an intellectual disability (ICF/ID)" means an institution that is primarily for the diagnosis, treatment, or rehabilitation of persons with an intellectual disability or persons with related conditions and that provides, in a protected residential setting, ongoing evaluation, planning, 24-hour supervision, coordination and integration of health or related services to help each person function at the greatest ability and is an approved Medicaid vendor.

"Intermediate care facility for persons with an intellectual disability level of care" means that the individual has a diagnosis of intellectual disability made in accordance with the criteria provided in the current version of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association; or has a related condition as defined in 42 CFR 435.1009; and needs assistance in at least three of the following major life areas: mobility, musculoskeletal skills, activities of daily living, domestic skills, toileting, eating skills, vision, hearing or speech or both, gross/fine motor skills, sensory-taste, smell, tactile, academic skills, vocational skills, social/community skills, behavior, and health care.

"Intermittent supported community living service" means supported community living service provided not more than 52 hours per month.

"Maintenance needs" means costs associated with rent or mortgage, utilities, telephone, food and household supplies.

"Managed care" means a system that provides the coordinated delivery of services and supports that are necessary and appropriate, delivered in the least restrictive settings and in the least intrusive manner. Managed care seeks to balance three factors:

1. Achieving high-quality outcomes for participants.
2. Coordinating access.
3. Containing costs.

"Managed care organization" means an entity that (1) is under contract with the department to provide services to Medicaid recipients and (2) meets the definition of "health maintenance organization" as defined in Iowa Code section 514B.1.

"Medical assessment" means a visual and physical inspection of the consumer, noting deviations from the norm, and a statement of the consumer's mental and physical condition that can be amendable to or resolved by appropriate actions of the provider.

"Medical institution" means a nursing facility, intermediate care facility for persons with an intellectual disability, or hospital which has been approved as a Medicaid vendor.

"Medical intervention" means consumer care in the areas of hygiene, mental and physical comfort, assistance in feeding and elimination, and control of the consumer's care and treatment to meet the physical and mental needs of the consumer in compliance with the plan of care in areas of health, prevention, restoration, and maintenance.

"Medical monitoring" means observation for the purpose of assessing, preventing, maintaining, and treating disease or illness based on the consumer's plan of care.

"Natural supports" means services and supports identified as wanted or needed by the consumer and provider by persons not for pay (family, friends, neighbors, coworkers, and others in the community) and organizations or entities that serve the general public.

"Organization" means the entity being certified.

"Organizational outcome" means a demonstration by the organization of actions taken by the organization to provide for services or supports to consumers.

"Outcome" means an action or event that follows as a result or consequence of the provision of a service or support.

"Procedures" means the steps to be taken to implement a policy.

“*Process*” means service or support provided by an agency to a consumer that will allow the consumer to achieve an outcome. This can include a written, formal, consistent trackable method or an informal process that is not written but is trackable.

“*Program*” means a set of related resources and services directed to the accomplishment of a fixed set of goals and objectives for the population of a specified geographic area or for special target populations. It can mean an agency, organization, or unit of an agency, organization or institution.

“*Qualified intellectual disability professional*” means a person who has at least one year of experience working directly with persons with an intellectual disability or other developmental disabilities and who is one of the following:

1. A doctor of medicine or osteopathy.
2. A registered nurse.
3. An occupational therapist eligible for certification as an occupational therapist by the American Occupational Therapy Association or another comparable body.
4. A physical therapist eligible for certification as a physical therapist by the American Physical Therapy Association or another comparable body.
5. A speech-language pathologist or audiologist eligible for certification of Clinical Competence in Speech-Language Pathology or Audiology by the American Speech-Language Hearing Association or another comparable body or who meets the educational requirements for certification and who is in the process of accumulating the supervised experience required for certification.
6. A psychologist with a master’s degree in psychology from an accredited school.
7. A social worker with a graduate degree from a school of social work, accredited or approved by the Council on Social Work Education or another comparable body or who holds a bachelor of social work degree from a college or university accredited or approved by the Council of Social Work Education or another comparable body.
8. A professional recreation staff member with a bachelor’s degree in recreation or in a specialty area such as art, dance, music or physical education.
9. A professional dietitian who is eligible for registration by the American Dietetics Association.
10. A human services professional who must have at least a bachelor’s degree in a human services field including, but not limited to, sociology, special education, rehabilitation counseling and psychology.

“*Related condition*” means a severe, chronic disability that meets all the following conditions:

1. It is attributable to cerebral palsy, epilepsy, or any other condition, other than mental illness, found to be closely related to intellectual disability because the condition results in impairment of general intellectual functioning or adaptive behavior similar to that of a person with an intellectual disability and requires treatment or services similar to those required for a person with an intellectual disability.
2. It is manifested before the age of 22.
3. It is likely to continue indefinitely.
4. It results in substantial functional limitations in three or more of the following areas of major life activity:
 - Self-care.
 - Understanding and use of language.
 - Learning.
 - Mobility.
 - Self-direction.
 - Capacity for independent living.

“*Service plan*” means a person-centered, outcome-based plan of services which is written by the member’s case manager with input and direction from the member and which addresses all relevant services and supports being provided. The service plan is developed by the interdisciplinary team, which includes the member and, if appropriate, the member’s legal representative, member’s family, service providers, and others directly involved with the member.

“*SIS assessment*” means the Supports Intensity Scale® assessment developed and licensed by the American Association on Intellectual and Developmental Disabilities for use in the assessment of the support and service needs of individuals.

“*Specialized respite*” means respite provided on a staff-to-consumer ratio of one to one or higher to individuals with specialized medical needs requiring the care, monitoring or supervision of a licensed registered nurse or licensed practical nurse.

“*Staff*” means a person under the direction of the organization to perform duties and responsibilities of the organization.

“*Third-party payments*” means payments from an attorney, individual, institution, corporation, insurance company, or public or private agency which is liable to pay part or all of the medical costs incurred as a result of injury, disease or disability by or on behalf of an applicant or a past or present recipient of Medicaid.

“*Usual caregiver*” means a person or persons who reside with the consumer and are available on a 24-hour-per-day basis to assume responsibility for the care of the consumer.

[ARC 9650B, IAB 8/10/11, effective 10/1/11; ARC 0306C, IAB 9/5/12, effective 11/1/12; ARC 2050C, IAB 7/8/15, effective 7/1/15; ARC 2168C, IAB 9/30/15, effective 11/4/15; ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 3874C, IAB 7/4/18, effective 8/8/18]

441—83.61(249A) Eligibility. To be eligible for HCBS intellectual disability waiver services a person must meet certain eligibility criteria and be determined to need a service(s) available under the program.

83.61(1) Eligibility criteria. All of the following criteria must be met. The person must:

a. Have a diagnosis of intellectual disability as defined in rule 441—83.60(249A). The diagnosis shall be initially established and recertified as follows:

Age	Initial application to HCBS intellectual disability waiver program	Recertification for persons with a diagnosis of moderate, severe or profound level of severity	Recertification for persons with a diagnosis of mild or unspecified level of severity
0 through 17 years	Psychological documentation within three years of the application date substantiating a diagnosis of intellectual disability as defined in rule 441—83.60(249A)	After the initial psychological evaluation, substantiate a diagnosis of intellectual disability as defined in rule 441—83.60(249A) every six years and when a significant change occurs	After the initial psychological evaluation, substantiate a diagnosis of intellectual disability as defined in rule 441—83.60(249A) every three years and when a significant change occurs
18 years and above	Current psychological documentation substantiating a diagnosis of intellectual disability if the last testing date was (1) more than six years ago for an applicant with a diagnosis of mild or unspecified severity, or (2) more than ten years ago for an applicant with a diagnosis of moderate, severe or profound level of severity	Psychological documentation substantiating a diagnosis of intellectual disability made since the member reached 22 years of age	Psychological documentation substantiating a diagnosis of intellectual disability every six years and whenever a significant change occurs

b. Be eligible for Medicaid under SSI, SSI-related, FMAP, or FMAP-related coverage groups; eligible under the special income level (300 percent) coverage group; or become eligible through application of the institutional deeming rules or would be eligible for Medicaid if in a medical institution.

c. Be certified as being in need for long-term care that, but for the waiver, would otherwise be provided in an ICF/ID. The IME medical services unit shall be responsible for the initial approval, and the IME medical services unit or a managed care organization will be responsible for the annual approval of the certification of the level of care based on the data collected by the case manager and interdisciplinary team on a tool designated by the department.

d. Be a recipient of the Medicaid case management services or be identified to receive Medicaid case management services immediately following program enrollment.

e. Have service needs that can be met by this waiver program. At a minimum, a consumer must receive one billable unit of service per calendar quarter under this program.

f. Have a service plan completed annually and approved by the department in accordance with rule 441—83.67(249A).

g. For individual supported employment and long-term job coaching services:

- (1) Be at least 16 years of age.
- (2) The services must not be available to the member through one of the following:
 1. Special education and related services as defined in the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.); or
 2. A program funded under Section 110 of the Rehabilitation Act of 1973 (29 U.S.C. 730).
- (3) Not reside in a medical institution.
- (4) Have documented in the waiver service plan a goal to achieve or to sustain individual employment.
 - h.* For small-group supported employment services:
 - (1) Be at least 16 years of age.
 - (2) The services must not be available to the member through one of the following:
 1. Special education and related services as defined in the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.); or
 2. A program funded under Section 110 of the Rehabilitation Act of 1973 (29 U.S.C. 730).
 - (3) Have documented in the waiver service plan a goal to achieve or to sustain individual employment.
 - (4) Have documented in the waiver service plan that the choice to receive individual supported employment services was offered and explained in a manner sufficient to ensure informed choice, after which the choice to receive small-group supported employment services was made.
 - (5) Not reside in a medical institution.
 - i.* For prevocational services:
 - (1) Be at least 16 years of age.
 - (2) The services must not be available to the member through one of the following:
 1. Special education and related services as defined in the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.); or
 2. A program funded under Section 110 of the Rehabilitation Act of 1973 (29 U.S.C. 730).
 - (3) Have documented in the waiver service plan a goal to achieve or to sustain individual employment.
 - (4) Have documented in the waiver service plan that the choice to receive individual supported employment services was offered and explained in a manner sufficient to ensure informed choice, after which the choice to receive small-group supported employment services was made.
 - (5) Not reside in a medical institution.
 - j.* Choose HCBS intellectual disability waiver services rather than ICF/ID services.
 - k.* To be eligible for interim medical monitoring and treatment services the consumer must be:
 - (1) Under the age of 21;
 - (2) Currently receiving home health agency services under rule 441—78.9(249A) and require medical assessment, medical monitoring, and regular medical intervention or intervention in a medical emergency during those services. (The home health aide services for which the consumer is eligible must be maximized before the consumer accesses interim medical monitoring and treatment.);
 - (3) Residing in the consumer's family home or foster family home; and
 - (4) In need of interim medical monitoring and treatment as ordered by a physician.
 - l.* Be assigned an HCBS intellectual disability payment slot pursuant to subrule 83.61(4).
 - m.* For residential-based supported community living services, meet all of the following additional criteria:
 - (1) Be less than 18 years of age.
 - (2) Be preapproved as appropriate for residential-based supported community living services by the bureau of long-term care. Requests for approval shall be submitted in writing to the DHS Bureau of Long-Term Care, 1305 East Walnut Street, Des Moines, Iowa 50319-0114, and shall include the following:
 1. Social history;
 2. Case history that includes previous placements and service programs;
 3. Medical history that includes major illnesses and current medications;

4. Current psychological evaluations and consultations;
5. Summary of all reasonable and appropriate service alternatives that have been tried or considered;
6. Any current court orders in effect regarding the child;
7. Any legal history;
8. Whether the child is at risk of out-of-home placement or the proposed placement would be less restrictive than the child's current placement for services;
9. Whether the proposed placement would be safe for the child and for other children living in that setting; and
10. Whether the interdisciplinary team is in agreement with the proposed placement.

(3) Either:

1. Be residing in an ICF/ID;
2. Be at risk of ICF/ID placement, as documented by an interdisciplinary team assessment pursuant to paragraph 83.61(2) "a"; or
3. Be a child whose long-term placement outside the home is necessary because continued stay in the home would be a detriment to the health and welfare of the child or the family, and all service options to keep the child in the home have been reviewed by an interdisciplinary team, as documented in the service file.

n. For day habilitation, be 16 years of age or older.

o. For the consumer choices option as set forth in 441—subrule 78.41(5), not be living in a residential care facility.

83.61(2) Need for services.

a. Applicants currently receiving Medicaid case management shall have the applicable staff coordinate with the department to arrange completion of Form 470-4694 for children under the age of five and, for all others, a SIS assessment.

b. Applicants not receiving services as set forth in paragraph 83.61(2) "a" shall have a department service worker or case manager:

- (1) Arrange for completion of Form 470-4694 for children under the age of five and, for all others, a SIS assessment for the initial level of care determination;
- (2) Establish an initial interdisciplinary team for HCBS intellectual disability waiver services; and
- (3) With the initial interdisciplinary team, identify the applicant's needs and desires as well as the availability and appropriateness of services.

c. Applicants meeting other eligibility criteria who do not have a Medicaid case manager shall be referred to a Medicaid case manager.

d. Services shall not exceed the number of maximum units established for each service.

e. The cost of services shall not exceed unit expense maximums. Requests shall only be reviewed for funding needs exceeding the supported community living service unit cost maximum. Requests require special review by the department and may be denied as not cost-effective.

f. The case manager shall coordinate with the department for completion of Form 470-4694 for children under the age of five and, for all others, to arrange a SIS assessment for the initial level of care determination within 30 days from the date of the HCBS application unless the case manager can document difficulty in locating information necessary to arrange the assessment or other circumstances beyond the case manager's control.

g. At initial enrollment, the case manager shall establish an interdisciplinary team for each applicant and, with the team, identify the applicant's need for service based on the applicant's needs and desires as well as the availability and appropriateness of services. The Medicaid case manager shall complete an annual review thereafter. The following criteria shall be used for the initial and ongoing identification of need for services:

(1) The assessment shall be based on the results of the most recent Form 470-4694 for children under the age of five and, for all others, the SIS assessment or of the SIS contractor's off-year review.

(2) Service plans must be developed or reviewed to reflect use of all appropriate nonwaiver Medicaid services so as not to replace or duplicate those services.

(3) Service plans for applicants aged 20 or under which include supported community living services beyond intermittent shall be approved (signed and dated) by the designee of the bureau of long-term care. The service worker, department QIDP, or Medicaid case manager shall attach a written request for a variance from the maximum for intermittent supported community living with a summary of services and service costs. The written request for the variance shall provide a rationale for requesting supported community living beyond intermittent. The rationale shall contain sufficient information for the designee to make a decision regarding the need for supported community living beyond intermittent.

h. Interim medical monitoring and treatment services must be needed because all usual caregivers are unavailable to provide care due to one of the following circumstances:

(1) Employment. Interim medical monitoring and treatment services are to be received only during hours of employment.

(2) Academic or vocational training. Interim medical monitoring and treatment services provided while a usual caregiver participates in postsecondary education or vocational training shall be limited to 24 periods of no more than 30 days each per caregiver as documented by the service worker. Time spent in high school completion, adult basic education, GED, or English as a second language does not count toward the limit.

(3) Absence from the home due to hospitalization, treatment for physical or mental illness, or death of the usual caregiver. Interim medical monitoring and treatment services under this subparagraph are limited to a maximum of 30 days.

(4) Search for employment.

1. Care during job search shall be limited to only those hours the usual caregiver is actually looking for employment, including travel time.

2. Interim medical monitoring and treatment services may be provided under this paragraph only during the execution of one job search plan of up to 30 working days in a 12-month period, approved by the department service worker or targeted case manager pursuant to 441—subparagraph 170.2(2) “b”(5).

3. Documentation of job search contacts shall be furnished to the department service worker or targeted case manager.

83.61(3) *HCBS intellectual disability waiver program limit.* The number of persons receiving HCBS intellectual disability waiver services in the state shall be limited to the number of payment slots provided in the HCBS intellectual disability waiver approved by the Centers for Medicare and Medicaid Services (CMS). The department shall make a request to CMS to adjust the program limit as deemed necessary.

a. The payment slots are available on a statewide basis. These slots shall be available based on the prioritized need of an applicant pursuant to subrule 83.61(4).

b. When services are denied because the limit is reached, a notice of decision denying service based on the limit and stating that the person’s name will be put on a waiting list shall be sent to the person by the department.

83.61(4) *Securing a payment slot.* The department shall determine if a payment slot is available for each applicant for the HCBS intellectual disability waiver.

a. A payment slot shall be assigned to the applicant upon confirmation of an available slot.

(1) Once a payment slot is assigned, the department shall give written notice to the applicant.

(2) The department shall hold the payment slot for the applicant as long as reasonable efforts are being made to arrange services and the applicant has not been determined to be ineligible for the program. If services have not been initiated and reasonable efforts are no longer being made to arrange services, the slot shall revert for use by the next person on the waiting list, if applicable. The applicant originally assigned the slot must reapply for a new slot.

b. If no payment slot is available, the applicant shall be placed on a statewide priority waiting list. The department shall assess each applicant to determine the applicant’s priority need. The assessment shall be made for all applicants who are on a waiting list maintained by the state or a county on September 30, 2011, and for all new applications received on or after October 1, 2011.

(1) Emergency need criteria are as follows:

1. The usual caregiver has died or is incapable of providing care, and no other caregivers are available to provide needed supports.

2. The applicant has lost primary residence or will be losing housing within 30 days and has no other housing options available.

3. The applicant is living in a homeless shelter and no alternative housing options are available.

4. There is founded abuse or neglect by a caregiver or others living within the home of the applicant, and the applicant must move from the home.

5. The applicant cannot meet basic health and safety needs without immediate supports.

(2) Urgent need criteria are as follows:

1. The caregiver will need support within 60 days in order for the applicant to remain living in the current situation.

2. The caregiver will be unable to continue to provide care within the next 60 days.

3. The caregiver is 55 years of age or older and has a chronic or long-term physical or psychological condition that limits the ability to provide care.

4. The applicant is living in temporary housing and plans to move within 31 to 120 days.

5. The applicant is losing permanent housing and plans to move within 31 to 120 days.

6. The caregiver will be unable to be employed if services are not available.

7. There is a potential risk of abuse or neglect by a caregiver or others within the home of the applicant.

8. The applicant has behaviors that put the applicant at risk.

9. The applicant has behaviors that put others at risk.

10. The applicant is at risk of facility placement when needs could be met through community-based services.

(3) Applicants who meet an emergency need criterion shall be placed on the priority waiting list based on the total number of criteria in subparagraph 83.61(4) "b"(1) that are met. If applicants meet an equal number of criteria, the position on the waiting list shall be based on the date of application and the age of the applicant. The applicant who has been on the waiting list longer shall be placed higher on the waiting list. If the application date is the same, the older applicant shall be placed higher on the waiting list.

(4) Applicants who meet an urgent need criterion shall be placed on the priority waiting list after applicants who meet emergency need criteria. The position on the waiting list shall be based on the total number of criteria in subparagraph 83.61(4) "b"(2) that are met. If applicants meet an equal number of criteria, the position on the waiting list shall be based on the date of application and the age of the applicant. The applicant who has been on the waiting list longer shall be placed higher on the waiting list. If the application date is the same, the older applicant shall be placed higher on the waiting list.

(5) Applicants who do not meet emergency or urgent need criteria shall be placed lower on the waiting list than the applicants meeting urgent need criteria, based on the date of application. If the application date is the same, the older applicant shall be placed higher on the waiting list.

(6) Applicants shall remain on the waiting list until a payment slot has been assigned to them for use, they withdraw from the list, or they become ineligible for the waiver. If there is a change in an applicant's need, the applicant may contact the local department office and request that a new assessment be completed. The outcome of the assessment shall determine placement on the waiting list as directed in this subrule.

c. To maintain the approved number of members in the program, persons shall be selected from the waiting list as payment slots become available, based on their priority order on the waiting list.

(1) Once a payment slot is assigned, the department shall give written notice to the person within five working days.

(2) The department shall hold the payment slot for 30 days for the person to file a new application. If an application has not been filed within 30 days, the slot shall revert for use by the next person on the waiting list, if applicable. The person originally assigned the slot must reapply for a new slot.

[ARC 9650B, IAB 8/10/11, effective 10/1/11; ARC 0191C, IAB 7/11/12, effective 7/1/12; ARC 0306C, IAB 9/5/12, effective 11/1/12; ARC 0359C, IAB 10/3/12, effective 12/1/12; ARC 2050C, IAB 7/8/15, effective 7/1/15; ARC 2168C, IAB 9/30/15, effective 11/4/15; ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 2471C, IAB 3/30/16, effective 5/4/16; ARC 3184C, IAB 7/5/17, effective 8/9/17]

441—83.62(249A) Application.

83.62(1) *Application for HCBS intellectual disability waiver services.* The application process as specified in rules 441—76.1(249A) to 441—76.6(249A) shall be followed.

83.62(2) Rescinded IAB 6/5/96, effective 8/1/96.

83.62(3) *Approval of application.*

a. Applications for the HCBS intellectual disability waiver program shall be processed in 30 days unless the case manager or worker can document difficulty in locating and arranging services or other circumstance beyond the worker's control. In these cases a decision shall be made as soon as possible.

b. Decisions shall be mailed or given to the applicant on the date when both service and income maintenance eligibility determinations are completed.

c. An applicant shall be given the choice between HCBS waiver services and ICF/ID care. The case manager or worker shall have the consumer or legal representative indicate the consumer's choice of care.

d. HCBS intellectual disability waiver services provided before eligibility for the waiver is approved shall not be reimbursed by the HCBS waiver program.

e. Services provided when the person is a consumer of group foster care services or is an inpatient in a medical institution shall not be reimbursed.

f. HCBS intellectual disability waiver services are not available in conjunction with other Medicaid waiver services or group foster care services.

g. Rescinded IAB 5/6/09, effective 7/1/09.

83.62(4) *Effective date of eligibility.*

a. Deeming of parental income and resources ceases the month following the month in which a person requires care in a medical institution.

b. The effective date of eligibility for the waiver for persons who are already determined eligible for Medicaid is the date on which the person is determined to meet the criteria set forth in rule 441—83.61(249A).

c. The effective date of eligibility for the waiver for persons who qualify for Medicaid due to eligibility for the waiver services is the date on which the person is determined to meet criteria set forth in rule 441—83.61(249A) and when the eligibility factor set forth in 441—subrule 75.1(7) and for married persons, in rule 441—75.5(249A) have been satisfied.

d. Eligibility continues until the consumer fails to meet eligibility criteria listed in rule 441—83.61(249A). Consumers who are inpatients in a medical institution for 120 consecutive days shall receive a review by the interdisciplinary team to determine additional inpatient needs for possible termination from the HCBS program. Consumers shall be reviewed for eligibility under other Medicaid coverage groups. The consumer or legal representative shall participate in the review and receive formal notification of that decision through Form 470-0602, Notice of Decision.

If the consumer returns home before the effective date of the notice of decision and the consumer's needs can still be met by the HCBS waiver services, the denial may be rescinded and eligibility may continue.

e. Eligibility and service reimbursement are effective through the last day of the month of the previous annual service plan staffing meeting and the corresponding long-term care need determination.

83.62(5) *Attribution of resources.* For the purposes of attributing resources as provided in rule 441—75.5(249A), the date on which the waiver applicant met the level of care criteria in a medical institution as established by the peer review organization shall be used as the date of entry to the medical institution. Only one attribution of resources shall be completed per person. Attributions completed for prior institutionalizations shall be applied to the waiver application.

[ARC 7741B, IAB 5/6/09, effective 7/1/09; ARC 9650B, IAB 8/10/11, effective 10/1/11; ARC 0306C, IAB 9/5/12, effective 11/1/12; ARC 2168C, IAB 9/30/15, effective 11/4/15; ARC 3234C, IAB 8/2/17, effective 9/6/17]

441—83.63(249A) Client participation. Persons who are eligible under the 300 percent group must contribute a predetermined client participation amount to the costs of the services.

83.63(1) Computation of client participation. Client participation shall be computed by deducting an amount for the maintenance needs of the individual which is 300 percent of the maximum SSI grant for an individual from the client's total income.

83.63(2) Limitation on payment. If the sum of the third-party payment and client participation equals or exceeds the reimbursement for the specific HCBS waiver service, Medicaid will make no payments for the HCBS waiver service. However, Medicaid will make payments to other medical vendors.

441—83.64(249A) Redetermination. A redetermination of nonfinancial eligibility for HCBS intellectual disability waiver services shall be completed at least once every 12 months. In years in which a SIS assessment is not completed for an individual five years of age or older, the SIS contractor shall conduct a review in collaboration with the case manager, documenting any changes in the member's functional status since the previous SIS or other full assessment. Form 470-4694 shall be completed annually for children under the age of five.

A redetermination of continuing eligibility factors shall be made when a change in circumstances occurs that affects eligibility in accordance with rule 441—83.61(249A).

83.64(1) The IME medical services unit or the member's managed care organization shall be responsible for annual redetermination of the level of care.

83.64(2) The managed care organization must submit documentation to the IME medical services unit for all reassessments, performed at least annually, which indicate a change in the member's level of care. The IME medical services unit shall make a final determination for any reassessments which indicate a change in the level of care. If the level of care reassessment indicates no change in level of care, the member is approved to continue at the already established level of care.

[ARC 9650B, IAB 8/10/11, effective 10/1/11; ARC 2168C, IAB 9/30/15, effective 11/4/15; ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 3184C, IAB 7/5/17, effective 8/9/17]

441—83.65(249A) Rescinded IAB 6/5/96, effective 8/1/96.

441—83.66(249A) Allowable services. Services allowable under the HCBS intellectual disability waiver are supported community living, respite, personal emergency response system, nursing, home health aide, home and vehicle modification, supported employment, consumer-directed attendant care, interim medical monitoring and treatment, transportation, adult day care, day habilitation, prevocational services, financial management, independent support brokerage, self-directed personal care, self-directed community supports and employment, and individual-directed goods and services as set forth in rule 441—78.41(249A).

[ARC 9650B, IAB 8/10/11, effective 10/1/11]

441—83.67(249A) Service plan. A service plan shall be prepared for each HCBS intellectual disability waiver consumer.

83.67(1) Development. The service plan shall be developed by the interdisciplinary team, which includes the consumer, and, if appropriate, the legal representative, consumer's family, case manager or service worker, service providers, and others directly involved.

83.67(2) Retention. The service plan shall be stored by the case manager for a minimum of three years.

83.67(3) Interdisciplinary team meeting. The interdisciplinary team meeting shall be conducted before the current service plan expires.

83.67(4) Information in plan. The plan shall be in accordance with 441—subrule 24.4(3) and shall additionally include the following information to assist in evaluating the program:

- a. A listing of all services received by a consumer at the time of waiver program enrollment.
- b. For supported community living:
 - (1) The consumer's living environment at the time of waiver enrollment.
 - (2) The number of hours per day of on-site staff supervision needed by the consumer.
 - (3) The number of other waiver consumers who will live with the consumer in the living unit.

c. An identification and justification of any restriction of the consumer's rights including, but not limited to:

- (1) Maintenance of personal funds.
- (2) Self-administration of medications.
- d. The name of the service provider responsible for providing each service.
- e. The service funding source.
- f. The amount of the service to be received by the consumer.
- g. Whether the consumer has elected the consumer choices option and, if so:
 - (1) The independent support broker selected by the consumer; and
 - (2) The financial management service selected by the consumer.
- h. A plan for emergencies and identification of the supports available to the consumer in an emergency.

i. For members receiving daily supported community living, day habilitation or adult day care: the following standard scores from the most recently completed SIS assessment:

- (1) Score on subsection 1A: Exceptional Medical Support Needs.
- (2) Score on subsection 1B: Exceptional Behavioral Support Needs.
- (3) Sum total of standard scores on the following subsections:
 1. Subsection 2A: Home Living Activities;
 2. Subsection 2B: Community Living Activities;
 3. Subsection 2E: Health and Safety Activities; and
 4. Subsection 2F: Social Activities.

83.67(5) Documentation. The Medicaid case manager shall ensure that the consumer's case file contains the consumer's service plan and documentation supporting the diagnosis of mental retardation.

83.67(6) Approval of plan. The plan shall be approved through the Individualized Services Information System (ISIS). Services shall be entered into ISIS based on the service plan.

- a. Services must be authorized and entered into ISIS before the plan implementation date.
- b. The department has 15 working days after receipt of the summary and service costs in which to approve the services and service cost or request modification of the service plan unless the parties mutually agree to extend that time frame.

c. If the department and the service worker or case manager are unable to agree on the terms of the services or service cost within 10 days, the department has final authority regarding the services and service cost.

[ARC 9650B, IAB 8/10/11, effective 10/1/11; ARC 0191C, IAB 7/11/12, effective 7/1/12; ARC 0359C, IAB 10/3/12, effective 12/1/12; ARC 3481C, IAB 12/6/17, effective 12/1/17; ARC 3790C, IAB 5/9/18, effective 6/13/18]

441—83.68(249A) Adverse service actions.

83.68(1) Denial. An application for services shall be denied when it is determined by the department that:

- a. The applicant is not eligible for the services.
- b. Service needs exceed the service unit or reimbursement maximums.
- c. Service needs are not met by the services provided.
- d. Needed services are not available or received from qualifying providers.
- e. No HCBS intellectual disability waiver service is identified in the applicant's service plan.
- f. There is another community resource available to provide the service or a similar service free of charge to the applicant that will meet the applicant's needs.
- g. Completion or receipt of required documents by the department for the HCBS program applicant has not occurred.

83.68(2) Reduction. A particular service may be reduced when the department determines that the provisions of 441—subrule 130.5(3), paragraph "a" or "b," apply.

83.68(3) Termination. A particular service may be terminated when the department determines that:

- a. The provisions of 441—subrule 130.5(2) paragraph "d," "g," or "h," apply.
- b. Needed services are not available or received from qualifying providers.

- c. No HCBS intellectual disability waiver service is identified in the member's annual service plan.
- d. Service needs are not met by the services provided.
- e. Services needed exceed the service unit or reimbursement maximums.
- f. Completion or receipt of required documents by the department for the HCBS program consumer has not occurred.
- g. The consumer receives services from other Medicaid waiver programs.
- h. The consumer or legal representative through the interdisciplinary process requests termination from the services.

[ARC 9650B, IAB 8/10/11, effective 10/1/11]

441—83.69(249A) Appeal rights. Notice of adverse action and right to appeal shall be given in accordance with 441—Chapter 7 and rule 441—130.5(234).

[ARC 0191C, IAB 7/11/12, effective 7/1/12; ARC 0306C, IAB 9/5/12, effective 11/1/12; ARC 0359C, IAB 10/3/12, effective 12/1/12]

441—83.70(249A) County reimbursement. Rescinded ARC 0191C, IAB 7/11/12, effective 7/1/12.

441—83.71(249A) Conversion to the X-PERT system. Rescinded IAB 8/7/02, effective 10/1/02.

441—83.72(249A) Rent subsidy program. Members in the HCBS intellectual disability waiver program may be eligible for a rent subsidy. See 265—Chapter 24.

[ARC 9650B, IAB 8/10/11, effective 10/1/11]

These rules are intended to implement Iowa Code sections 249A.3 and 249A.4.

441—83.73 to 83.80 Reserved.

DIVISION V—BRAIN INJURY WAIVER SERVICES

441—83.81(249A) Definitions.

“Adaptive” means age appropriate skills related to taking care of one's self and the ability to relate to others in daily living situations. These skills include limitations that occur in the areas of communication, self-care, home living, social skills, community use, self-direction, safety, functional academics, leisure and work.

“Adult” means a person with a brain injury aged 18 years or over.

“Appropriate” means that the services or supports or activities provided or undertaken by the organization are relevant to the consumer's needs, situation, problems, or desires.

“Assessment” means the review of the consumer's current functioning in regard to the consumer's situation, needs, strengths, abilities, desires and goals.

“Attorney in fact under a durable power of attorney for health care” means an individual who is designated by a durable power of attorney for health care, pursuant to Iowa Code chapter 144B, as an agent to make health care decisions on behalf of an individual and who has consented to act in that capacity.

“Basic individual respite” means respite provided on a staff-to-consumer ratio of one to one or higher to individuals without specialized needs requiring the care of a licensed registered nurse or licensed practical nurse.

“Behavior” means skills related to regulating one's own behavior including coping with demands from others, making choices, conforming conduct to laws, and displaying appropriate sociosexual behavior.

“Brain injury” means clinically evident damage to the brain resulting directly or indirectly from trauma, infection, anoxia, vascular lesions or tumor of the brain, not primarily related to degenerative or aging processes, which temporarily or permanently impairs a person's physical, cognitive, or behavioral functions. The person must have a diagnosis from the following list:

Malignant neoplasms of brain, cerebrum.

Malignant neoplasms of brain, frontal lobe.

Malignant neoplasms of brain, temporal lobe.
Malignant neoplasms of brain, parietal lobe.
Malignant neoplasms of brain, occipital lobe.
Malignant neoplasms of brain, ventricles.
Malignant neoplasms of brain, cerebellum.
Malignant neoplasms of brain, brain stem.
Malignant neoplasms of brain, other part of brain, includes midbrain, peduncle, and medulla oblongata.

Malignant neoplasms of brain, cerebral meninges.
Malignant neoplasms of brain, cranial nerves.
Secondary malignant neoplasm of brain.
Secondary malignant neoplasm of other parts of the nervous system, includes cerebral meninges.
Benign neoplasm of brain and other parts of the nervous system, brain.
Benign neoplasm of brain and other parts of the nervous system, cranial nerves.
Benign neoplasm of brain and other parts of the nervous system, cerebral meninges.
Encephalitis, myelitis and encephalomyelitis.
Intracranial and intraspinal abscess.
Anoxic brain damage.
Subarachnoid hemorrhage.
Intracerebral hemorrhage.
Other and unspecified intracranial hemorrhage.
Occlusion and stenosis of precerebral arteries.
Occlusion of cerebral arteries.
Transient cerebral ischemia.
Acute, but ill-defined, cerebrovascular disease.
Other and ill-defined cerebrovascular diseases.
Fracture of vault of skull.
Fracture of base of skull.
Other and unqualified skull fractures.
Multiple fractures involving skull or face with other bones.
Concussion.
Cerebral laceration and contusion.
Cerebral edema.
Cerebral palsy.
Subarachnoid, subdural, and extradural hemorrhage following injury.
Other and unspecified intracranial hemorrhage following injury.
Intracranial injury of other and unspecified nature.
Poisoning by drugs, medicinal and biological substances.
Toxic effects of substances.
Effects of external causes.
Drowning and nonfatal submersion.
Asphyxiation and strangulation.
Child maltreatment syndrome.
Adult maltreatment syndrome.
Status epilepticus.

“Case management services” means those services established pursuant to Iowa Code chapter 225C.

“Child” means a person with a brain injury aged 17 years or under.

“Client participation” means the amount of the consumer’s income that the person must contribute to the cost of brain injury waiver services, exclusive of medical vendor payments, before Medicaid will provide additional reimbursement.

“Deemed status” means acceptance of certification or licensure of a program or service by another certifying body in place of certification based on review and evaluation.

“Department” means the Iowa department of human services.

“Direct service” means services involving face-to-face assistance to a consumer such as transporting a consumer or providing therapy.

“Fiscal accountability” means the development and maintenance of budgets and independent fiscal review.

“Group respite” is respite provided on a staff-to-consumer ratio of less than one to one.

“Guardian” means a guardian appointed in probate court.

“Health” means skills related to the maintenance of one’s health including eating; illness identification, treatment and prevention; basic first aid; physical fitness; regular physical checkups and personal habits.

“Immediate jeopardy” means circumstances where the life, health, or safety of a person will be severely jeopardized if the circumstances are not immediately corrected.

“Intermediate care facility for persons with an intellectual disability level of care” means that the individual has a diagnosis of intellectual disability made in accordance with the criteria provided in the current version of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association; or has a related condition as defined in 42 CFR 435.1009; and needs assistance in at least three of the following major life areas: mobility, musculoskeletal skills, activities of daily living, domestic skills, toileting, eating skills, vision, hearing or speech or both, gross/fine motor skills, sensory-taste, smell, tactile, academic skills, vocational skills, social/community skills, behavior, and health care.

“Intermittent supported community living service” means supported community living service provided from one to three hours a day for not more than four days a week.

“Managed care organization” means an entity that (1) is under contract with the department to provide services to Medicaid recipients and (2) meets the definition of “health maintenance organization” as defined in Iowa Code section 514B.1.

“Medical assessment” means a visual and physical inspection of the consumer, noting deviations from the norm, and a statement of the consumer’s mental and physical condition that can be amendable to or resolved by appropriate actions of the provider.

“Medical institution” means a nursing facility, a skilled nursing facility, intermediate care facility for persons with an intellectual disability, or hospital which has been approved as a Medicaid vendor.

“Medical intervention” means consumer care in the areas of hygiene, mental and physical comfort, assistance in feeding and elimination, and control of the consumer’s care and treatment to meet the physical and mental needs of the consumer in compliance with the plan of care in areas of health, prevention, restoration, and maintenance.

“Medical monitoring” means observation for the purpose of assessing, preventing, maintaining, and treating disease or illness based on the consumer’s plan of care.

“Natural supports” means services and supports identified as wanted or needed by the consumer and provider by persons not for pay (family, friends, neighbors, coworkers, and others in the community) and organizations or entities that serve the general public.

“Nursing facility level of care” means that the following conditions are met:

1. The presence of a physical or mental impairment which restricts the member’s daily ability to perform the essential activities of daily living, bathing, dressing, and personal hygiene, and impedes the member’s capacity to live independently.

2. The member’s physical or mental impairment is such that self-execution of required nursing care is improbable or impossible.

“Organization” means the entity being certified.

“Organizational outcome” means a demonstration by the organization of actions taken by the organization to provide for services or supports to consumers.

“Outcome” means an action or event that follows as a result or consequence of the provision of a service or support.

“Procedures” means the steps to be taken to implement a policy.

“*Process*” means service or support provided by an agency to a consumer that will allow the consumer to achieve an outcome. This can include a written, formal, consistent trackable method or an informal process that is not written but is trackable.

“*Program*” means a set of related resources and services directed to the accomplishment of a fixed set of goals and objectives for the population of a specified geographic area or for special target populations. It can mean an agency, organization, or unit of an agency, organization or institution.

“*Qualified brain injury professional*” means one of the following who meets the educational and licensure or certification requirements for the profession as required in the state of Iowa and who has two years’ experience working with people living with a brain injury: a psychologist; psychiatrist; physician; physician assistant; registered nurse; certified teacher; social worker; mental health counselor; physical, occupational, recreational, or speech therapist; or a person with a bachelor of arts or science degree in psychology, sociology, or public health or rehabilitation services.

“*Service coordination*” means activities designed to help individuals and families locate, access, and coordinate a network of supports and services that will allow them to live a full life in the community.

“*Service plan*” means a person-centered, outcome-based plan of services which is written by the member’s case manager with input and direction from the member and which addresses all relevant services and supports being provided. The service plan is developed by the interdisciplinary team, which includes the member and, if appropriate, the member’s legal representative, member’s family, service providers, and others directly involved with the member.

“*Skilled nursing facility level of care*” means that the following conditions are met:

1. The member’s medical condition requires skilled nursing services or skilled rehabilitation services as defined in 42 CFR 409.31(a), 409.32, and 409.34.
2. Services are provided in accordance with the general provisions for all Medicaid providers and services as described in rule 441—79.9(249A).
3. Documentation submitted for review indicates that the member has:
 - a. A physician order for all skilled services.
 - b. Services that require the skills of medical personnel, including registered nurses, licensed practical nurses, physical therapists, occupational therapists, speech pathologists, or audiologists.
 - c. An individualized care plan that identifies support needs.
 - d. Confirmation that skilled services are provided to the member.
 - e. Skilled services that are provided by, or under the supervision of, medical personnel as described above.
 - f. Skilled nursing services that are needed and provided seven days a week or skilled rehabilitation services that are needed and provided at least five days a week.

“*Specialized respite*” means respite provided on a staff-to-consumer ratio of one to one or higher to individuals with specialized medical needs requiring the care, monitoring or supervision of a licensed registered nurse or licensed practical nurse.

“*Staff*” means a person under the direction of the organization to perform duties and responsibilities of the organization.

“*Third-party payments*” means payments from an individual, institution, corporation, or public or private provider which is liable to pay part or all of the medical costs incurred as a result of injury or disease on behalf of a consumer of medical assistance.

“*Usual caregiver*” means a person or persons who reside with the consumer and are available on a 24-hour-per-day basis to assume responsibility for the care of the consumer.

[ARC 0306C, IAB 9/5/12, effective 11/1/12; ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 3184C, IAB 7/5/17, effective 8/9/17; ARC 3874C, IAB 7/4/18, effective 8/8/18]

441—83.82(249A) Eligibility. To be eligible for brain injury waiver services a consumer must meet eligibility criteria and be determined to need a service allowable under the program.

83.82(1) Eligibility criteria. All of the following criteria must be met. The person must:

- a. Have a diagnosis of brain injury.

b. Be eligible for Medicaid under SSI, SSI-related, FMAP, or FMAP-related coverage groups or be eligible under the special income level (300 percent) coverage group consistent with a level of care in a medical institution.

c. Be at least one month of age.

d. Be a U.S. citizen and Iowa resident.

e. Rescinded IAB 7/11/01, effective 7/1/01.

f. Be determined by the IME medical services unit as in need of intermediate care facility for persons with an intellectual disability (ICF/ID), skilled nursing, or ICF level of care based on information submitted on a completed Form 470-4694 for children aged 3 and under, the interRAI - Pediatric Home Care (PEDS-HC) for those aged 4 to 20, or the interRAI - Home Care (HC) for those aged 21 and over and other supporting documentation as relevant. Form 470-4694, the interRAI - Pediatric Home Care (PEDS-HC), and the interRAI - Home Care (HC) are available on request from the IME medical services unit. Copies of the completed information submission tool for an individual are available to that individual from the individual's case manager or managed care organization.

g. Be assessed by the IME medical services unit as able to live in a home- or community-based setting where all medically necessary service needs can be met within the scope of this waiver.

h. At a minimum, receive a waiver service each quarter in addition to case management.

i. Choose HCBS.

j. To be eligible for interim medical monitoring and treatment services the consumer must be:

(1) Under the age of 21;

(2) Currently receiving home health agency services under rule 441—78.9(249A) and require medical assessment, medical monitoring, and regular medical intervention or intervention in a medical emergency during those services. (The home health aide services for which the consumer is eligible must be maximized before the consumer accesses interim medical monitoring and treatment.);

(3) Residing in the consumer's family home or foster family home; and

(4) In need of interim medical monitoring and treatment as ordered by a physician.

k. Receive services in a community, not an institutional, setting.

l. Be assigned a state payment slot within the yearly total approved by the Centers for Medicare and Medicaid Services.

m. For the consumer choices option as set forth in rule 441—subrule 78.43(15), not be living in a residential care facility.

n. For individual supported employment and long-term job coaching services:

(1) Be at least 16 years of age.

(2) The services must not be available to the member through one of the following:

1. Special education and related services as defined in the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.); or

2. A program funded under Section 110 of the Rehabilitation Act of 1973 (29 U.S.C. 730).

(3) Not reside in a medical institution.

(4) Have documented in the waiver service plan a goal to achieve or to sustain individual employment and an expectation that this service will result in this outcome.

o. For small-group supported employment services:

(1) Be at least 16 years of age.

(2) The services must not be available to the member through one of the following:

1. Special education and related services as defined in the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.); or

2. A program funded under Section 110 of the Rehabilitation Act of 1973 (29 U.S.C. 730).

(3) Have documented in the waiver service plan a goal to achieve or to sustain individual employment.

(4) Have documented in the waiver service plan that the choice to receive individual supported employment services was offered and explained in a manner sufficient to ensure informed choice, after which the choice to receive small-group supported employment services was made.

(5) Not reside in a medical institution.

- p.* For prevocational services:
- (1) Be at least 16 years of age.
 - (2) The services must not be available to the member through one of the following:
 1. Special education and related services as defined in the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.); or
 2. A program funded under Section 110 of the Rehabilitation Act of 1973 (29 U.S.C. 730).
 - (3) Have documented in the waiver service plan a goal to achieve or to sustain individual employment and an expectation that this service will result in community employment.
 - (4) Have documented in the waiver service plan that the choice to receive individual supported employment services was offered and explained in a manner sufficient to ensure informed choice, after which the choice to receive prevocational services was made.

83.82(2) Need for services.

a. The applicant shall have a service plan approved by the department that is developed by the certified case manager for this waiver as identified by the county of residence. This must be completed before services provision and annually thereafter. The case manager shall establish the interdisciplinary team for the applicant and, with the team, identify the applicant's need for service based on the applicant's needs and desires as well as the availability and appropriateness of services using the following criteria:

- (1) The assessment shall be based, in part, on information provided to the IME medical services unit.
- (2) Service plans must be developed to reflect use of all appropriate nonwaiver Medicaid state services so as not to replace or duplicate those services.
- (3) Service plans for applicants aged 20 or under which include supported community living services beyond intermittent shall not be approved until a home health provider has made a request to cover the service through all nonwaiver Medicaid services.
- (4) Service plans for applicants aged 20 or under which include supported community living services beyond intermittent must be approved (signed and dated) by the designee of the bureau of long-term care. The Medicaid case manager must request in writing more than intermittent supported community living with a summary of services and service costs, and submit a written justification with the service plan. The rationale must contain sufficient information for the bureau's designee to make a decision regarding the need for supported community living beyond intermittent.

b. Interim medical monitoring and treatment services must be needed because all usual caregivers are unavailable to provide care due to one of the following circumstances:

- (1) Employment. Interim medical monitoring and treatment services are to be received only during hours of employment.
- (2) Academic or vocational training. Interim medical monitoring and treatment services provided while a usual caregiver participates in postsecondary education or vocational training shall be limited to 24 periods of no more than 30 days each per caregiver as documented by the service worker. Time spent in high school completion, adult basic education, GED, or English as a second language does not count toward the limit.
- (3) Absence from the home due to hospitalization, treatment for physical or mental illness, or death of the usual caregiver. Interim medical monitoring and treatment services under this subparagraph are limited to a maximum of 30 days.
- (4) Search for employment.
 1. Care during job search shall be limited to only those hours the usual caregiver is actually looking for employment, including travel time.
 2. Interim medical monitoring and treatment services may be provided under this paragraph only during the execution of one job search plan of up to 30 working days in a 12-month period, approved by the department service worker or targeted case manager pursuant to 441—subparagraph 170.2(2) "b"(5).
 3. Documentation of job search contacts shall be furnished to the department service worker or targeted case manager.

c. The consumer shall access, if a child, all other services for which the person is eligible and which are appropriate to meet the person's needs as a precondition of eligibility for the HCBS BI waiver.

d. The total cost of brain injury waiver services, excluding the cost of case management and home and vehicle modifications, shall not exceed \$3,013.08 per month.

83.82(3) *HCBS brain injury (BI) waiver program limit for persons requiring the ICF/MR level of care.* Rescinded IAB 7/11/01, effective 7/1/01.

83.82(4) *Securing a state payment slot.*

a. The county department office shall enter all waiver applications into the individualized services information system (ISIS) to determine if a payment slot is available for all new applicants for the HCBS BI waiver program.

(1) For applicants not currently receiving Medicaid, the county department office shall make the entry by the end of the fifth working day after receipt of a completed Form 470-2927 or 470-2927(S), Health Services Application, or within five working days after receipt of disability determination, whichever is later.

(2) For current Medicaid members, the county department office shall make the entry by the end of the fifth working day after receipt of a written request signed and dated by the waiver applicant.

b. If no payment slot is available, the department shall enter the applicant on a waiting list according to the following:

(1) Applicants not currently eligible for Medicaid shall be entered on the waiting list on the basis of the date a completed Form 470-2927 or 470-2927(S), Health Services Application, is received by the department or upon receipt of disability determination, whichever is later. Applicants currently eligible for Medicaid shall be added to the waiting list on the basis of the date the applicant requests HCBS BI program services.

(2) In the event that more than one application is received at one time, applicants shall be entered on the waiting list on the basis of the month of birth, January being month one and the lowest number.

c. Persons who do not fall within the available slots shall have their applications rejected but their names shall be maintained on the waiting list. As slots become available, persons shall be selected from the waiting list to maintain the number of approved persons on the program based on their order on the waiting list.

[**ARC 0191C**, IAB 7/11/12, effective 7/1/12; **ARC 0306C**, IAB 9/5/12, effective 11/1/12; **ARC 0359C**, IAB 10/3/12, effective 12/1/12; **ARC 0548C**, IAB 1/9/13, effective 1/1/13; **ARC 0665C**, IAB 4/3/13, effective 6/1/13; **ARC 0842C**, IAB 7/24/13, effective 7/1/13; **ARC 1056C**, IAB 10/2/13, effective 11/6/13; **ARC 1445C**, IAB 4/30/14, effective 7/1/14; **ARC 2471C**, IAB 3/30/16, effective 5/4/16; **ARC 2848C**, IAB 12/7/16, effective 11/15/16; **ARC 2936C**, IAB 2/1/17, effective 3/8/17; **ARC 3184C**, IAB 7/5/17, effective 8/9/17]

441—83.83(249A) Application.

83.83(1) *Application for financial eligibility.* The application process as specified in rules 441—76.1(249A) to 441—76.6(249A) shall be followed.

83.83(2) *Approval of application for eligibility.*

a. Applications for the determination of ability of the consumer to have all medically necessary service needs met within the scope of this waiver shall be initiated on behalf of the consumer and with the consumer's consent or with the consent of the consumer's legal representative by the discharge planner of the medical facility where the consumer resides at the time of application or the case manager. The discharge planner or case manager shall provide to the IME medical services unit all appropriate information needed regarding all the medically necessary service needs of the consumer. After completing the determination of ability to have all medically necessary service needs met within the scope of this waiver, the IME medical services unit shall inform the discharge planner or case manager on behalf of the consumer or the consumer's legal representative and send to the income maintenance worker a copy of the decision as to whether all of the consumer's service needs can be met in a home- or community-based setting.

b. Eligibility for the HCBS BI waiver shall be effective as of the date when both the service eligibility and financial eligibility have been completed. Decisions shall be mailed or given to the consumer or the consumer's legal representative on the date when each eligibility determination is completed.

c. An applicant shall be given the choice between waiver services and institutional care. The applicant or legal representative shall sign the applicable information submission tool listed in paragraph

83.82(1) “f,” indicating that the applicant has elected home- and community-based services. This shall be arranged by the medical facility discharge planner or case manager.

d. The medical facility discharge planner, if there is one involved, shall contact the consumer’s managed care organization or the designated case manager to initiate development of the consumer’s service plan and initiation of waiver services.

e. HCBS BI waiver services provided prior to both approvals of eligibility for the waiver cannot be paid.

f. HCBS BI waiver services are not available in conjunction with other HCBS waiver programs or group foster care services.

g. The Medicaid case manager shall establish an HCBS BI waiver interdisciplinary team for each consumer and, with the team, identify the consumer’s “need for service” based on the consumer’s needs and desires as well as the availability and appropriateness of services.

83.83(3) Effective date of eligibility.

a. The effective date of eligibility for the waiver for persons who are already determined eligible for Medicaid is the date on which the person is determined to meet all of the criteria set forth in rule 441—83.82(249A).

b. The effective date of eligibility for the waiver for persons who qualify for Medicaid due to eligibility for the waiver services is the date on which the person is determined to meet all of the criteria set forth in rule 441—83.82(249A) and when the eligibility factors set forth in 441—subrule 75.1(7) and for married persons, in rule 441—75.5(249A), have been satisfied.

c. Eligibility for the waiver continues until the consumer fails to meet eligibility criteria listed in rule 441—83.82(249A). Consumers who return to inpatient status in a medical institution for more than 120 consecutive days shall be reviewed by the IME medical services unit to determine additional inpatient needs for possible termination from the brain injury waiver. The consumer shall be reviewed for eligibility under other Medicaid coverage groups in accordance with rule 441—76.11(249A). The consumer shall be notified of that decision through Form 470-0602, Notice of Decision.

If the consumer returns home before the effective date of the notice of decision and the consumer’s condition has not substantially changed, the denial may be rescinded and eligibility may continue.

83.83(4) Attribution of resources. For the purposes of attributing resources as provided in rule 441—75.5(249A), the date on which the waiver consumer meets the level of care criteria in a medical institution as established by the peer review organization shall be used as the date of entry to the medical institution. Only one attribution of resources shall be completed per person. Attributions completed for prior institutionalizations shall be applied to the waiver application.

[ARC 0306C, IAB 9/5/12, effective 11/1/12; ARC 3184C, IAB 7/5/17, effective 8/9/17; ARC 3234C, IAB 8/2/17, effective 9/6/17]

441—83.84(249A) Client participation. Consumers who are financially eligible under 441—subrule 75.1(7) (the 300 percent group) must contribute a predetermined participation amount to the cost of brain injury waiver services.

83.84(1) Computation of client participation. Client participation shall be computed by deducting an amount for the maintenance needs of the consumer which is 300 percent of the maximum SSI grant for an individual from the consumer’s total income. For a couple, client participation is determined as if each person were an individual.

83.84(2) Limitation on payment. If the sum of the third-party payment and client participation equals or exceeds the reimbursement for the specific brain injury waiver service, Medicaid shall make no payments for the waiver service. However, Medicaid shall make payments to other medical providers.

441—83.85(249A) Redetermination. A complete financial redetermination of eligibility for brain injury waiver shall be completed at least once every 12 months. A redetermination of continuing eligibility factors shall be made when a change in circumstances occurs that affects eligibility in accordance with rule 441—83.82(249A). A redetermination shall contain the components listed in rule 441—83.82(249A).

441—83.86(249A) Allowable services. Services allowable under the brain injury waiver are case management, respite, personal emergency response, supported community living, behavioral programming, family counseling and training, home and vehicle modification, specialized medical equipment, prevocational services, transportation, supported employment, adult day care, consumer-directed attendant care, interim medical monitoring and treatment, financial management, independent support brokerage, self-directed personal care, self-directed community supports and employment, and individual-directed goods and services as set forth in rule 441—78.43(249A).

441—83.87(249A) Service plan. A service plan shall be prepared and utilized for each HCBS BI waiver consumer. The service plan shall be developed by an interdisciplinary team, which includes the consumer, and, if appropriate, the legal representative, consumer's family, case manager, providers, and others directly involved. The service plan shall be stored by the case manager for a minimum of three years. The service plan staffing shall be conducted before the current service plan expires.

83.87(1) Information in plan. The plan shall be in accordance with 441—subrule 24.4(3) and shall additionally include the following information to assist in evaluating the program:

- a. A listing of all services received by a consumer at the time of waiver program enrollment.
- b. For supported community living:
 - (1) The consumer's living environment at the time of waiver enrollment.
 - (2) The number of hours per day of on-site staff supervision needed by the consumer.
 - (3) The number of other waiver consumers who will live with the consumer in the living unit.
- c. An identification and justification of any restriction of a consumer's rights including, but not limited to:
 - (1) Maintenance of personal funds.
 - (2) Self-administration of medications.
- d. The names of all providers responsible for providing all services.
- e. All service funding sources.
- f. The amount of the service to be received by the consumer.
- g. Whether the consumer has elected the consumer choices option and, if so:
 - (1) The independent support broker selected by the consumer; and
 - (2) The financial management service selected by the consumer.
- h. A plan for emergencies and identification of the supports available to the consumer in an emergency.

83.87(2) Use of nonwaiver services. Service plans must be developed to reflect use of all appropriate nonwaiver Medicaid services and so as not to replace or duplicate those services. Service plans for members aged 20 or under which include supported community living services beyond intermittent must be approved (signed and dated) by the designee of the bureau of long-term care. The Medicaid case manager shall attach a written request for a variance from the limitation on supported community living to intermittent.

83.87(3) Annual assessment. The IME medical services unit shall assess the member annually and certify the member's need for long-term care services. The IME medical services unit shall be responsible for determining the level of care based on the completed information submission tool listed in paragraph 83.82(1) "f" and other supporting documentation as relevant.

a. The IME medical services unit or the member's managed care organization shall be responsible for annual redetermination of the level of care.

b. The managed care organization must submit documentation to the IME medical services unit for all reassessments, performed at least annually, which indicate a change in the member's level of care. The IME medical services unit shall make a final determination for any reassessments which indicate a change in the level of care. If the level of care reassessment indicates no change in level of care, the member is approved to continue at the already established level of care.

83.87(4) Service file. The Medicaid case manager must ensure that the consumer service file contains the consumer's service plan.

a. to d. Rescinded IAB 8/7/02, effective 10/1/02.
 [ARC 0191C, IAB 7/11/12, effective 7/1/12; ARC 0306C, IAB 9/5/12, effective 11/1/12; ARC 0359C, IAB 10/3/12, effective 12/1/12; ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 3184C, IAB 7/5/17, effective 8/9/17]

441—83.88(249A) Adverse service actions.

83.88(1) Denial. An application for services shall be denied when it is determined by the department that:

- a.* The consumer is not eligible for the services because all of the medically necessary service needs cannot be met in a home- or community-based setting.
- b.* Service needs exceed the service unit or reimbursement maximums.
- c.* Service needs are not met by the services provided.
- d.* Needed services are not available or received from qualifying providers.
- e.* The brain injury waiver service is not identified in the consumer's service plan.
- f.* There is another community resource available to provide the service or a similar service free of charge to the consumer that will meet the consumer's needs.
- g.* The consumer receives services from other Medicaid waiver providers.
- h.* The consumer or legal representative through the interdisciplinary process requests termination from the services.

83.88(2) Reduction. A particular service may be reduced when the department determines that the provisions of 441—subrule 130.5(3), paragraph “a” or “b,” apply.

83.88(3) Termination. A particular service may be terminated when the department determines that:

- a.* The provisions of 441—subrule 130.5(2), paragraph “d,” “g,” or “h,” apply.
- b.* Needed services are not available or received from qualifying providers.
- c.* The brain injury waiver service is not identified in the consumer's annual service plan.
- d.* Service needs are not met by the services provided.
- e.* Services needed exceed the service unit or reimbursement maximums.
- f.* Completion or receipt of required documents by the department or the medical facility discharge planner for the brain injury waiver service consumer has not occurred.
- g.* The consumer receives services from other Medicaid providers.
- h.* The consumer or legal representative through the interdisciplinary process requests termination from the services.

441—83.89(249A) Appeal rights. Notice of adverse actions and right to appeal shall be given in accordance with 441—Chapter 7 and rule 441—130.5(234).

[ARC 0191C, IAB 7/11/12, effective 7/1/12; ARC 0306C, IAB 9/5/12, effective 11/1/12; ARC 0359C, IAB 10/3/12, effective 12/1/12]

441—83.90(249A) County reimbursement. Rescinded ARC 0191C, IAB 7/11/12, effective 7/1/12.

441—83.91(249A) Conversion to the X-PERT system. Rescinded IAB 8/7/02, effective 10/1/02.

These rules are intended to implement Iowa Code sections 249A.3 and 249A.4.

441—83.92 to 83.100 Reserved.

DIVISION VI—PHYSICAL DISABILITY WAIVER SERVICES

441—83.101(249A) Definitions.

“*Adaptive*” means age-appropriate skills related to taking care of one's self and the ability to relate to others in daily living situations. These skills include limitations that occur in the areas of communication, self-care, home living, social skills, community use, self-direction, safety, functional academics, leisure and work.

“*Adult*” means a person with a physical disability aged 18 years to 64 years.

“*Appropriate*” means that the services or supports or activities provided or undertaken by the organization are relevant to the consumer's needs, situation, problems, or desires.

“*Assessment*” means the review of the consumer’s current functioning in regard to the consumer’s situation, needs, strengths, abilities, desires and goals.

“*Attorney in fact under a durable power of attorney for health care*” means an individual who is designated by a durable power of attorney for health care, pursuant to Iowa Code chapter 144B, as an agent to make health care decisions on behalf of an individual and who has consented to act in that capacity.

“*Behavior*” means skills related to regulating one’s own behavior including coping with demands from others, making choices, controlling impulses, conforming conduct to laws, and displaying appropriate sociosexual behavior.

“*Client participation*” means the amount of the consumer’s income that the person must contribute to the cost of physical disability waiver services, exclusive of medical vendor payments, before Medicaid will provide additional reimbursement.

“*Department*” means the Iowa department of human services.

“*Guardian*” means a guardian appointed in probate court for an adult.

“*Intermediate care facility for persons with an intellectual disability level of care*” means that the individual has a diagnosis of intellectual disability made in accordance with the criteria provided in the current version of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association; or has a related condition as defined in 42 CFR 435.1009; and needs assistance in at least three of the following major life areas: mobility, musculoskeletal skills, activities of daily living, domestic skills, toileting, eating skills, vision, hearing or speech or both, gross/fine motor skills, sensory-taste, smell, tactile, academic skills, vocational skills, social/community skills, behavior, and health care.

“*Managed care organization*” means an entity that (1) is under contract with the department to provide services to Medicaid recipients and (2) meets the definition of “health maintenance organization” as defined in Iowa Code section 514B.1.

“*Medical institution*” means a nursing facility, a skilled nursing facility, intermediate care facility for persons with an intellectual disability, or hospital which has been approved as a Medicaid vendor.

“*Nursing facility level of care*” means that the following conditions are met:

1. The presence of a physical or mental impairment which restricts the member’s daily ability to perform the essential activities of daily living, bathing, dressing, and personal hygiene, and impedes the member’s capacity to live independently.

2. The member’s physical or mental impairment is such that self-execution of required nursing care is improbable or impossible.

“*Physical disability*” means a severe, chronic condition that is attributable to a physical impairment that results in substantial limitations of physical functioning in three or more of the following areas of major life activities: self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, and economic self-sufficiency.

“*Service plan*” means a person-centered, outcome-based plan of services which is written by the member’s case manager with input and direction from the member and which addresses all relevant services and supports being provided. The service plan is developed by the interdisciplinary team, which includes the member and, if appropriate, the member’s legal representative, member’s family, service providers, and others directly involved with the member.

“*Skilled nursing facility level of care*” means that the following conditions are met:

1. The member’s medical condition requires skilled nursing services or skilled rehabilitation services as defined in 42 CFR 409.31(a), 409.32, and 409.34.

2. Services are provided in accordance with the general provisions for all Medicaid providers and services as described in rule 441—79.9(249A).

3. Documentation submitted for review indicates that the member has:

a. A physician order for all skilled services.

b. Services that require the skills of medical personnel, including registered nurses, licensed practical nurses, physical therapists, occupational therapists, speech pathologists, or audiologists.

c. An individualized care plan that identifies support needs.

- d. Confirmation that skilled services are provided to the member.
- e. Skilled services that are provided by, or under the supervision of, medical personnel as described above.
- f. Skilled nursing services that are needed and provided seven days a week or skilled rehabilitation services that are needed and provided at least five days a week.

“*Third-party payments*” means payments from an individual, institution, corporation, or public or private provider which is liable to pay part or all of the medical costs incurred as a result of injury or disease on behalf of a consumer of medical assistance.

“*Waiver year*” means a 12-month period commencing on April 1 of each year.

[ARC 0306C, IAB 9/5/12, effective 11/1/12; ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 3874C, IAB 7/4/18, effective 8/8/18]

441—83.102(249A) Eligibility. To be eligible for physical disability waiver services, a consumer must meet eligibility criteria set forth in subrule 83.102(1) and be determined to need a service allowable under the program per subrule 83.102(2).

83.102(1) Eligibility criteria. All of the following criteria must be met. The person must:

- a. Have a physical disability.
- b. Be blind or disabled as determined by the receipt of social security disability benefits or by a disability determination made through the department. Disability determinations are made according to supplemental security income guidelines under Title XVI of the Social Security Act or the disability guidelines for the Medicaid employed people with disabilities coverage group.
- c. Be ineligible for the HCBS intellectual disability waiver.
- d. Have the ability to hire, supervise, and fire the provider as determined by the service worker, and be willing to do so, or have a parent or guardian named by probate court, or attorney in fact under a durable power of attorney for health care who will take this responsibility on behalf of the consumer.
- e. Be eligible for Medicaid under 441—Chapter 75.
- f. Be aged 18 years to 64 years.
- g. Rescinded IAB 2/7/01, effective 2/1/01.
- h. Be in need of skilled nursing or intermediate care facility level of care based on information submitted on a completed interRAI - Pediatric Home Care (PEDS-HC) for those aged 18 to 20 or the interRAI - Home Care (HC) for those aged 21 and over and other supporting documentation as relevant. The interRAI - Pediatric Home Care (PEDS-HC) and the interRAI - Home Care (HC) are available on request from the IME medical services unit. Copies of the completed information submission tool for an individual are available to that individual from the individual’s case manager or managed care organization.

(1) Initial decisions on level of care shall be made for the department by the IME medical services unit within two working days of receipt of medical information. The IME medical services unit determines whether the level of care requirement is met based on medical necessity and the appropriateness of the level of care under 441—subrules 79.9(1) and 79.9(2).

(2) Adverse decisions by the IME medical services unit may be appealed to the department pursuant to 441—Chapter 7.

- i. Choose HCBS.
- j. Use a minimum of one unit of service per calendar quarter under this program.
- k. For the consumer choices option as set forth in 441—subrule 78.46(6), not be living in a residential care facility.

83.102(2) Need for services.

a. The applicant shall have a service plan which is developed by the applicant and a department service worker. The plan must be completed and approved before service provision.

(1) The designated case manager shall identify the need for service based on the needs of the applicant, as documented in the information submission tool listed in 83.102(1)“h,” as well as the availability and appropriateness of services.

(2) The service worker shall have a face-to-face visit with the member at least annually.

b. The total cost of physical disability waiver services, excluding the cost of home and vehicle modifications, shall not exceed \$705.84 per month.

83.102(3) Slots. The total number of persons receiving HCBS physical disability waiver services in the state shall be limited to the number provided in the waiver approved by the Secretary of the U.S. Department of Health and Human Services. These slots shall be available on a first-come, first-served basis.

83.102(4) County payment slots for persons requiring the ICF/MR level of care. Rescinded IAB 10/6/99, effective 10/1/99.

83.102(5) Securing a slot.

a. The county department office shall enter all waiver applications into the individualized services information system (ISIS) to determine if a slot is available for all new applicants for the HCBS physical disability waiver program.

(1) For applicants not currently receiving Medicaid, the county department office shall make the entry by the end of the fifth working day after receipt of a completed Form 470-2927 or 470-2927(S), Health Services Application, or within five working days after receipt of disability determination, whichever is later.

(2) For current Medicaid members, the county department office shall make the entry by the end of the fifth working day after receipt of a written request signed and dated by the waiver applicant.

b. If no slot is available, the department shall enter applicants on the HCBS physical disabilities waiver waiting list according to the following:

(1) Applicants not currently eligible for Medicaid shall be entered on the basis of the date a completed Form 470-2927 or 470-2927(S), Health Services Application, is received by the department or upon receipt of disability determination, whichever is later. Applicants currently eligible for Medicaid shall be added on the basis of the date the applicant requests HCBS physical disability program services. In the event that more than one application is received on the same day, applicants shall be entered on the waiting list on the basis of the day of the month of their birthday, the lowest number being first on the list. Any subsequent tie shall be decided by the month of birth, January being month one and the lowest number.

(2) Persons who do not fall within the available slots shall have their applications rejected but their names shall be maintained on the waiting list. As slots become available, persons shall be selected from the waiting list to maintain the number of approved persons on the program based on their order on the waiting list.

83.102(6) Securing a county payment slot. Rescinded IAB 10/6/99, effective 10/1/99.

83.102(7) HCBS physical disability waiver waiting list. When services are denied because the limit on the number of slots is reached, a notice of decision denying service based on the limit and stating that the person's name shall be put on a waiting list shall be sent to the person by the department.

[ARC 9650B, IAB 8/10/11, effective 10/1/11; ARC 0306C, IAB 9/5/12, effective 11/1/12; ARC 0548C, IAB 1/9/13, effective 1/1/13; ARC 0665C, IAB 4/3/13, effective 6/1/13; ARC 0842C, IAB 7/24/13, effective 7/1/13; ARC 1056C, IAB 10/2/13, effective 11/6/13; ARC 1445C, IAB 4/30/14, effective 7/1/14; ARC 2848C, IAB 12/7/16, effective 11/15/16; ARC 2936C, IAB 2/1/17, effective 3/8/17; ARC 3184C, IAB 7/5/17, effective 8/9/17]

441—83.103(249A) Application.

83.103(1) Application for financial eligibility. The application process as specified in rules 441—76.1(249A) to 441—76.6(249A) shall be followed. Applications for this program may only be filed on or after April 1, 1999.

83.103(2) Approval of application for eligibility.

a. Applications for this waiver shall be initiated on behalf of the applicant who is a resident of a medical institution with the applicant's consent or with the consent of the applicant's legal representative by the discharge planner of the medical facility where the applicant resides at the time of application.

(1) The discharge planner shall contact the member's managed care organization or designated case manager to arrange for completion of the appropriate information submission tool as listed in paragraph 83.102(1) "h."

(2) After completing the determination of the level of care needed by the applicant, the IME medical services unit shall inform the income maintenance worker and the discharge planner of the IME medical services unit's decision.

b. Applications for this waiver shall be initiated by the applicant, the applicant's parent or legal guardian, or the applicant's attorney in fact under a durable power of attorney for health care on behalf of the applicant who is residing in the community.

(1) The applicant's managed care organization or the designated case manager shall arrange for the completion of the appropriate information submission tool as listed in paragraph 83.102(1) "h" and submit it to the IME medical services unit.

(2) After completing the determination of the level of care needed by the applicant, the IME medical services unit shall inform the income maintenance worker and the applicant, the applicant's parent or legal guardian, or the applicant's attorney in fact under a durable power of attorney for health care.

c. Eligibility for this waiver shall be effective as of the date when both the eligibility criteria in subrule 83.102(1) and need for services in subrule 83.102(2) have been established. Decisions shall be mailed or given to the applicant, the applicant's parent or legal guardian, or the applicant's attorney in fact under a durable power of attorney for health care on the date when each eligibility determination is completed.

d. An applicant shall be given the choice between waiver services and institutional care. The applicant or the applicant's parent, legal guardian, or attorney in fact under a durable power of attorney for health care shall sign the information submission tool, indicating that the applicant has elected home- and community-based services.

e. The applicant, the applicant's parent or guardian, or the applicant's attorney in fact under a durable power of attorney for health care shall cooperate with the designated case manager in the development of the service plan prior to the start of services.

f. HCBS physical disability waiver services provided prior to both approvals of eligibility for the waiver cannot be paid.

g. HCBS physical disability waiver services are not available in conjunction with other HCBS waiver programs. The consumer may also receive in-home health-related care service if eligible for that program.

83.103(3) *Effective date of eligibility.*

a. The effective date of eligibility for the waiver for persons who are already determined eligible for Medicaid is the date on which the person is determined to meet all of the criteria set forth in subrule 83.102(1).

b. The effective date of eligibility for the waiver for persons who qualify for Medicaid due to eligibility for the waiver services is the date on which the person is determined to meet all of the criteria set forth in subrule 83.102(1) and when the eligibility factors set forth in 441—subrule 75.1(7) and, for married persons, in rule 441—75.5(249A), have been satisfied.

c. Eligibility for the waiver continues until the consumer fails to meet eligibility criteria listed in subrule 83.102(1). Consumers who return to inpatient status in a medical institution for more than 120 consecutive days shall be reviewed by the IME medical services unit to determine additional inpatient needs for possible termination from the physical disability waiver. The consumer shall be reviewed for eligibility under other Medicaid coverage groups in accordance with rule 441—76.11(249A). The consumer shall be notified of that decision through Form 470-0602, Notice of Decision.

If the consumer returns home before the effective date of the notice of decision and the consumer's condition has not substantially changed, the denial may be rescinded and eligibility may continue.

83.103(4) *Attribution of resources.* For the purposes of attributing resources as provided in rule 441—75.5(249A), the date on which the waiver consumer meets the institutional level of care requirement as determined by the IME medical services unit or an appeal decision shall be used as the date of entry to the medical institution. Only one attribution of resources shall be completed per person. Attributions completed for a prior institutionalization shall be applied to the waiver application.

[ARC 0306C, IAB 9/5/12, effective 11/1/12; ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 3184C, IAB 7/5/17, effective 8/9/17; ARC 3234C, IAB 8/2/17, effective 9/6/17]

441—83.104(249A) Client participation. Consumers who are financially eligible under 441—subrule 75.1(7) (the 300 percent group) must contribute a client participation amount to the cost of physical disability waiver services.

83.104(1) Computation of client participation. Client participation shall be computed by deducting a maintenance needs allowance equal to 300 percent of the maximum SSI grant for an individual from the consumer's total income. For a couple, client participation is determined as if each person were an individual.

83.104(2) Limitation on payment. If the sum of the third-party payment and client participation equals or exceeds the reimbursement for the specific physical disability waiver service, Medicaid shall make no payments for the waiver service. However, Medicaid shall make payments to other medical providers.

441—83.105(249A) Redetermination. A complete financial redetermination of eligibility for the physical disability waiver shall be completed at least once every 12 months. A redetermination of continuing eligibility factors shall be made when a change in circumstances occurs that affects eligibility in accordance with rule 441—83.102(249A). A redetermination shall contain the components listed in rule 441—83.102(249A).

441—83.106(249A) Allowable services. The services allowable under the physical disability waiver are consumer-directed attendant care, home and vehicle modification, personal emergency response system, transportation, specialized medical equipment, financial management, independent support brokerage, self-directed personal care, self-directed community supports and employment, and individual-directed goods and services as set forth in rule 441—78.46(249A).

441—83.107(249A) Individual service plan. An individualized service plan shall be prepared and used for each HCBS physical disability waiver consumer. The service plan shall be developed and approved by the consumer, the consumer's interdisciplinary team and the designated case manager prior to services beginning and payment being made to the provider.

83.107(1) Information in plan. The plan shall be in accordance with 441—subrule 24.4(3) and shall additionally include the following information to assist in evaluating the program:

- a. A listing of all services received by a consumer at the time of waiver program enrollment.
- b. The name of all providers responsible for providing all services.
- c. All service funding sources.
- d. The amount of the service to be received by the consumer.
- e. Whether the consumer has elected the consumer choices option and, if so:
 - (1) The independent support broker selected by the consumer; and
 - (2) The financial management service selected by the consumer.
- f. A plan for emergencies and identification of the supports available to the consumer in an emergency.

83.107(2) Annual assessment. The IME medical services unit or a managed care organization shall review the member's need for continued care annually and recertify the member's need for long-term care services, pursuant to paragraph 83.102(1) "h" and the appeal process at rule 441—83.109(249A), based on the appropriate information submission tool as listed in paragraph 83.102(1) "h" and other supporting documentation as relevant.

a. The IME medical services unit or the member's managed care organization shall be responsible for annual redetermination of the level of care.

b. The managed care organization must submit documentation to the IME medical services unit for all reassessments, performed at least annually, which indicate a change in the member's level of care. The IME medical services unit shall make a final determination for any reassessments which indicate a change in the level of care. If the level of care reassessment indicates no change in level of care, the member is approved to continue at the already established level of care.

83.107(3) Case file. Rescinded IAB 8/7/02, effective 10/1/02.
 [ARC 0306C, IAB 9/5/12, effective 11/1/12; ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 3184C, IAB 7/5/17, effective 8/9/17]

441—83.108(249A) Adverse service actions.

83.108(1) Denial. An application for services shall be denied when it is determined by the department that:

- a. All of the medically necessary service needs cannot be met in a home- or community-based setting.
- b. Service needs exceed the reimbursement maximums.
- c. Service needs are not met by the services provided.
- d. Needed services are not available or received from qualifying providers.
- e. The physical disability waiver service is not identified in the consumer's service plan.
- f. There is another community resource available to provide the service or a similar service free of charge to the consumer that will meet the consumer's needs.
- g. The consumer receives services from other Medicaid waiver providers.
- h. The consumer or legal representative requests termination from the services.

83.108(2) Reduction. A particular service may be reduced when the department determines that the provisions of 441—subrule 130.5(3), paragraph “a” or “b,” apply.

83.108(3) Termination. A particular service may be terminated when the department determines that:

- a. The provisions of 441—subrule 130.5(2), paragraph “d,” “g,” or “h,” apply.
- b. Needed services are not available or received from qualifying providers.
- c. The physical disability waiver service is not identified in the consumer's annual service plan.
- d. Service needs are not met by the services provided.
- e. Services needed exceed the service unit or reimbursement maximums.
- f. Completion or receipt of required documents by the consumer for the physical disability waiver service has not occurred.
- g. The consumer receives services from other Medicaid providers.
- h. The consumer or legal representative requests termination from the services.

441—83.109(249A) Appeal rights. Notice of adverse actions and right to appeal shall be given in accordance with 441—Chapter 7 and rule 441—130.5(234).

83.109(1) Appeal to county. Rescinded IAB 2/7/01, effective 2/1/01.

83.109(2) Reconsideration request to IME medical services unit. Rescinded IAB 9/5/12, effective 11/1/12.
 [ARC 0306C, IAB 9/5/12, effective 11/1/12]

441—83.110(249A) County reimbursement. Rescinded IAB 10/6/99, effective 10/1/99.

441—83.111(249A) Conversion to the X-PERT system. Rescinded IAB 8/7/02, effective 10/1/02.
 These rules are intended to implement Iowa Code sections 249A.3 and 249A.4.

441—83.112 to 83.120 Reserved.

DIVISION VII—HCBS CHILDREN'S MENTAL HEALTH WAIVER SERVICES

441—83.121(249A) Definitions.

“*Assessment*” means the review of the consumer's current functioning in regard to the consumer's situation, needs, abilities, desires, and goals.

“*Care coordinator*” means the professional who assists members in care coordination as described in 441—paragraph 78.53(1)“b.”

“*Case manager*” means the person designated to provide Medicaid targeted case management services for the consumer.

“*CMS*” means the Centers for Medicare and Medicaid Services, a division of the U.S. Department of Health and Human Services.

“*Consumer*” means an individual up to the age of 18 who is included in a Medicaid coverage group listed in 441—75.1(249A) and is a recipient of children’s mental health waiver services.

“*Deeming*” means considering parental or spousal income or resources as income or resources of a consumer in determining eligibility for a consumer according to Supplemental Security Income program guidelines.

“*Department*” means the Iowa department of human services.

“*Guardian*” means a parent of a consumer or a legal guardian appointed by the court.

“*HCBS*” means home- and community-based services provided under a Medicaid waiver.

“*IME*” means the Iowa Medicaid enterprise.

“*IME medical services unit*” means the contracted entity in the Iowa Medicaid enterprise that determines level of care for consumers initially applying for or continuing to receive children’s mental health waiver services.

“*Integrated health home*” means the provision of services to enrolled members as described in 441—subrule 78.53(1).

“*Interdisciplinary team*” means the consumer, the consumer’s family, and persons of varied professional and nonprofessional backgrounds with knowledge of the consumer’s needs, as designated by the consumer and the consumer’s family, who meet to develop a service plan based on the individualized needs of the consumer.

“*ISIS*” means the department’s individualized services information system.

“*Local office*” means a department of human services office as described in 441—subrule 1.4(2).

“*Managed care organization*” means an entity that (1) is under contract with the department to provide services to Medicaid recipients and (2) meets the definition of “health maintenance organization” as defined in Iowa Code section 514B.1.

“*Medical institution*” means a nursing facility, an intermediate care facility for persons with an intellectual disability, a psychiatric hospital or psychiatric medical institution for children, or a state mental health institute that has been approved as a Medicaid vendor.

“*Mental health professional*” means a person who meets all of the following conditions:

1. Holds at least a master’s degree in a mental health field including, but not limited to, psychology, counseling and guidance, psychiatric nursing and social work; or is a doctor of medicine or osteopathic medicine; and
2. Holds a current Iowa license when required by the Iowa professional licensure laws (such as a psychiatrist, a psychologist, a marital and family therapist, a mental health counselor, an advanced registered nurse practitioner, a psychiatric nurse, or a social worker); and
3. Has at least two years of postdegree experience supervised by a mental health professional in assessing mental health problems, mental illness, and service needs and in providing mental health services.

“*Psychiatric medical institution for children level of care*” means that the member has been diagnosed with a serious emotional disturbance and an independent team as identified in 441—subrule 85.22(3) has certified that ambulatory care resources available in the community do not meet the treatment needs of the recipient, that proper treatment of the recipient’s psychiatric condition requires services on an inpatient basis under the direction of a physician, and that the services can reasonably be expected to improve the recipient’s condition or prevent further regression so that the services will no longer be needed.

“*Serious emotional disturbance*” means a diagnosable mental, behavioral, or emotional disorder that (1) is of sufficient duration to meet diagnostic criteria for the disorder specified by the current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric Association; and (2) has resulted in a functional impairment that substantially interferes with or limits a consumer’s role or functioning in family, school, or community activities. “Serious emotional disturbance” shall not include neurodevelopmental disorders, substance-related disorders, or conditions or problems classified in the current version of the DSM as “other conditions that may be a

focus of clinical attention,” unless these conditions co-occur with another diagnosable serious emotional disturbance.

“*Service plan*” means a person-centered, outcome-based plan of services that is written by the member’s case manager with input and direction from the member and that addresses all relevant services and supports being provided. The service plan is developed by the interdisciplinary team, which includes the member and, if appropriate, the member’s legal representative, member’s family, service providers, and others directly involved with the member.

“*Skill development*” means that the service provided is habilitative and is intended to impart an ability or capacity to the consumer. Supervision without habilitation is not skill development.

“*Targeted case management*” means Medicaid case management services accredited under 441—Chapter 24 and provided according to 441—Chapter 90 for consumers eligible for the children’s mental health waiver.

“*Waiver year*” for the children’s mental health waiver means a 12-month period commencing on July 1 of each year.

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441—83.122(249A) Eligibility. To be eligible for children’s mental health waiver services, a consumer must meet all of the following requirements:

83.122(1) Age. The consumer must be under 18 years of age.

83.122(2) Diagnosis. The consumer must be diagnosed with a serious emotional disturbance.

a. Initial certification. For initial application to the HCBS children’s mental health waiver program, psychological documentation that substantiates a mental health diagnosis of serious emotional disturbance as determined by a mental health professional must be current within the 12-month period before the application date.

b. Ongoing certification. A mental health professional must complete an annual evaluation that substantiates a mental health diagnosis of serious emotional disturbance.

83.122(3) Level of care. The applicant must be certified as being in need of a level of care that, but for the waiver, would be provided in a psychiatric hospital serving children under the age of 21. The IME medical services unit or a managed care organization shall certify the applicant’s level of care annually based on information submitted on Form 470-4694, Case Management Comprehensive Assessment, for children aged 3 and under or on the interRAI - Child and Youth Mental Health (ChYMH) for those aged 4 to 20 and other supporting documentation as relevant. For those aged 12 to 18, the interRAI - Adolescent Supplement shall also be completed in addition to the interRAI - Child and Youth Mental Health (ChYMH). Form 470-4694, the interRAI - Child and Youth Mental Health (ChYMH), and the interRAI - Adolescent Supplement are available on request from the IME medical services unit. Copies of the completed information submission tool for an individual are available to that individual from the individual’s case manager, integrated health home care coordinator or managed care organization.

83.122(4) Financial eligibility. The consumer must be eligible for Medicaid as follows:

a. Be eligible for Medicaid under an SSI, SSI-related, FMAP, or FMAP-related coverage group; or

b. Be eligible under the special income level (300 percent) coverage group; or

c. Become eligible through application of the institutional deeming rules; or

d. Would be eligible for Medicaid if in a medical institution. For this purpose, deeming of parental or spousal income or resources ceases in the month after the month of application.

83.122(5) Choice of program. The applicant must choose HCBS children’s mental health waiver services over institutional care, as indicated by the signature of the applicant’s parent or legal guardian on the assessment.

83.122(6) Need for service. The consumer must have service needs that can be met under the children’s mental health waiver program, as documented in the service plan developed in accordance with rule 441—83.12(249A).

a. The consumer must be a recipient of case management or integrated health home services or be identified to receive case management or integrated health home services immediately following program enrollment.

b. The total cost of children's mental health waiver services needed to meet the member's needs, excluding the cost of environmental modifications, adaptive devices and therapeutic resources, may not exceed \$2,006.34 per month.

c. At a minimum, each consumer must receive one billable unit of a children's mental health waiver service per calendar quarter.

d. A consumer may not receive children's mental health waiver services and foster family care services under 441—Chapter 202 at the same time.

e. A consumer may be enrolled in only one HCBS waiver program at a time.
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441—83.123(249A) Application. The Medicaid application process as specified in rules 441—76.1(249A) to 441—76.6(249A) shall be followed for an application for HCBS children's mental health waiver services.

83.123(1) Program limit. The number of persons who may be approved for the HCBS children's mental health waiver shall be subject to the number of consumers to be served as set forth in the federally approved HCBS children's mental health waiver. When the number of applicants exceeds the number of consumers specified in the approved waiver, the consumer's application shall be rejected and the consumer's name shall be placed on a waiting list.

a. The local office shall determine if a payment slot is available by the end of the fifth working day after receipt of:

- (1) A completed Form 470-2297, Health Services Application, from a consumer who is not currently a Medicaid member; or
- (2) A written request signed and dated by a Medicaid member's parent or legal guardian.

b. When a payment slot is available, the local office shall enter the application into ISIS to begin the waiver approval process.

(1) The department shall hold the payment slot for the consumer as long as reasonable efforts are being made to arrange services and the consumer has not been determined to be ineligible for the program.

(2) If services have not been initiated and reasonable efforts are no longer being made to arrange services, the slot shall revert for use by the next consumer on the waiting list, if applicable. The consumer must reapply for a new slot.

c. If no payment slot is available, the department shall enter the names of persons on a waiting list according to the following:

(1) The names of applicants not currently eligible for Medicaid shall be entered on the waiting list on the basis of the date a completed Form 470-2927 or 470-2927(S), Health Services Application, is received by the department;

(2) The names of Medicaid members shall be added to the waiting list on the date as specified in paragraph 83.123(1) "a."

(3) In the event that more than one application is received at one time, the names of consumers shall be entered on the waiting list on the basis of the month of birth, January being month one and the lowest number.

d. Consumers whose names are on the waiting list shall be contacted to reapply as slots become available, based on the order of the waiting list, so that the number of approved consumers on the program is maintained.

(1) Once a payment slot is assigned, the department shall give written notice to the consumer within five working days.

(2) The department shall hold the payment slot for 30 days for the consumer to file a new application.

(3) If an application has not been filed within 30 days, the slot shall revert for use by the next consumer on the waiting list, if applicable. The consumer originally assigned the slot must reapply for a new slot.

83.123(2) Approval of waiver eligibility.

a. Time limit. Applications for the HCBS children's mental health waiver program shall be processed within 30 days unless one or more of the following conditions exist:

(1) An application has been filed and is pending for federal Supplemental Security Income (SSI) benefits.

(2) The application is pending because the department has not received information for a reason that is beyond the control of the consumer or the department.

(3) The application is pending because the assessment has not been completed. When a determination is not completed 90 days after the date of application due to the lack of a completed assessment, the application shall be denied.

b. Notice of decisions. The department shall mail or give decisions to the applicant on the dates when eligibility and level of care determinations are completed.

83.123(3) Effective date of eligibility. The effective date of a consumer's eligibility for children's mental health waiver services shall be the first date that all of the following conditions exist:

a. All eligibility requirements are met; and

b. Eligibility and level of care determinations have been made.

[ARC 0306C, IAB 9/5/12, effective 11/1/12; ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 3184C, IAB 7/5/17, effective 8/9/17]

441—83.124(249A) Financial participation. A consumer must contribute to the cost of children's mental health waiver services to the extent of the consumer's total income less 300 percent of the maximum monthly payment for one person under the federal Supplemental Security Income (SSI) program.

441—83.125(249A) Redetermination. The department shall redetermine a consumer's eligibility for the children's mental health waiver at least once every 12 months or when there is significant change in the consumer's situation or condition.

83.125(1) Eligibility review.

a. Every 12 months, the department shall review a consumer's eligibility in accordance with procedures in rule 441—76.7(249A). The review shall verify continuing eligibility factors as specified in rule 441—83.122(249A).

b. The IME medical services unit or a managed care organization shall review the member's need for continued care annually and recertify the member's need for long-term care services, pursuant to rule 441—83.122(249A) and the appeal process at rule 441—83.129(249A), based on the completed information submission tool designated in 83.122(3) and other supporting documentation as relevant.

c. The IME medical services unit or the member's managed care organization shall be responsible for annual redetermination of the level of care.

d. The managed care organization must submit documentation to the IME medical services unit for all reassessments, performed at least annually, which indicate a change in the member's level of care. The IME medical services unit shall make a final determination for any reassessments which indicate a change in the level of care. If the level of care reassessment indicates no change in level of care, the member is approved to continue at the already established level of care.

83.125(2) Continuation of eligibility. A consumer's waiver eligibility shall continue until one of the following conditions occurs.

a. The consumer fails to meet eligibility criteria listed in rule 441—83.122(249A).

b. The consumer is an inpatient of a medical institution for 120 or more consecutive days.

(1) After the consumer has spent 120 consecutive days in a medical institution, the local office shall terminate the consumer's waiver eligibility and review the consumer for eligibility under other Medicaid coverage groups. The local office shall notify the consumer and the consumer's parents or legal guardian through Form 470-0602, Notice of Decision.

(2) If the consumer returns home after 120 consecutive days, the consumer must reapply for children's mental health waiver services, and the IME medical services unit must redetermine the consumer's level of care.

c. The consumer does not reside at the consumer's natural home for a period of 60 consecutive days. After the consumer has resided outside the home for 60 consecutive days, the local office shall terminate the consumer's waiver eligibility and review the consumer for eligibility under other Medicaid coverage groups. The local office shall notify the consumer and the consumer's parents or legal guardian through Form 470-0602, Notice of Decision.

83.125(3) Payment slot. When a consumer loses waiver eligibility, the consumer's assigned payment slot shall revert for use to the next consumer on the waiting list.

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441—83.126(249A) Allowable services. Services allowable under the children's mental health waiver shall be provided as set forth in rule 441—78.52(249A) and shall include:

1. Environmental modifications, adaptive devices and therapeutic resources;
2. Family and community support services;
3. In-home family therapy; and
4. Respite care.

441—83.127(249A) Service plan. The consumer's case manager or integrated health home care coordinator shall prepare an individualized service plan for each consumer that meets the requirements set for case plans in rule 441—130.7(234).

83.127(1) The service plan shall be developed through an interdisciplinary team process.

83.127(2) The service plan shall be developed annually or when there is significant change in the consumer's situation or condition.

83.127(3) The service plan shall be based on information in the completed information submission tool designated in subrule 83.122(3) and other supporting documentation as relevant.

83.127(4) The service plan shall specify the type and frequency of the waiver services and the providers that will deliver the services.

83.127(5) The service plan shall identify and justify any restriction of the consumer's rights.

[ARC 0306C, IAB 9/5/12, effective 11/1/12; ARC 3184C, IAB 7/5/17, effective 8/9/17]

441—83.128(249A) Adverse service actions.

83.128(1) Denial. An application for children's mental health waiver services shall be denied when the department determines that:

- a. The consumer is not eligible for or in need of waiver services.
- b. Needed services are not available or received from qualified providers.
- c. Service needs exceed the limit on aggregate monthly costs established in 83.122(6) "c" or are not met by the services provided.

83.128(2) Termination. A consumer's participation in the children's mental health waiver program may be terminated when the department determines that:

- a. The provisions of 441—paragraph 130.5(2) "a," "b," "c," "g," or "h" apply.
- b. The costs of the children's mental health waiver services for the consumer exceed the aggregate monthly costs established in 83.122(6) "c."
- c. The consumer receives care in a hospital, nursing facility, psychiatric hospital serving children under the age of 21, or psychiatric medical institution for children for 120 days in any one stay.
- d. The physical or mental condition of the consumer requires more care than can be provided in the consumer's own home, as determined by the consumer's case manager or integrated health home care coordinator.
- e. Service providers are not available.

83.128(3) Reduction. Reduction of services shall apply as specified in 441—paragraphs 130.5(3) "a" and "b."

[ARC 3184C, IAB 7/5/17, effective 8/9/17; ARC 3234C, IAB 8/2/17, effective 9/6/17]

441—83.129(249A) Appeal rights. Notice of adverse action and right to appeal shall be given in accordance with 441—Chapter 7 and rule 441—130.5(234).

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Rescinded **ARC 3875C**, IAB 7/4/18, effective 8/8/18; see 481—Chapter 72

HOMELAND SECURITY AND EMERGENCY MANAGEMENT DEPARTMENT[605]

[Prior to 12/23/92, see Disaster Services Division[607]; renamed Emergency Management Division by
1992 Iowa Acts, chapter 1139, section 21]

[Prior to 3/31/04, see Emergency Management Division[605]; renamed Homeland Security and Emergency Management
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CHAPTER 10

911 TELEPHONE SYSTEMS

[Prior to 4/18/90, see Public Defense[601]Ch 10]

[Prior to 5/12/93, Disaster Services Division[607]Ch 10]

605—10.1(34A) Program description. The purpose of this program is to provide for the orderly development, installation, and operation of 911 emergency telephone systems and to provide a mechanism for the funding of these systems, either in whole or in part. These systems shall be operated under governmental management and control for the public benefit. These rules shall apply to each joint 911 service board or alternative 28E entity as provided in Iowa Code chapter 34A and to each provider of 911 service.

[ARC 3233C, IAB 8/2/17, effective 9/6/17]

605—10.2(34A) Definitions. As used in this chapter, unless context otherwise requires:

“*Access line*” means an exchange access line that has the ability to access dial tone and reach a public safety answering point.

“*Automatic location identification (ALI)*” means a system capability that enables an automatic display of information defining a geographical location of the telephone used to place the 911 call.

“*Automatic number identification (ANI)*” means a capability that enables the automatic display of the number of the telephone used to place the 911 call.

“*Call attendant*” means the person who initially answers a 911 call.

“*Call detail recording*” means a means of establishing chronological and operational accountability for each 911 call processed, consisting minimally of the caller’s telephone number, the date and time the 911 telephone equipment established initial connection (trunk seizure), the time the call was answered, the time the call was transferred (if applicable), the time the call was disconnected, the trunk line used, and the identity of the call attendant’s position, also known as an ANI printout.

“*Call relay method*” means the 911 call is answered at the PSAP, where the pertinent information is gathered, and the call attendant relays the caller’s information to the appropriate public or private safety agency for further action.

“*Call transfer method*” means the call attendant determines the appropriate responding agency and transfers the 911 caller to that agency.

“*Central office (CO)*” means a telephone company facility that houses the switching and trunking equipment serving telephones in a defined area.

“*Coin-free access (CFA)*” means coin-free dialing or no-coin dial tone which enables a caller to dial 911 or “0” for operator without depositing money or incurring a charge.

“*Communications service*” means a service capable of accessing, connecting with, or interfacing with a 911 system by dialing, initializing, or otherwise activating the system exclusively through the digits 911 by means of a local telephone device, wireless communications device or any other device capable of interfacing with the 911 system.

“*Competitive local exchange service provider*” means the same as defined in Iowa Code section 476.96.

“*Conference transfer*” means the capability of transferring a 911 call to the action agency and allowing the call attendant to monitor or participate in the call after it has been transferred to the action agency.

“*Direct dispatch method*” means 911 call answering and radio-dispatching functions, for a particular agency, are both performed at the PSAP.

“*Director*,” unless otherwise noted, means the director of the homeland security and emergency management department.

“*Emergency call*” means a telephone request or text message request for service which requires immediate action to prevent loss of life, reduce bodily injury, prevent or reduce loss of property and respond to other emergency situations determined by local policy.

“*Emergency communications service surcharge*” means a charge established by the program manager in accordance with Iowa Code section 34A.7A.

“Emergency services internet protocol network” or *“ESInet”* means a system using broadband packet-switched technology that is capable of supporting the transmission of varying types of data to be shared by all public and private safety agencies that are involved in an emergency.

“Enhanced 911 (E911)” means the general term referring to emergency telephone systems with specific electronically controlled features, such as ALI, ANI, and selective routing.

“Enhanced 911 (E911) operating authority” means the public entity, which operates an E911 telephone system for the public benefit, within a defined enhanced 911 service area.

“Enhanced wireless 911 service, phase I” means an emergency wireless telephone system with specific electronically controlled features such as ANI, specific indication of wireless communications tower site location, selective routing by geographic location of the tower site.

“Enhanced wireless 911 service, phase II” means an emergency wireless telephone system with specific electronically controlled features such as ANI and ALI and selective routing by geographic location of the 911 caller.

“Exchange” means a defined geographic area served by one or more central offices in which the telephone company furnishes services.

“Geographic information system” or *“GIS”* means a system designed to capture, store, manipulate, analyze, manage, and present spatial or geographical data.

“Implementation” means the activity between formal approval of an E911 service plan and a given system design, and commencement of operations.

“Joint 911 service board” means those entities that are created under the provisions of Iowa Code section 34A.3, which include the legal entities created pursuant to Iowa Code chapter 28E referenced in Iowa Code subsection 34A.3(3), and that operate a 911 telephone system for the public benefit within a defined 911 service area.

“Local exchange carrier” means the same as defined in Iowa Code section 476.96.

“Next generation 911 network” means an internet protocol-enabled system that enables the public to transmit digital information to public safety answering points and is responsible for the delivery of all 911 messages within the state. “Next generation 911 network” replaces enhanced 911 and includes but is not limited to 911 voice and nonvoice messages generated by originating service providers, ESInet, GIS, cybersecurity, and other system components.

“Next generation 911 network service provider” means a vendor or vendors selected by the department to provide next generation 911 network functionality.

“911 call” means any telephone call that is made by dialing the digits 911.

“911 call processing equipment” means equipment owned by the department that functions in a host remote environment, provides 911 call processing functionality to public safety answering points, and utilizes the next generation 911 network. “911 call processing equipment” includes but is not limited to computer aided dispatch, voice logging recorders, mapping, and emergency medical dispatch.

“911 call processing equipment provider” means a vendor or vendors selected by the department to provide 911 call processing equipment.

“911 call transport provider” means a vendor or vendors selected by the department to deliver aggregated wireline 911 call traffic to the next generation 911 network and from the next generation 911 network to public safety answering points.

“911 communications council” means the council as established under the provisions of Iowa Code section 34A.15.

“911 program manager” means that person appointed by the director of the homeland security and emergency management department, and working with the 911 communications council, to perform the duties specifically set forth in Iowa Code chapter 34A and this chapter.

“911 service area” means the geographic area encompassing at least one entire county, and which may encompass a geographical area outside the one entire county not restricted to county boundaries, serviced or to be serviced under a 911 service plan.

“911 service plan” means a plan, produced by a joint 911 service board, which includes the information required by Iowa Code subsection 34A.2(2) as amended by 2018 Iowa Acts, House File 2254, section 2.

“*911 system*” means a telephone system that automatically connects a caller, dialing the digits 911, to a PSAP.

“*Nonrecurring costs*” means one-time charges incurred by a joint E911 service board or operating authority including, but not limited to, expenditures for E911 service plan preparation, capital outlay, communications equipment to receive and dispatch emergency calls, installation, and initial license to use subscriber names, addresses and telephone information.

“*One-button transfer*” means another term for a (fixed) transfer which allows the call attendant to transfer an incoming call by pressing a single button. For example, one button would transfer voice and data to a fire agency, and another button would be used for police, also known as “selective transfer.”

“*Originating service provider*” means a communications provider that allows its users or subscribers to originate 911 voice or nonvoice messages from the public to public safety answering points, including but not limited to wireline, wireless, and voice over internet protocol services.

“*Political subdivision*” means a geographic or territorial division of the state that would have the following characteristics: defined geographic area, responsibilities for certain functions of local government, public elections and public officers, and taxing power. Excluded from this definition are departments and divisions of state government and agencies of the federal government.

“*Prepaid wireless telecommunications service*” means a wireless communications service that provides the right to utilize mobile wireless service as well as other nontelecommunications services, including the download of digital products delivered electronically, content and ancillary services, which must be paid for in advance, and that is sold in predetermined units or dollars of which the amount declines with use in a known amount.

“*Provider*” means a person, company or other business that provides, or offers to provide, 911 equipment, installation, maintenance, or access services.

“*Public or private safety agency*” means a unit of state or local government, a special purpose district, or a private firm, which provides or has the authority to provide firefighting, police, ambulance, emergency medical services or hazardous materials response.

“*Public safety answering point (PSAP)*” means a 24-hour, state, local, or contracted communications facility, which has been designated by the local service board to receive 911 service calls and dispatch emergency response services in accordance with the E911 service plan.

“*Public switched telephone network*” means a complex of diversified channels and equipment that automatically routes communications between the calling person and called person or data equipment.

“*Recurring costs*” means repetitive charges incurred by a joint E911 service board or operating authority including, but not limited to, personnel time directly associated with database management and personnel time directly associated with addressing, lease of access lines, lease of equipment, network access fees, communications equipment to receive and dispatch emergency calls, and applicable maintenance costs.

“*Selective routing (SR)*” means a 911 system feature that enables all 911 calls originating from within a defined geographical region to be answered at a predesignated PSAP.

“*Subscriber*” means any person, firm, association, corporation, agencies of federal, state and local government, or other legal entity responsible by law for payment for communication service from the telephone utility.

“*Tariff*” means a document filed by a telephone company with the state telephone utility regulatory commission which lists the communication services offered by the company and gives a schedule for rates and charges.

“*Telecommunications device for the deaf (TDD)*” means any type of instrument, such as a typewriter keyboard connected to the caller’s telephone and involving special equipment at the PSAP which allows an emergency call to be made without speaking, also known as a TTY.

“*Telematics*” means a vehicle-based mobile data application which can automatically call for assistance if the vehicle is in an accident.

“*Trunk*” means a circuit used for connecting a subscriber to the public switched telephone network.

“*Voice over internet protocol service*” means a service to which all of the following apply:

1. The service provides real-time, two-way voice communications transmitted using internet protocol or a successor protocol.
2. The service is offered to the public, or such classes of users as to be effectively available to the public.
3. The service has the capability to originate traffic to, and terminate traffic from, the public switched telephone network or a successor network.

“*Wireless communications service*” means commercial mobile radio service. “Wireless communications service” includes any wireless two-way communications used in cellular telephone service, personal communications service, or the functional or competitive equivalent of a radio-telephone communications line used in cellular telephone service, a personal communications service, or a network access line. “Wireless communications service” does not include a service whose customers do not have access to 911 or 911-like service, a communications channel utilized only for data transmission, or a private telecommunications system.

“*Wireless communications service provider*” means a company that offers wireless communications service to users of wireless devices including but not limited to cellular, personal communications services, mobile satellite services, and enhanced specialized mobile radio.

“*Wireless E911 phase 1*” means a 911 call made from a wireless device in which the wireless communications service provider delivers the call-back number and the address of the tower that received the call to the appropriate public safety answering point.

“*Wireless E911 phase 2*” means a 911 call made from a wireless device in which the wireless communications service provider delivers the call-back number and the latitude and longitude coordinates of the wireless device to the appropriate public safety answering point.

“*Wireless NG911 service area*” means the geographic area to be served, or currently served, by a PSAP under a wireless NG911 service plan.

“*Wireline 911 service surcharge*” means a charge assessed on each wireline access line which physically terminates within the 911 service area in accordance with Iowa Code section 34A.7.

[ARC 8314B, IAB 11/18/09, effective 12/23/09; ARC 0602C, IAB 2/20/13, effective 3/27/13; ARC 1538C, IAB 7/9/14, effective 8/13/14; ARC 2270C, IAB 11/25/15, effective 12/30/15; ARC 2741C, IAB 10/12/16, effective 9/14/16; ARC 2835C, IAB 12/7/16, effective 1/11/17; ARC 3233C, IAB 8/2/17, effective 9/6/17; ARC 3868C, IAB 7/4/18, effective 8/8/18]

605—10.3(34A) Joint 911 service boards. Each county board of supervisors shall establish a joint 911 service board.

10.3(1) Membership.

a. Each political subdivision of the state, having a public safety agency serving territory within the county 911 service area, and each local emergency management agency as defined in Iowa Code section 29C.2 operating within the 911 service area is entitled to one voting membership. For the purposes of this paragraph, a township that operates a volunteer fire department providing fire protection services to the township, or a city that provides fire protection services through the operation of a volunteer fire department not financed through the operation of city government, shall be considered a political subdivision of the state having a public safety agency serving territory within the county.

b. Each private safety agency, such as privately owned ambulance services, airport security agencies, and private fire companies, serving territory within the county 911 service area, is entitled to a nonvoting membership on the board.

c. Public and private safety agencies headquartered outside but operating within a county 911 service area are entitled to membership according to their status as a public or private safety agency.

d. A political subdivision that does not operate its own public safety agency but contracts for the provision of public safety services is not entitled to membership on the joint 911 service board. However, its contractor is entitled to one voting membership according to the contractor’s status as a public or private safety agency.

e. The joint 911 service board elects a chairperson and vice chairperson.

f. The joint 911 service board shall annually submit a listing of members, to include the political subdivision they represent and, if applicable, the associated 28E agreement, to the 911 program manager.

A copy of the list shall be submitted within 30 days of adoption of the operating budget for the ensuing fiscal year and shall be on the prescribed form provided by the 911 program manager.

10.3(2) *Alternate 28E entity.* The joint 911 service board may organize as an Iowa Code chapter 28E agency as authorized in Iowa Code subsection 34A.3(3), provided that the 28E entity meets the voting and membership requirements of Iowa Code subsection 34A.3(1).

10.3(3) *Joint 911 service board bylaws.* Each joint 911 service board shall develop bylaws to specify, at a minimum, the following information:

- a. The name of the joint 911 service board.
- b. A list of voting and nonvoting members.
- c. The date for the commencement of operations.
- d. The mission.
- e. The powers and duties.
- f. The manner for financing activities and maintaining a budget.
- g. The manner for acquiring, holding and disposing of property.
- h. The manner for electing or appointing officers and terms of office.
- i. The manner by which members may vote to include, if applicable, the manner by which votes may be weighted.
- j. The manner for appointing, hiring, disciplining, and terminating employees.
- k. The rules for conducting meetings.
- l. The permissible method or methods to be employed in accomplishing the partial or complete termination of the board and the disposing of property upon such complete or partial termination.
- m. Any other necessary and proper rules or procedures.

Each member shall sign the adopted bylaws.

The joint 911 service board shall record the signed bylaws with the county recorder and shall forward a copy of the signed bylaws to the 911 program manager at the homeland security and emergency management department.

10.3(4) *Executive board.* The joint 911 service board may, through its bylaws, establish an executive board to conduct the business of the joint 911 service board. Members of the executive board must be selected from the eligible voting members of the joint 911 service board. The executive board will have such other duties and responsibilities as assigned by the joint 911 service board.

10.3(5) *Meetings.*

a. The provisions of Iowa Code chapter 21, “Official Meetings Open to the Public,” are applicable to joint 911 service boards.

b. Joint 911 service boards shall conduct meetings in accordance with their established bylaws and applicable state law.

[ARC 7695B, IAB 4/8/09, effective 5/13/09; ARC 8314B, IAB 11/18/09, effective 12/23/09; ARC 1538C, IAB 7/9/14, effective 8/13/14; ARC 3233C, IAB 8/2/17, effective 9/6/17]

605—10.4(34A) 911 service plan.

10.4(1) The joint 911 service board shall be responsible for developing a 911 service plan as required by Iowa Code section 34A.3 and as set forth in these rules. The plan will remain the property of the joint 911 service board. Each joint 911 service board shall coordinate planning with each contiguous joint 911 service board. A copy of the plan and any modifications and addenda shall be submitted to:

- a. The homeland security and emergency management department.
- b. All public and private safety agencies serving the 911 service area.
- c. All providers affected by the 911 service plan.

10.4(2) The 911 service plan shall, at a minimum, encompass the entire county, unless a waiver is granted by the director. Each plan shall include:

- a. The mailing address of the joint 911 service board.
- b. A list of voting members on the joint 911 service board.
- c. A list of nonvoting members on the joint 911 service board.
- d. The name of the chairperson and of the vice chairperson of the joint 911 service board.

- e.* A geographical description of the 911 service area.
- f.* A list of all public and private safety agencies within the 911 service area.
- g.* The number of public safety answering points within the 911 service area.
- h.* A statement of recurring and nonrecurring costs to be incurred by the joint 911 service board. These costs shall be limited to costs directly attributable to the provision of 911 service.
- i.* The total number of telephone access lines by a telephone company or companies having points of presence within the 911 service area and the number of this total that is exempt from surcharge collection as provided in rule 605—10.9(34A) and Iowa Code subsection 34A.7(3).
- j.* If applicable, a schedule for implementation of the plan throughout the 911 service area. A joint 911 service board may decide not to implement 911 service.
- k.* The total property valuation in the 911 service area.
- l.* Maps of the 911 service area showing:
 - (1) The jurisdictional boundaries of all law enforcement agencies serving the area.
 - (2) The jurisdictional boundaries of all firefighting districts and companies serving the area.
 - (3) The jurisdictional boundaries of all ambulance and emergency medical service providers operating in the area.
 - (4) The location of PSAP(s) within the service area.
- m.* A block drawing for each telephone central office within the service area showing the method by which the 911 call will be delivered to the PSAP(s).
- n.* A plan to migrate to an internet protocol-enabled next generation network.

10.4(3) All plan modifications and addenda shall be filed with, reviewed, and approved by the 911 program manager.

10.4(4) The 911 program manager shall base acceptance of the plan upon compliance with the provisions of Iowa Code chapter 34A and the rules herein.

10.4(5) The 911 program manager will notify in writing, within 20 days of review, the chairperson of the joint 911 service board of the approval or disapproval of the plan.

a. If the plan is disapproved, the joint 911 service board will have 90 days from receipt of notice to submit revisions/addenda.

b. Notice for disapproved plans will contain the reasons for disapproval.

c. The 911 program manager will notify the chairperson, in writing within 20 days of review, of the approval or disapproval of the revisions.

[**ARC 8314B**, IAB 11/18/09, effective 12/23/09; **ARC 0602C**, IAB 2/20/13, effective 3/27/13; **ARC 1538C**, IAB 7/9/14, effective 8/13/14; **ARC 3233C**, IAB 8/2/17, effective 9/6/17; **ARC 3868C**, IAB 7/4/18, effective 8/8/18]

605—10.5(34A) Wireline 911 service surcharge.

10.5(1) One source of funding for the 911 emergency communications system shall come from a surcharge of one dollar per month, per access line on each access line subscriber.

10.5(2) The 911 program manager shall notify local exchange carriers and competitive local exchange service providers scheduled to provide exchange access 911 service within a 911 service area that implementation of a 911 service plan has been approved by the joint 911 service board and by the 911 program manager and that collection of the surcharge is to begin within 60 days. The 911 program manager shall also provide notice to all affected public safety answering points. The 60-day notice to the carriers and providers shall also apply when an adjustment in the wireline surcharge rate is made.

10.5(3) The carriers and providers shall collect the surcharge as a part of their monthly billing to their subscribers. The surcharge shall appear as a single line item on a subscriber's monthly billing entitled "911 emergency communications service surcharge."

10.5(4) The carriers and providers may retain 1 percent of the surcharge collected as compensation for the billing and collection of the surcharge. If the compensation is insufficient to fully recover a carrier's or provider's costs for the billing and collection of the surcharge, the deficiency shall be included in the carrier's or provider's costs for rate-making purposes to the extent it is reasonable and just under Iowa Code section 476.6.

10.5(5) The carrier or provider shall remit the collected surcharge to the joint 911 service board on a calendar quarter basis within 20 days of the end of the quarter.

10.5(6) The joint 911 service board may request, not more than once each quarter, the following information from the carrier or provider:

- a. The identity of the exchange from which the surcharge is collected.
- b. The number of lines to which the surcharge was applied for the quarter.
- c. The number of refusals to pay per exchange, if applicable.
- d. The number of write-offs per exchange, if applicable.
- e. The number of lines exempt per exchange.
- f. The amount retained by the carrier or provider from the 1 percent administrative fee.

Access line counts and surcharge remittances are confidential public records as provided in Iowa Code section 34A.8.

10.5(7) Collection for a surcharge shall terminate if 911 service ceases to operate within the respective 911 service area. The 911 program manager for good cause may grant an extension.

a. The director shall provide 100 days' prior written notice to the joint 911 service board or the operating authority and to the carrier(s) or provider(s) collecting the fee of the termination of surcharge collection.

b. Individual subscribers within the 911 service area may petition the joint 911 service board or the operating authority for a refund. Petitions shall be filed within one year of termination. Refunds may be prorated and shall be based on funds available and subscriber access lines billed.

c. At the end of one year from the date of termination, any funds not refunded and remaining in the 911 service fund and all interest accumulated shall be retained by the joint 911 service board. However, if the joint 911 service board ceases to operate any 911 service, the balance in the 911 service fund shall be payable to the homeland security and emergency management department. Moneys received by the department shall be used only to offset the costs for the administration of the 911 program.

[ARC 0602C, IAB 2/20/13, effective 3/27/13; ARC 1538C, IAB 7/9/14, effective 8/13/14; ARC 3233C, IAB 8/2/17, effective 9/6/17]

605—10.6(34A) Waivers, variance request, and right to appeal.

10.6(1) All requests for variances or waivers shall be submitted to the 911 program manager in writing and shall contain the following information:

- a. A description of the variance(s) or waiver(s) being requested.
- b. Supporting information setting forth the reasons the variance or waiver is necessary.
- c. A copy of the resolution or minutes of the joint 911 service board meeting which authorizes the application for a variance or waiver.
- d. The signature of the chairperson of the joint 911 service board.

10.6(2) The 911 program manager may grant a variance or waiver based upon the provisions of Iowa Code chapter 34A or other applicable state law.

10.6(3) Upon receipt of a request for a variance or waiver, the 911 program manager shall evaluate the request and schedule a review within 20 working days of receipt of the request. Review shall be informal, and the petitioner may present materials, documents and testimony in support of the petitioner's request. The 911 program manager shall determine if the request meets the criteria established and shall issue a decision within 20 working days. The 911 program manager shall notify the petitioner, in writing, of the acceptance or rejection of the petition. If the petition is rejected, such notice shall include the reasons for denial.

[ARC 3233C, IAB 8/2/17, effective 9/6/17]

605—10.7(34A) NG911 Network Implementation and Operations Plan. Each joint 911 service board, the department of public safety, the 911 communications council, and originating service providers shall cooperate with the 911 program manager in preparing the NG911 Network Implementation and Operations Plan for statewide implementation of NG911 service.

10.7(1) *Plan specifications.* The NG911 Network Implementation and Operations Plan shall include, at a minimum, the following information:

- a. Maps showing the geographic location within the county of each PSAP that receives 911 emergency calls.
- b. A list of all public safety answering points within the state of Iowa.
- c. A set of guidelines for determining eligible cost as set forth in Iowa Code section 34A.7A.
- d. A schedule for the implementation and maintenance of the next generation 911 network.
- e. A schedule for the implementation, maintenance and cost sharing of 911 call processing equipment.

10.7(2) Adoption by reference. The “NG911 Network Implementation and Operations Plan,” effective July 1, 2018, and available from the Homeland Security and Emergency Management Department, 7900 Hickman Road, Suite 500, Windsor Heights, Iowa, or at the Law Library in the Capitol Building, Des Moines, Iowa, is hereby adopted by reference effective August 8, 2018.

[ARC 8314B, IAB 11/18/09, effective 12/23/09; ARC 0602C, IAB 2/20/13, effective 3/27/13; ARC 1538C, IAB 7/9/14, effective 8/13/14; ARC 2270C, IAB 11/25/15, effective 12/30/15; ARC 3233C, IAB 8/2/17, effective 9/6/17; ARC 3868C, IAB 7/4/18, effective 8/8/18]

605—10.8(34A) Emergency communications service surcharge.

10.8(1) The 911 program manager shall adopt a monthly surcharge of one dollar to be imposed on each originating service number provided in this state. The surcharge shall not be imposed on wireline-based communications or prepaid wireless telecommunications service.

10.8(2) The 911 program manager shall order the imposition of a surcharge uniformly on a statewide basis and simultaneously on all originating service numbers by giving at least 60 days’ prior notice to wireless carriers to impose a monthly surcharge as part of their periodic billings. The 60-day notice to wireless carriers shall also apply when the program manager is making an adjustment in the emergency communications service surcharge rate.

10.8(3) The emergency communications surcharge shall be one dollar per month, per customer service number, until changed by rule.

10.8(4) The originating service provider shall list the surcharge as a separate line item on the customer’s billing indicating that the surcharge is for 911 emergency telephone service. The originating service provider is entitled to retain 1 percent of any wireless surcharge collected as a fee for collecting the surcharge as part of the subscriber’s periodic billing. The emergency communications service surcharge is not subject to sales or use tax.

10.8(5) Surcharge funds shall be remitted on a calendar quarter basis by the close of business on the twentieth day following the end of the quarter with a remittance form as prescribed by the 911 program manager. Providers shall issue their checks or warrants to the Treasurer, State of Iowa, and remit to the 911 Program Manager, Homeland Security and Emergency Management Department, 7900 Hickman Road, Suite 500, Windsor Heights, Iowa 50324.

[ARC 8314B, IAB 11/18/09, effective 12/23/09; ARC 0602C, IAB 2/20/13, effective 3/27/13; ARC 1538C, IAB 7/9/14, effective 8/13/14; ARC 2270C, IAB 11/25/15, effective 12/30/15; ARC 3233C, IAB 8/2/17, effective 9/6/17]

605—10.9(34A) 911 emergency communications fund.

10.9(1) Emergency communications service surcharge money, collected and remitted by originating service providers, shall be placed in a fund within the state treasury under the control of the director.

10.9(2) Iowa Code section 8.33 shall not apply to moneys in the fund. Moneys earned as income, including as interest, from the fund shall remain in the fund until expended as provided in this subrule. However, moneys in the fund may be combined with other moneys in the state treasury for purposes of investment.

10.9(3) Moneys in the fund shall be expended and distributed in the following manner and order of priority:

- a. An amount as appropriated by the general assembly to the department shall be allocated to the director and program manager for implementation, support, and maintenance of the functions of the director and program manager and to employ the auditor of state to perform an annual audit of the 911 emergency communications fund.

b. The program manager shall allocate to each joint 911 service board and to the department of public safety a minimum of \$1,000 per calendar quarter for each PSAP within the service area of the department of public safety or joint 911 service board.

(1) The amount allocated under paragraph 10.9(3) “*b*” shall be 60 percent of the total amount of surcharge generated per calendar quarter. The minimum amount allocated to the department of public safety and the joint 911 board shall be \$1,000 per PSAP operated by the respective authority.

(2) Additional funds shall be allocated as follows:

1. Sixty-five percent of the total dollars available for allocation shall be allocated in proportion to the square miles of the 911 service area to the total square miles in this state.

2. Thirty-five percent of the total dollars available for allocation shall be allocated in proportion to the wireless 911 calls taken at the PSAP in the 911 service area to the total number of wireless 911 calls originating in this state.

(3) The funds allocated in paragraph 10.9(3) “*b*” shall be used by the PSAPs for costs related to the receipt and disposition of 911 calls.

c. The program manager shall allocate 10 percent of the total amount of surcharge generated per calendar quarter to wireless carriers to recover their costs to deliver wireless E911 phase I services as defined in the Federal Communications Commission (FCC) Docket 94-102 and further defined in the FCC’s letter to King County, Washington, dated May 7, 2001. If this allocation is insufficient to reimburse all wireless carriers for the wireless service provider’s eligible expenses, the program manager shall allocate a prorated amount to each wireless carrier equal to the percentage of the provider’s eligible expenses as compared to the total eligible expenses for all wireless carriers for the calendar quarter during which expenses were submitted. When prorated expenses are paid, the remaining unpaid expenses shall no longer be eligible for payment under paragraph 10.9(3) “*c*.” This allocation is for the period beginning July 1, 2013, and ending June 30, 2026.

d. 911 call delivery costs and GIS grants.

(1) The program manager shall reimburse next generation 911 network service providers, 911 call processing equipment providers, 911 call transport providers, and third-party 911 automatic location information database providers on a quarterly basis for the costs of maintaining and upgrading the next generation 911 network functionality, 911 call processing equipment, 911 call transport from the next generation 911 network to public safety answering points and from the wireless originating service provider network to the next generation 911 network, and the automatic location information database.

(2) The program manager may also provide grants to joint 911 service boards and the department of public safety for the purpose of developing and maintaining GIS data to be used in support of the next generation 911 network. The program manager shall provide guidelines, application forms, and notice of the availability of such grants on the department’s website, www.homelandsecurity.iowa.gov.

e. The department may, in a reserve account established within the 911 emergency communications fund, credit each fiscal year an amount of up to 12½ percent of the annual emergency communications service surcharge collected pursuant to rule 605—10.8(34A) and the prepaid wireless 911 surcharge collected pursuant to rule 605—10.17(34A). However, the moneys contained in such reserve account shall not exceed 12½ percent of the total surcharges collected for each fiscal year. Moneys credited to the reserve account shall only be used by the department for the purpose of repairing or replacing equipment in the event of a catastrophic equipment failure, as determined by the director.

f. If moneys remain in the fund after all obligations are fully paid under paragraphs 10.9(3) “*a*,” “*b*,” “*c*,” “*d*,” and “*e*,” remaining funds shall be expended and distributed in the following priority order:

(1) The director, in consultation with the program manager and the 911 communications council, may provide grants for nonrecurring costs to the department of public safety or joint 911 service board operating a PSAP agreeing to consolidate. For purposes of this subparagraph, “consolidate” means the consolidation of all PSAP systems, functions, 911 service areas, and physical facilities of two or more PSAPs, resulting in responsibility by the consolidated PSAP for all call answering and dispatch functions for the combined 911 service area. Such a grant to a PSAP shall not exceed one-half of the projected cost of consolidation, or \$200,000, whichever is less. The department of public safety or joint 911 service

board wishing to apply for such funds shall complete the Intent to Consolidate Application form found on the department's website, www.homelandsecurity.iowa.gov. Such applications shall provide a detailed consolidation plan and timeline.

(2) The program manager, in consultation with the 911 communications council, shall allocate an amount, not to exceed \$100,000 per fiscal year, for development of public awareness and educational programs related to the use of 911 by the public; for educational programs for personnel responsible for the maintenance, operation, and upgrading of local 911 systems; and for the expenses of members of the 911 communications council for travel, monthly meetings, and training, provided, however, that the members have not received reimbursement funds for such expenses from another source.

(3) The program manager shall allocate an equal amount of moneys to each PSAP for the following costs:

1. Costs related to the receipt and disposition of 911 calls, including hardware and software for an internet protocol-enabled next generation 911 network as specified in the NG911 Network Implementation and Operations Plan.

2. Local costs related to access the statewide interoperable communications system pursuant to Iowa Code section 29C.23.

(4) Any moneys remaining in the fund at the end of each fiscal year shall not revert to the general fund of the state but shall remain available for the purposes of the fund.

10.9(4) Payments to next generation 911 network service providers, 911 call processing equipment providers, 911 call transport providers, and third-party 911 automatic location identification database providers shall be made quarterly, based on original, itemized claims or invoices presented within 20 days of the end of the calendar quarter. Claims or invoices not submitted within 20 days of the end of the calendar quarter are not eligible for reimbursement and may not be included in future claims and invoices. Payments to providers shall be made in accordance with these rules and the State Accounting Policy and Procedures Manual.

10.9(5) Next generation 911 network service providers, 911 call processing equipment providers, 911 call transport providers, and third-party 911 automatic location identification database providers shall be reimbursed for only those items and services that are defined as eligible in the NG911 Network Implementation and Operations Plan and when initiation of service has been ordered and authorized by the 911 program manager.

10.9(6) If it is found that an overpayment has been made to an entity, the 911 program manager shall attempt recovery of the debt from the entity by certified letter. Due diligence shall be documented and retained at the homeland security and emergency management department. If resolution of the debt does not occur and the debt is at least \$50, the homeland security and emergency management department will then utilize the income offset program through the department of revenue. Until resolution of the debt has occurred, the homeland security and emergency management department may withhold future payments to the entity.

[**ARC 0602C**, IAB 2/20/13, effective 3/27/13; **ARC 1538C**, IAB 7/9/14, effective 8/13/14; **ARC 2270C**, IAB 11/25/15, effective 12/30/15; **ARC 2741C**, IAB 10/12/16, effective 9/14/16; **ARC 2835C**, IAB 12/7/16, effective 1/11/17; **ARC 3233C**, IAB 8/2/17, effective 9/6/17; **ARC 3868C**, IAB 7/4/18, effective 8/8/18]

605—10.10(34A) 911 surcharge exemptions. The following agencies, individuals, and organizations are exempt from imposition of the 911 surcharge:

1. Federal agencies and tax-exempt instrumentalities of the federal government.
2. Indian tribes for access lines on the tribe's reservation upon filing a statement with the joint 911 service board, signed by appropriate authority, requesting surcharge exemption.
3. An enrolled member of an Indian tribe for access lines on the reservation, who does not receive 911 service, and who annually files a signed statement with the joint 911 service board that the person is an enrolled member of an Indian tribe living on a reservation and does not receive 911 service. However, once 911 service is provided, the member is no longer exempt.
4. Official station testing lines owned by the provider.
5. Individual wireline subscribers to the extent that they shall not be required to pay on a single periodic billing the surcharge on more than 100 access lines, or their equivalent, in a 911 service area.

All other subscribers not listed above, that have or will have the ability to access 911, are required to pay the surcharge, if imposed by the official order of the 911 program manager.
[ARC 3233C, IAB 8/2/17, effective 9/6/17]

605—10.11(34A) 911 service fund.

10.11(1) The department of public safety and each joint 911 service board have the responsibility for the 911 service fund.

a. A 911 service fund shall be established in the office of the county treasurer for each joint 911 service board and with the state treasurer for the department of public safety.

b. Collected surcharge moneys and any interest thereon, as authorized in Iowa Code chapter 34A, shall be deposited into the 911 service fund. 911 surcharge moneys must be kept separate from all other sources of revenue utilized for 911 systems.

c. For joint 911 service boards, withdrawal of moneys from the 911 service fund shall be made on warrants drawn by the county auditor, per Iowa Code section 331.506, supported by claims and vouchers approved by the chairperson or vice chairperson of the joint 911 service board or the appropriate operating authority so designated in writing.

d. For the department of public safety, withdrawal of moneys from the 911 service fund shall be made in accordance with state laws and administrative rules.

10.11(2) The 911 service funds shall be subject to examination by the department at any time during usual business hours. 911 service funds are subject to the audit provisions of Iowa Code chapter 11. A copy of all audits of the 911 service fund shall be furnished to the department within 30 days of receipt. If through the audit or monitoring process the department determines that a joint 911 service board is not adhering to an approved plan or does not have a valid board membership, or if the department determines that a joint 911 service board or the department of public safety is not using funds in the manner prescribed in these rules or Iowa Code chapter 34A, the director may, after notice and hearing, suspend surcharge imposition and order termination of expenditures from the 911 service fund. The joint 911 service board or department of public safety is not eligible to receive or expend surcharge moneys until such time as the 911 program manager determines that the board or department of public safety is in compliance with the approved plan, board membership, and fund usage limitations.

[ARC 8314B, IAB 11/18/09, effective 12/23/09; ARC 1538C, IAB 7/9/14, effective 8/13/14; ARC 3233C, IAB 8/2/17, effective 9/6/17]

605—10.12(34A) Operating budgets. Rescinded ARC 3233C, IAB 8/2/17, effective 9/6/17.

605—10.13(34A) Limitations on use of funds. Surcharge moneys in the 911 service fund may be used to pay recurring and nonrecurring costs including, but not limited to, 911 call processing equipment, internet and telephone access, software, database, addressing, initial training, and other start-up, capital, and ongoing expenditures. 911 surcharge moneys shall be used only to pay costs directly attributable to the provision of 911 telephone systems and services and may include costs directly attributable to the receipt and disposition of the 911 call.

[ARC 0602C, IAB 2/20/13, effective 3/27/13; ARC 3233C, IAB 8/2/17, effective 9/6/17; ARC 3868C, IAB 7/4/18, effective 8/8/18]

605—10.14(34A) Minimum operational and technical standards.

10.14(1) Each 911 system, supplemented with 911 surcharge moneys, shall, at a minimum, employ the following features:

a. ALI (automatic location identification).

b. ANI (automatic number identification).

c. Ability to selectively route.

d. Each PSAP shall provide two emergency seven-digit numbers arranged in rollover configuration for use by telephone company operators for transferring a calling party to the PSAP over the wireline network. Wireless calls must be transferred to PSAPs that are capable of accepting ANI and ALI.

e. ANI and ALI information shall be maintained and updated in such a manner as to allow for 95 percent or greater degree of accuracy.

10.14(2) 911 public safety answering points shall adhere to the following minimum standards:

a. The PSAP shall operate 7 days per week, 24 hours per day, with operators on duty at all times.

b. The primary published emergency number in the 911 service area shall be 911.

c. All PSAPs will maintain interagency communications capabilities for emergency coordination purposes, to include radio as well as land line direct or dial line.

d. Each PSAP shall develop and maintain a PSAP standard operating procedure for receiving and dispatching emergency calls.

e. The date and time of each 911 emergency call shall be documented using an automated call detail recording device or other communications center log. Such logs shall be maintained for a period of not less than one year.

f. If a call transfer method of handling 911 calls is employed, a 99 percent degree of reliability of transferred calls from a PSAP to responding agencies shall be maintained. All transferred calls shall employ, to the closest extent possible, conference transfer capabilities which provide that the call be announced and monitored by the PSAP operator to ensure that the call has been properly transferred.

g. PSAPs not employing the transfer method of handling 911 emergency calls shall use the call relay method. Information shall be exchanged between the PSAP receiving the call and an appropriate emergency response agency or dispatch center having jurisdiction in the area of the emergency. In no case during an emergency 911 call shall the caller be referred to another telephone number and required to hang up and redial. The call relay method shall also prevail in circumstances where emergency calls enter the 911 system (whether by design or by happenstance) from outside the E911 service area.

h. Access control and security of PSAPs and associated dispatch centers shall be designed to prevent disruption of operations and provide a safe and secure environment of communication operations.

i. PSAP supervision shall ensure that all telephone company employees, whose normal activities may involve contact with facilities associated with the 911 service, are familiar with safeguarding of facilities' procedures.

j. Emergency electrical power shall be provided for the PSAP environment that will ensure continuous operations and communications during a power outage. Such power should start automatically in the event of power failure and shall have the ability to be sustained for a minimum of 48 hours.

k. The PSAP shall make every attempt to disallow the intrusion by automatic dialers, alarm systems, or automatic dialing and announcing devices on a 911 trunk. If intrusion by one of these devices should occur, those responsible for PSAP operations shall make every attempt to contact the responsible party to ensure there is no such further occurrence by notifying the party that knowing and intentional interference with emergency telephone calls constitutes a crime under Iowa Code section 727.5. Those responsible for PSAP operations shall report persons who repeatedly use automatic dialers, alarm systems, or automatic announcing devices on 911 trunk lines to the county attorney for investigation of possible violations of section 727.5.

l. Each PSAP shall be equipped with an appropriate telecommunications device for the deaf (TDD) in accordance with 28 CFR Part 35.162, July 26, 1991.

10.14(3) Originating service providers shall adhere to the following minimum requirements:

a. The PSAP and the 911 program manager shall be notified of all service interruptions in accordance with 47 CFR Part 4.

b. The originating service provider shall respond, within a reasonable length of time, to all appropriate requests for information from the director, the department of public safety, a joint 911 service board or operating authority and shall expressly comply with the provisions of Iowa Code section 34A.8.

c. Access to the wireless 911 selective router and next generation 911 network shall be approved by the 911 program manager. Originating service providers must provide the company name, address

and point of contact with their request. If the originating service provider utilizes a third-party vendor, the vendor must provide this information listing the vendor's customer's requested information.

10.14(4) Voluntary standards. Current technical and operational standards applying to 911 systems and services can be found in the "American Society for Testing and Materials Standard Guide for Planning and Developing 911 Enhanced Telephone Systems" and in publications issued by the National Emergency Number Association. Master street address guides are encouraged to be developed and maintained by using National Emergency Number Association technical standards 02-010 and 02-011. Standards contained in these documents shall be considered as guidance, and adherence thereto shall be voluntary. Notwithstanding the minimum standards published in these rules, it is intended that 911 originating service providers and joint 911 service boards and operating authorities employ the best and most affordable technologies and methods available in providing 911 services to the public.

[ARC 0602C, IAB 2/20/13, effective 3/27/13; ARC 1538C, IAB 7/9/14, effective 8/13/14; ARC 3233C, IAB 8/2/17, effective 9/6/17]

605—10.15(34A) Administrative hearings and appeals.

10.15(1) 911 program manager decisions regarding the acceptance or refusal of a 911 service plan, in whole or in part, the implementation of 911 and the imposition of the 911 surcharge within a specific 911 service area may be contested by an affected party.

10.15(2) Request for hearing shall be made in writing to the homeland security and emergency management department director within 30 days of the 911 program manager's mailing or serving of a decision and shall state the reason(s) for the request and shall be signed by the appropriate authority.

10.15(3) The director shall schedule a hearing within 10 working days of receipt of the request for hearing. The director shall preside over the hearing, at which time the appellant may present any evidence, documentation, or other information regarding the matter in dispute.

10.15(4) The director shall issue a ruling regarding the matter within 20 working days of the hearing.

10.15(5) Any party adversely affected by the director's ruling may file a written request for a rehearing within 20 days of issuance of the ruling. A rehearing will be conducted only when additional evidence is available, the evidence is material to the case, and good cause existed for the failure to present the evidence at the initial hearing. The director will schedule a hearing within 20 days after the receipt of the written request. The director shall issue a ruling regarding the matter within 20 working days of the hearing.

10.15(6) Any party adversely affected by the director's ruling may file a written appeal to the director of the homeland security and emergency management department. The appeal request shall contain information identifying the appealing party, the ruling being appealed, specific findings or conclusions to which exception is taken, the relief sought, and the grounds for relief. The director shall issue a ruling regarding the matter within 90 days of the hearing. The director's ruling constitutes final agency action for purposes of judicial review.

[ARC 7695B, IAB 4/8/09, effective 5/13/09; ARC 0602C, IAB 2/20/13, effective 3/27/13; ARC 1538C, IAB 7/9/14, effective 8/13/14; ARC 3233C, IAB 8/2/17, effective 9/6/17]

605—10.16(34A) Confidentiality. All financial or operations information provided by an originating service provider to the 911 program manager shall be identified by the provider as confidential trade secrets under Iowa Code section 22.7(3) and shall be kept confidential as provided under Iowa Code section 22.7(3) and 605—Chapter 5. Such information shall include numbers of accounts, numbers of customers, revenues, expenses, and the amounts collected from said originating service provider for deposit in the fund. Notwithstanding such requirements, aggregate amounts and information may be included in reports issued by the director if the aggregated information does not reveal any information attributable to an individual originating service provider.

[ARC 0602C, IAB 2/20/13, effective 3/27/13; ARC 1538C, IAB 7/9/14, effective 8/13/14; ARC 3233C, IAB 8/2/17, effective 9/6/17]

605—10.17(34A) Prepaid wireless 911 surcharge. Administration of the prepaid wireless 911 surcharge is under the control of the Iowa department of revenue. To administer this function, the

department of revenue has adopted rules that can be found in 701—paragraph 224.6(2)“b” and rule 701—224.8(34A).

[ARC 0602C, IAB 2/20/13, effective 3/27/13; ARC 3233C, IAB 8/2/17, effective 9/6/17]

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PROFESSIONAL LICENSURE DIVISION[645]

Created within the Department of Public Health[641] by 1986 Iowa Acts, chapter 1245.
Prior to 7/29/87, for Chs. 20 to 22 see Health Department[470] Chs. 152 to 154.

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CHAPTER 200

LICENSURE OF PHYSICAL THERAPISTS AND PHYSICAL THERAPIST ASSISTANTS

[Prior to 3/6/02, see 645—200.3(147) to 645—200.8(147), 645—200.11(272C), and 645—202.3(147) to 645—202.7(147)]

[Prior to 12/24/03, see 645—ch 201]

645—200.1(147) Definitions. For purposes of these rules, the following definitions shall apply:

“*Active license*” means a license that is current and has not expired.

“*Assistive personnel*” means any person who carries out physical therapy and is not licensed as a physical therapist or physical therapist assistant. This definition does not include students as defined in Iowa Code section 148A.3(2).

“*Board*” means the board of physical and occupational therapy.

“*Department*” means the department of public health.

“*Grace period*” means the 30-day period following expiration of a license when the license is still considered to be active. In order to renew a license during the grace period, a licensee is required to pay a late fee.

“*Impairment*” means a mechanical, physiological or developmental loss or abnormality, a functional limitation, or a disability or other health- or movement-related condition.

“*Inactive license*” means a license that has expired because it was not renewed by the end of the grace period. The category of “inactive license” may include licenses formerly known as lapsed, inactive, delinquent, closed, or retired.

“*Licensee*” means any person licensed to practice as a physical therapist or physical therapist assistant in the state of Iowa.

“*License expiration date*” means the fifteenth day of the birth month every two years after initial licensure.

“*Licensure by endorsement*” means the issuance of an Iowa license to practice physical therapy to an applicant who is or has been licensed in another state.

“*Mandatory training*” means training on identifying and reporting child abuse or dependent adult abuse required of physical therapists or physical therapist assistants 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.

“*On site*” means:

1. To be continuously on site and present in the department or facility where assistive personnel are performing services;

2. To be immediately available to assist the person being supervised in the services being performed; and

3. To provide continued direction of appropriate aspects of each treatment session in which a component of treatment is delegated to assistive personnel.

“Physical therapist” means a person licensed under this chapter to practice physical therapy.

“Physical therapist assistant” means a person licensed under this chapter to assist in the practice of physical therapy.

“Physical therapy” means that branch of science that deals with the evaluation and treatment of human capabilities and impairments, including:

1. Evaluation of individuals with impairments in order to determine a diagnosis, prognosis, and plan of therapeutic treatment and intervention, and to assess the ongoing effects of intervention;

2. Use of the effective properties of physical agents and modalities, including but not limited to mechanical and electrotherapeutic devices, heat, cold, air, light, water, electricity, and sound, to prevent, correct, minimize, or alleviate an impairment;

3. Use of therapeutic exercises to prevent, correct, minimize, or alleviate an impairment;

4. Use of rehabilitative procedures to prevent, correct, minimize, or alleviate an impairment, including but not limited to the following procedures:

- Manual therapy, including soft-tissue and joint mobilization and manipulation;

- Therapeutic massage;

- Prescription, application, and fabrication of assistive, adaptive, orthotic, prosthetic, and supportive devices and equipment;

- Airway clearance techniques;

- Integumentary protection and repair techniques; and

- Debridement and wound care;

5. Interpretation of performances, tests, and measurements;

6. The establishment and modification of physical therapy programs;

7. The establishment and modification of treatment planning;

8. The establishment and modification of consultative services;

9. The establishment and modification of instructions to the patient, including but not limited to functional training relating to movement and mobility;

10. Participation, administration and supervision attendant to physical therapy and educational programs and facilities.

“PT” means physical therapist.

“PTA” means physical therapist assistant.

“Reactivate” or *“reactivation”* means the process as outlined in rule 645—200.15(17A,147,272C) by which an inactive license is restored to active status.

“Reciprocal license” means the issuance of an Iowa license to practice physical therapy to an applicant who is currently licensed in another state which has a mutual agreement with the Iowa board of physical and occupational therapy 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.

645—200.2(147) Requirements for licensure. The following criteria shall apply to licensure:

200.2(1) The applicant shall complete a board-approved application. Application forms may be obtained from the board’s website (www.idph.iowa.gov/licensure) or directly from the board office, or the applicant may complete the application online at ibplicense.iowa.gov. All paper applications shall be sent to the Board of Physical and Occupational Therapy, Professional Licensure Division, Fifth Floor, Lucas State Office Building, Des Moines, Iowa 50319-0075.

200.2(2) The applicant shall complete the application form according to the instructions contained in the application. If the application is not completed according to the instructions, the application will not be reviewed by the board.

200.2(3) Each application shall be accompanied by the appropriate fees payable by check or money order to the Board of Physical and Occupational Therapy. The fees are nonrefundable.

200.2(4) No application will be considered by the board until official copies of academic transcripts sent directly from the school to the board of physical and occupational therapy have been received by the board. An applicant shall have successfully completed a physical therapy education program accredited by a national accreditation agency approved by the board.

200.2(5) Notification of eligibility for the examination shall be sent to the applicant by the board.

200.2(6) The candidate shall have the examination score sent directly from the testing service to the board.

200.2(7) Licensees who were issued their initial licenses within six months prior to the renewal date shall not be required to renew their licenses until the renewal date two years later.

200.2(8) Submitting complete application materials. An application for a physical therapist or physical therapist assistant license will be considered active for two years from the date the application is received. If the applicant does not submit all materials within this time period or if the applicant does not meet the requirements for the license, the application shall be considered incomplete. An applicant whose application is filed incomplete must submit a new application, supporting materials, and the application fee. The board shall destroy incomplete applications after two years.

[ARC 3445C, IAB 11/8/17, effective 12/13/17]

645—200.3(147) Requirements for practice prior to licensure. Rescinded IAB 12/19/07, effective 1/23/08.

645—200.4(147) Examination requirements for physical therapists and physical therapist assistants. The following criteria shall apply to the written examination(s):

200.4(1) The applicant shall take and pass the National Physical Therapy Examination (NPTE) or other nationally recognized equivalent examination as defined by the board.

200.4(2) The applicant shall abide by the following criteria:

a. For examinations taken prior to July 1, 1994, satisfactory completion shall be defined as receiving an overall examination score exceeding 1.5 standard deviations below the national average.

b. For examinations completed after July 1, 1994, satisfactory completion shall be defined as receiving an overall examination score equal to or greater than the criterion-referenced passing point recommended by the Federation of State Boards of Physical Therapy.

200.4(3) Before the board may approve an applicant for testing beyond three attempts, an applicant shall demonstrate evidence satisfactory to the board of having successfully completed additional coursework. The Federation of State Boards of Physical Therapy (FSBPT) determines the total number of times an applicant may take the examination in a lifetime. The board will not approve an applicant for testing when the applicant has exhausted the applicant's lifetime opportunities for taking the examination, as determined by FSBPT.

200.4(4) The applicant shall be notified by the board in writing of examination results.

200.4(5) Special accommodations. To eliminate discrimination and guarantee fairness under Title II of the Americans with Disabilities Act (ADA), an individual who has a qualifying disability may request an examination accommodation.

a. Disability requirements. An applicant is an individual who has a physical or mental impairment that substantially limits that individual in one or more major life activities, who has a record of such a physical or mental disability, or who is regarded as having such a physical or mental impairment.

(1) Physical impairment, as defined by the ADA, means any physiological disorder or condition, cosmetic disfigurement, or anatomical loss affecting one or more of the following body systems: neurological, musculoskeletal, special sense organs, respiratory (including speech organs), cardiovascular, reproductive, digestive, genitourinary, hemic and lymphatic, skin, and endocrine.

(2) Mental impairment, as defined by the ADA, means any mental or psychological disorder, such as mental retardation, organic brain syndrome, emotional or mental illness, and specific learning disabilities.

b. To be considered an impairment that limits a major life activity, the disability shall impair an activity that an average person can perform with little or no difficulty, for example, walking, seeing, hearing, speaking, breathing, learning, performing manual tasks, caring for oneself, working, sitting, standing, lifting, or reading.

c. To verify the accommodation, the applicant must submit appropriate documentation that uses professionally recognized criteria; that details how the disability leads to functional limitations; and that illustrates how the limitation or limitations inhibit the individual from performing one or more major life activities.

d. An evaluator shall on the documentation provide a signature, verify the diagnosis, verify the professionally recognized test/assessment, and recommend the accommodation. The evaluator shall be a licensed health care professional, including but not limited to a physician who practices in a field that includes, but may not be limited to, neurology, family practice, orthopedics, physical medical medicine and rehabilitation, and psychiatry; or a psychologist who performs evaluations to assess individuals for mental disorders that might impact those individuals' academic or testing performance.

e. An accommodation shall not give the individual an unfair advantage over others taking the examination, shall not change the purpose of the examination, and shall not guarantee that the individual will pass the examination.

f. The board and staff shall maintain confidentiality of all medical and diagnostic information and records.

[ARC 0094C, IAB 4/18/12, effective 5/23/12; ARC 1659C, IAB 10/15/14, effective 11/19/14; ARC 2481C, IAB 4/13/16, effective 5/18/16]

645—200.5(147) Educational qualifications.

200.5(1) The applicant must present proof of meeting the following requirements for licensure as a physical therapist or physical therapist assistant:

a. Educational requirements—physical therapists. Physical therapists shall graduate from a physical therapy program accredited by a national accreditation agency approved by the board.

b. Educational requirements—physical therapist assistants. Physical therapist assistants shall graduate from a PTA program accredited by a national accreditation agency approved by the board.

200.5(2) Foreign-trained applicants shall:

a. Submit an English translation and an equivalency evaluation of their educational credentials through the following organization: Foreign Credentialing Commission on Physical Therapy, Inc., 124 West Street South, Third Floor, Alexandria, VA 22314; telephone (703)684-8406; website www.fcpt.org. The credentials of a foreign-educated physical therapist or foreign-educated physical therapist assistant licensure applicant who does not hold a license in another state or territory of the United States and is applying for licensure by taking the examination should be evaluated using the most current version of the Federation of State Boards of Physical Therapy (FSBPT) Coursework Tool (CWT). The credentials of a foreign-educated physical therapist or physical therapist assistant who has been a licensed PT or PTA under the laws of another jurisdiction should be evaluated using the version of the FSBPT CWT that covers the date the applicant graduated from the applicant's respective physical therapist or physical therapist assistant education program. The professional curriculum must be equivalent to the Commission on Accreditation in Physical Therapy Education standards. An applicant shall bear the expense of the curriculum evaluation.

b. Submit certified proof of proficiency in the English language by achieving on the Test of English as a Foreign Language (IBT-TOEFL) a total score of at least 89 on the Internet-based TOEFL as well as accompanying minimum scores in the four test components as follows: 24 in writing; 26 in speaking; 21 in reading comprehension; and 18 in listening comprehension. This examination is administered by Educational Testing Services, Inc., P.O. Box 6157, Princeton, NJ 08541-6157. An applicant shall bear the expense of the TOEFL examination. Applicants may be exempt from the TOEFL examination

when the native language is English, physical therapy education was completed in a school approved by the Commission on Accreditation in Physical Therapy Education (CAPTE), language of instruction in physical therapy was English, language of the textbooks was English, and the applicant's transcript was in English.

c. Submit an official statement from each country's or territory's board of examiners or other regulatory authority regarding the status of the applicant's license, including issue date, expiration date and information regarding any pending or prior investigations or disciplinary action. The applicants shall request such statements from all entities in which they are currently or formerly licensed.

d. Receive a final determination from the board regarding the application for licensure.
[ARC 9328B, IAB 1/12/11, effective 2/16/11; ARC 0094C, IAB 4/18/12, effective 5/23/12; ARC 3445C, IAB 11/8/17, effective 12/13/17]

645—200.6(147) Delegation by a supervising physical therapist. A supervising physical therapist may delegate the performance of physical therapy services to a physical therapist assistant only if done in accordance with the statutes and rules governing the practice of physical therapy. A physical therapist assistant may assist in the practice of physical therapy only to the extent allowed by the supervising physical therapist. The supervisory requirements stated in this rule are minimal. It is the professional responsibility and duty of the supervising physical therapist to provide the physical therapist assistant with more supervision if deemed necessary in the supervising physical therapist's professional judgment.

200.6(1) Supervision requirements. A supervising physical therapist who delegates the performance of physical therapy services to a physical therapist assistant shall provide supervision to the physical therapist assistant at all times when the physical therapist assistant is providing delegated physical therapy services. Supervision means that the physical therapist shall be readily available on site or telephonically anytime the physical therapist assistant is providing physical therapy services so that the physical therapist assistant may contact the physical therapist for advice, assistance, or instruction.

200.6(2) Functions that cannot be delegated. The following are functions that only a physical therapist may provide and that cannot be delegated to a physical therapist assistant:

- a. Interpretation of referrals;
- b. Initial physical therapy evaluation and reevaluations;
- c. Identification, determination, or modification of patient problems, goals, and plans of care;
- d. Final discharge evaluation and establishment of a discharge plan;
- e. Delegation of and instruction in the physical therapy services to be rendered by a physical therapist assistant or unlicensed assistive personnel including, but not limited to, specific tasks or procedures, precautions, special problems, and contraindicated procedures; and
- f. Timely review of documentation, reexamination of the patient, and revision of the plan of care when indicated.

200.6(3) Physical therapist responsibilities. At all times, the supervising physical therapist shall be responsible for the physical therapy plan of care and for all physical therapy services provided, including all physical therapy services delegated to a physical therapist assistant. In addition, the supervising physical therapist shall:

- a. Be responsible for the evaluation and development of a plan of care for use by the physical therapist assistant; and
- b. Not delegate a physical therapy service that exceeds the competency or skill set of the physical therapist assistant; and
- c. Ensure that a physical therapist assistant holds an active physical therapist assistant license issued by the board; and
- d. Ensure that a physical therapist assistant is aware of how the supervising physical therapist can be contacted telephonically when the physical therapist is not providing on-site supervision; and
- e. Arrange for an alternate physical therapist to provide supervision when the physical therapist has scheduled or unscheduled absences during time periods in which a physical therapist assistant will be providing delegated physical therapy services; and

f. Ensure that a physical therapist assistant is informed when a patient's plan of care is transferred to a different supervising physical therapist; and

g. Directly participate in physical therapy services upon the physical therapist assistant's request for a reexamination, when a change in the plan of care is needed, prior to any planned discharge, and in response to a change in the patient's medical status; and

h. Hold regularly scheduled meetings with the physical therapist assistant to evaluate the physical therapist assistant's performance, assess the progress of a patient, and make changes to the plan of care as needed. The frequency of meetings should be determined by the supervising physical therapist based on the needs of the patient, the supervisory needs of the physical therapist assistant, and any planned discharge. The supervising physical therapist shall provide direction and instruction to the physical therapist assistant that are adequate to ensure the safety and welfare of the patient.

200.6(4) *Physical therapist assistant responsibilities.* A physical therapist assistant shall only provide physical therapy services under the supervision of a physical therapist. In addition, the physical therapist assistant shall:

a. Only provide physical therapy services that have been delegated by the supervising physical therapist; and

b. Only provide physical therapy services that are within the competency and skill set of the physical therapist assistant; and

c. Consult the supervising physical therapist if the physical therapist assistant believes that any procedure is not in the best interest of the patient; and

d. Contact the supervising physical therapist regarding any change or lack of change in a patient's condition that may require assessment by the supervising physical therapist; and

e. Refer inquiries that require interpretation to the supervising physical therapist; and

f. Ensure that the identification of the supervising physical therapist is included in the documentation for any visit when physical therapy services were provided by the physical therapist assistant; and

g. Only sign a treatment record if the provision of physical therapy services was done in accordance with the statutes and rules governing the practice of a physical therapist assistant.

200.6(5) *Ratio.* A physical therapist shall determine the number of physical therapist assistants who can be supervised safely and competently and shall not exceed that number; but in no case shall a physical therapist supervise more than four physical therapist assistants per calendar day. A physical therapist assistant who performs any delegated physical therapy services on behalf of the supervising physical therapist on a particular day shall be counted in determining the maximum ratio, regardless of the location of the physical therapist assistant or the number of patients treated.

200.6(6) *Minimum frequency of direct participation by a supervising physical therapist.* A supervising physical therapist shall use professional judgment to determine how frequently the physical therapist needs to directly participate in physical therapy services when delegating to a physical therapist assistant, the frequency of which shall be based on the needs of the patient. Direct participation can occur through an in-person or telehealth visit. The supervising physical therapist shall ensure that the patient record clearly indicates which visits included direct participation by the supervising physical therapist. The following are the minimum standards, which are expected to be exceeded when dictated by the supervising physical therapist's professional judgment, for the required frequency of direct participation by the supervising physical therapist when physical therapy services involve delegation to a physical therapist assistant:

a. Hospital inpatient and skilled nursing. For hospital inpatients and skilled nursing patients, a supervising physical therapist must directly participate in physical therapy services a minimum of once per calendar week. A calendar week is defined as Sunday through Saturday.

b. All other settings. In all other settings, a supervising physical therapist must directly participate in the provision of physical therapy services at least every eighth visit or every 30 calendar days, whichever comes first.

200.6(7) *Unlicensed assistive personnel.* A physical therapist is responsible for patient care provided by unlicensed assistive personnel under the physical therapist's supervision. A physical

therapist is responsible for ensuring the qualifications of any unlicensed assistive personnel and shall maintain written documentation of their education or training. Unlicensed assistive personnel may assist a physical therapist assistant in the delivery of physical therapy services only if the physical therapist assistant maintains in-sight supervision of the unlicensed assistive personnel and the physical therapist assistant is primarily and significantly involved in the patient's care. Unlicensed assistive personnel shall not provide independent patient care unless each of the following standards is satisfied:

- a.* The physical therapist has direct participation in the patient's treatment or evaluation, or both, each treatment day;
- b.* Unlicensed assistive personnel may provide independent patient care only while under the on-site supervision of the physical therapist;
- c.* Documentation made in a physical therapy record by unlicensed assistive personnel shall be cosigned by the physical therapist; and
- d.* The physical therapist provides periodic reevaluation of any unlicensed assistive personnel's performance in relation to the patient.

[ARC 3876C, IAB 7/4/18, effective 8/8/18]

645—200.7(147) Licensure by endorsement.

200.7(1) An applicant who has been a licensed PT or PTA under the laws of another jurisdiction shall file an application for licensure by endorsement with the board office. The board may receive by endorsement any applicant from the District of Columbia or another state, territory, province or foreign country who:

- a.* Submits to the board a completed application;
- b.* Pays the licensure fee;
- c.* Shows evidence of licensure requirements that are similar to those required in Iowa;
- d.* Submits a copy of the scores from the appropriate professional examination to be sent directly from the examination service to the board;
- e.* Provides official copies of the academic transcripts sent directly from the school to the board; and
- f.* Provides verification of license(s) from every jurisdiction in which the applicant has been licensed, sent directly from the jurisdiction(s) to the board office. Web-based verification may be substituted for verification direct from the jurisdiction's board office if the verification provides:
 - (1) Licensee's name;
 - (2) Date of initial licensure;
 - (3) Current licensure status; and
 - (4) Any disciplinary action taken against the license.

200.7(2) In addition to the requirements of 200.7(1), a physical therapist applicant shall:

- a.* Have completed 40 hours of board-approved continuing education during the immediately preceding two-year period; or
- b.* Have practiced as a licensed physical therapist for a minimum of 2,080 hours during the immediately preceding two-year period; or
- c.* Have served the equivalent of one year as a full-time faculty member teaching physical therapy in an accredited school of physical therapy for at least one of the immediately preceding two years; or
- d.* Have successfully passed the examination within a period of two years from the date of examination to the time application is completed for licensure.

200.7(3) In addition to the requirements of 200.7(1), a physical therapist assistant applicant shall:

- a.* Have completed 20 hours of board-approved continuing education during the immediately preceding two-year period; or
- b.* Have practiced as a licensed physical therapist assistant for a minimum of 2,080 hours during the immediately preceding two-year period; or
- c.* Have successfully passed the examination for physical therapist assistants within a period of one year from the date of examination to the time application for licensure is completed.

200.7(4) Individuals who were issued their licenses by endorsement within six months of the license renewal date will not be required to renew their licenses until the next renewal two years later.

200.7(5) An applicant for licensure under subrule 200.7(1) must include with this application a sworn statement of previous physical therapy practice from an employer or professional associate, detailing places and dates of employment and verifying that the applicant has practiced physical therapy at least 2,080 hours or taught as the equivalent of a full-time faculty member for at least one of the immediately preceding years during the last two-year time period.

200.7(6) Foreign-trained applicants applying for licensure by endorsement shall also meet the requirements outlined in subrule 200.5(2).

[ARC 3445C, IAB 11/8/17, effective 12/13/17]

645—200.8(147) Licensure by reciprocal agreement. Rescinded IAB 12/17/08, effective 1/21/09.

645—200.9(147) License renewal.

200.9(1) The biennial license renewal period for a license to practice as a physical therapist or physical therapist assistant shall begin on the sixteenth day of the birth month and end on the fifteenth day of the birth month 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.

200.9(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.

200.9(3) A licensee seeking renewal shall:

a. Meet the continuing education requirements of rule 645—203.2(148A) and the mandatory reporting requirements of subrule 200.9(4). A licensee whose license was reactivated during the current renewal compliance period may use continuing education credit earned during the compliance period for the first renewal following reactivation; and

b. Submit the completed renewal application and renewal fee before the license expiration date.

200.9(4) Mandatory reporter training requirements.

a. A licensee who in the scope of professional practice regularly examines, attends, counsels or treats children in Iowa shall indicate on the renewal application completion of two hours of training in child abuse identification and reporting in the previous five years of condition(s) for waiver of this requirement as identified in paragraph “e.”

b. A licensee who in the scope of professional practice regularly examines, attends, counsels or treats adults in Iowa shall indicate on the renewal application completion of two hours of training in dependent adult abuse identification and reporting in the previous five years or condition(s) for waiver of this requirement as identified in paragraph “e.”

c. A licensee who in the scope of professional practice regularly examines, attends, counsels or treats both adults and children in Iowa shall indicate on the renewal application completion of training in abuse identification and reporting for dependent adults and children in the previous five years or condition(s) for waiver of this requirements as identified in paragraph “e.”

Training may be completed through separate courses as identified in paragraphs “a” and “b” or in one combined two-hour course that includes curricula for identifying and reporting child abuse and dependent adult abuse. The course shall be a curriculum approved by the Iowa department of public health abuse education review panel.

d. The licensee shall maintain written documentation for five years after mandatory training as identified in paragraphs “a” to “c,” including program date(s), content, duration, and proof of participation.

e. The requirement for mandatory training for identifying and reporting child and dependent adult abuse shall be suspended if the board determines that suspension is in the public interest or that a person at the time of license renewal:

(1) Is engaged in active duty in the military service of this state or the United States.

(2) Holds a current waiver by the board based on evidence of significant hardship in complying with training requirements, including an exemption of continuing education requirements or extension of time in which to fulfill requirements due to a physical or mental disability or illness as identified in 645—Chapter 4.

f. The board may select licensees for audit of compliance with the requirements in paragraphs “a” to “e.”

200.9(5) Upon receiving the information required by this rule and the required fee, board staff shall administratively issue a two-year license and shall send the licensee a wallet card by regular mail. In the event the board receives adverse information on the renewal application, the board shall issue the renewal license but may refer the adverse information for further consideration or disciplinary investigation.

200.9(6) Persons licensed to practice as physical therapists or physical therapist assistants shall keep their renewal licenses displayed in a conspicuous public place at the primary site of practice.

200.9(7) Late renewal. The license shall become a late license 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 5.13(4). To renew a late license, the licensee shall complete the renewal requirements and submit the late fee within the grace period.

200.9(8) Inactive license. A licensee who fails to renew the license by the end of the grace period has an inactive license. A licensee whose license is inactive continues to hold the privilege of licensure in Iowa, but may not practice as a physical therapist or a physical therapist assistant in Iowa until the license is reactivated. A licensee who practices as a physical therapist or a physical therapist assistant 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 0094C, IAB 4/18/12, effective 5/23/12]

645—200.10(272C) Exemptions for inactive practitioners. Rescinded IAB 9/14/05, effective 10/19/05.

645—200.11(272C) Lapsed licenses. Rescinded IAB 9/14/05, effective 10/19/05.

645—200.12(147) Duplicate certificate or wallet card. Rescinded IAB 12/17/08, effective 1/21/09.

645—200.13(147) Reissued certificate or wallet card. Rescinded IAB 12/17/08, effective 1/21/09.

645—200.14(17A,147,272C) License denial. Rescinded IAB 12/17/08, effective 1/21/09.

645—200.15(17A,147,272C) License reactivation. To apply for reactivation of an inactive license, a licensee shall:

200.15(1) Submit a reactivation application on a form provided by the board.

200.15(2) Pay the reactivation fee that is due as specified in 645—subrule 5.13(5).

200.15(3) Provide verification of current competence to practice physical therapy by satisfying one of the following criteria:

a. If the license has been on inactive status for five years or less, an applicant must provide the following:

(1) Verification of the license(s) from every jurisdiction in which the applicant is or has been licensed and is or has been practicing during the time period the Iowa license was inactive, sent directly from the jurisdiction(s) to the board office. Web-based verification may be substituted for verification from a jurisdiction’s board office if the verification includes:

1. Licensee’s name;
2. Date of initial licensure;
3. Current licensure status; and
4. Any disciplinary action taken against the license; and

(2) Verification of completion of 20 hours of continuing education for a physical therapy assistant and 40 hours of continuing education for a physical therapist 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 40 hours of continuing education for a physical therapy assistant and 80 hours of continuing education for a physical therapist within two years of application for reactivation; or evidence of successful completion of the professional examination required for initial licensure completed within one year prior to the submission of an application for reactivation.

645—200.16(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 200.15(17A,147,272C) prior to practicing physical therapy in this state.

These rules are intended to implement Iowa Code chapters 17A, 147, 148A and 272C.

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[◊] Two or more ARCs

CHAPTER 203
CONTINUING EDUCATION FOR PHYSICAL THERAPISTS
AND PHYSICAL THERAPIST ASSISTANTS

645—203.1(272C) Definitions. For the purpose of these rules, the following definitions shall apply:

“*Active license*” means a license that is current and has not expired.

“*Audit*” means the selection of licensees for verification of satisfactory completion of continuing education requirements during a specified time period.

“*Board*” means the board of physical and occupational therapy.

“*Continuing education*” means planned, organized learning acts designed to maintain, improve, or expand a licensee’s knowledge and skills in order for the licensee to develop new knowledge and skills relevant to the enhancement of practice, education, or theory development to improve the safety and welfare of the public.

“*Hour of continuing education*” means at least 50 minutes spent by a licensee in actual attendance at and completion of an approved continuing education activity.

“*Inactive license*” means a license that has expired because it was not renewed by the end of the grace period. The category of “inactive license” may include licenses formerly known as lapsed, inactive, delinquent, closed, or retired.

“*Independent study*” means a subject/program/activity that a person pursues autonomously and that meets standards for approval criteria in the rules and includes a posttest.

“*License*” means license to practice.

“*Licensee*” means any person licensed to practice as a physical therapist or physical therapist assistant in the state of Iowa.

645—203.2(148A) Continuing education requirements.

203.2(1) The biennial continuing education compliance period shall extend for a two-year period that begins on the sixteenth day of the birth month and ends two years later on the fifteenth day of the birth month.

a. Requirements for physical therapist licensees. Each biennium, each person who is licensed to practice as a physical therapist in this state shall be required to complete a minimum of 40 hours of continuing education approved by the board; a minimum of 30 hours shall be directly and primarily related to the clinical application of physical therapy.

b. Requirements for physical therapist assistant licensees. Each biennium, each person who is licensed to practice as a physical therapist assistant in this state shall be required to complete a minimum of 20 hours of continuing education approved by the board; a minimum of 15 hours shall be directly and primarily related to the clinical application of physical therapy.

203.2(2) Requirements of new licensees. Those persons licensed for the first time shall not be required to complete continuing education as a prerequisite for the first renewal of their licenses. Continuing education hours acquired anytime from the initial licensing until the second license renewal may be used. The new licensee will be required to complete a minimum of 40 hours of continuing education per biennium for physical therapists and a minimum of 20 hours for physical therapist assistants each subsequent license renewal.

203.2(3) Hours of continuing education credit may be obtained by attending and participating in a continuing education activity. These hours must be in accordance with these rules.

203.2(4) No hours of continuing education shall be carried over into the next biennium except for a new licensee. A licensee whose license was reactivated during the current renewal compliance period may use continuing education earned during the compliance period for the first renewal following reactivation.

203.2(5) It is the responsibility of each licensee to finance the cost of continuing education.

[ARC 9328B, IAB 1/12/11, effective 2/16/11; ARC 1659C, IAB 10/15/14, effective 11/19/14]

645—203.3(148A,272C) Standards.

203.3(1) General criteria. A continuing education activity which meets all of the following criteria is appropriate for continuing education credit if the continuing education activity:

- a. Constitutes an organized program of learning which contributes directly to the professional competency of the licensee;
- b. Pertains to subject matters which integrally relate to the practice of the profession;
- c. Is conducted by individuals who have specialized education, training and experience by reason of which said individuals should be considered qualified concerning the subject matter of the program.

At the time of audit, the board may request the qualifications of presenters;

- d. Fulfills stated program goals, objectives, or both; and
- e. Provides proof of attendance to licensees in attendance including:
 - (1) Date, location, course title, presenter(s);
 - (2) Number of program contact hours; and
 - (3) Certificate of completion or evidence of successful completion of the course provided by the course sponsor.

203.3(2) Specific criteria.

a. Licensees may obtain continuing education hours of credit by:

- (1) Attending workshops, conferences, or symposiums.
- (2) Accessing online training, such as viewing interactive conferences, attending webinars, or completing online training courses.

(3) Completing an American Physical Therapy Association-approved postprofessional clinical residency or fellowship. A licensee will receive 1 hour of credit for every 2 hours spent in clinical residency, up to a maximum of 20 hours. Clinical residency hours may not be used for credit if the licensee is also seeking credit hours earned for postprofessional academic coursework in the same renewal period.

(4) Directly supervising students for clinical education if the students being supervised are from an accredited physical therapist or physical therapist assistant program and are participating in a full-time clinical experience (defined as approximately 40 hours per week, ranging from 1 to 18 weeks). One hour will be awarded for every 160 contact hours of supervision. A maximum of 8 hours for a physical therapist and 4 hours for a physical therapist assistant may be awarded per biennium. The physical therapist or physical therapist assistant must have documentation from the accredited educational program indicating the number of hours spent supervising a student.

(5) Presenting professional programs that meet the criteria listed in this rule. Two hours of credit will be awarded for each hour of presentation for the first offering of the course. A course schedule or brochure must be maintained for audit.

(6) Completing academic courses that directly relate to the professional competency of the licensee. Official transcripts indicating successful completion of academic courses that apply to the field of physical therapy will be necessary in order for the licensee to receive the following continuing education credits:

1 academic semester hour = 15 continuing education hours of credit

1 academic trimester hour = 12 continuing education hours of credit

1 academic quarter hour = 10 continuing education hours of credit

(7) Teaching in an approved college, university, or graduate school. The licensee may receive the following continuing education credits on a one-time basis for the first offering of a course:

1 academic semester hour = 15 continuing education hours of credit

1 academic trimester hour = 12 continuing education hours of credit

1 academic quarter hour = 10 continuing education hours of credit

(8) Authoring research or other activities, the results of which are published in a recognized professional publication. The licensee shall receive 5 hours of credit per page.

(9) Participating in professional organizations related to the practice of physical therapy, with 1 credit hour received for each six months of active service as an officer, delegate, or committee

member, for a maximum of 4 hours of credit per biennium. Verification of participation must be provided by the professional organization to document the continuing education credit.

b. Continuing education hours of credit in the following topics are not considered to be directly and primarily related to the clinical application of physical therapy and therefore must not exceed a maximum combined total of 10 hours of credit for a physical therapist licensee and 5 hours of credit for a physical therapist assistant licensee:

(1) Business-related topics, such as marketing, time management, government regulations, and other like topics.

(2) Personal skills topics, such as career burnout, communication skills, human relations, and other like topics.

(3) General health topics, such as clinical research, CPR, mandatory reporter training, and other like topics.

[ARC 9328B, IAB 1/12/11, effective 2/16/11; ARC 1659C, IAB 10/15/14, effective 11/19/14; ARC 3876C, IAB 7/4/18, effective 8/8/18]

645—203.4(148A,272C) Audit of continuing education report. Rescinded IAB 12/17/08, effective 1/21/09.

645—203.5(148A,272C) Automatic exemption. Rescinded IAB 12/17/08, effective 1/21/09.

645—203.6(272C) Continuing education exemption for disability or illness. Rescinded IAB 12/17/08, effective 1/21/09.

645—203.7(148A,272C) Grounds for disciplinary action. Rescinded IAB 12/17/08, effective 1/21/09.

645—203.8(272C) Continuing education exemption for disability or illness. Rescinded IAB 9/14/05, effective 10/19/05.

645—203.9(148A,272C) Reinstatement of inactive practitioners. Rescinded IAB 9/14/05, effective 10/19/05.

645—203.10(272C) Hearings. Rescinded IAB 9/14/05, effective 10/19/05.

These rules are intended to implement Iowa Code section 272C.2 and chapter 148A.

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[◇] Two or more ARCs

CHAPTER 206
LICENSURE OF OCCUPATIONAL THERAPISTS
AND OCCUPATIONAL THERAPY ASSISTANTS

[Prior to 3/6/02, see 645—201.3(147,148B,272C) to 645—201.7(147) and 645—201.9(272C)]

645—206.1(147) Definitions. For purposes of these rules, the following definitions shall apply:

“*Active license*” means a license that is current and has not expired.

“*Board*” means the board of physical and occupational therapy.

“*Department*” means the department of public health.

“*Grace period*” means the 30-day period following expiration of a license when the license is still considered to be active. In order to renew a license during the grace period, a licensee is required to pay a late fee.

“*Inactive license*” means a license that has expired because it was not renewed by the end of the grace period. The category of “inactive license” may include licenses formerly known as lapsed, inactive, delinquent, closed, or retired.

“*Licensee*” means any person licensed to practice as an occupational therapist or occupational therapy assistant in the state of Iowa.

“*License expiration date*” means the fifteenth day of the birth month every two years after initial licensure.

“*Licensure by endorsement*” means the issuance of an Iowa license to practice occupational therapy to an applicant who is or has been licensed in another state.

“*Licensure examination*” means the examination administered by the National Board for Certification in Occupational Therapy.

“*Mandatory training*” means training on identifying and reporting child abuse or dependent adult abuse required of occupational therapists or occupational therapy assistants 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.

“*NBCOT*” means the National Board for Certification in Occupational Therapy.

“*Occupational therapist*” means a person licensed under this chapter to practice occupational therapy.

“*Occupational therapy assistant*” means a person licensed under this chapter to assist in the practice of occupational therapy.

“*Occupational therapy practice*” means the therapeutic use of occupations, including everyday life activities with individuals, groups, populations, or organizations, to support participation, performance, and function in roles and situations in home, school, workplace, community, and other settings. Occupational therapy services are provided for habilitation, rehabilitation, and the promotion of health and wellness to those who have or are at risk for developing an illness, injury, disease, disorder, condition, impairment, disability, activity limitation, or participation restriction. Occupational therapy addresses the physical, cognitive, psychosocial, sensory-perceptual, and other aspects of performance in a variety of contexts and environments to support engagement in occupations that affect physical and mental health, well-being, and quality of life. The practice of occupational therapy includes:

1. Evaluation of factors affecting activities of daily living (ADL), instrumental activities of daily living (IADL), rest and sleep, education, work, play, leisure, and social participation, including:

- Client factors, including body functions (such as neuromusculoskeletal, sensory-perceptual, visual, mental, cognitive, and pain factors) and body structures (such as cardiovascular, digestive, nervous, integumentary, genitourinary systems, and structures related to movement) and values, beliefs, and spirituality.

- Habits, routines, roles, rituals, and behavior patterns.

- Physical and social environments; cultural, personal, temporal and virtual contexts; and activity demands that affect performance.

- Performance skills, including motor and praxis, sensory-perceptual, emotional regulation, cognitive, communication and social skills.
2. Methods or approaches selected to direct the process of interventions, including:
 - Establishment of a skill or ability that has not yet developed or remediation or restoration of a skill or ability that is impaired or is in decline.
 - Compensation, modification, or adaptation of activity or environment to enhance performance or to prevent injuries, disorders, or other conditions.
 - Retention and enhancement of skills or abilities without which performance in everyday life activities would decline.
 - Promotion of health and wellness, including the use of self-management strategies, to enable or enhance performance in everyday life activities.
 - Prevention of barriers to performance and participation, including injury and disability prevention.
 3. Interventions and procedures to promote or enhance safety and performance in activities of daily living (ADL), instrumental activities of daily living (IADL), rest and sleep, education, work, play, leisure, and social participation, including:
 - Therapeutic use of occupations, exercises, and activities.
 - Training in self-care, self-management, health management and maintenance, home management, community/work reintegration, and school activities and work performance.
 - Development, remediation, or compensation of neuromusculoskeletal, sensory-perceptual, visual, mental, and cognitive functions, pain tolerance and management, and behavioral skills.
 - Therapeutic use of self, including one's personality, insights, perceptions, and judgments, as part of the therapeutic process.
 - Education and training of individuals, including family members, caregivers, groups, populations, and others.
 - Care coordination, case management, and transition services.
 - Consultative services to groups, programs, organizations, or communities.
 - Modification of environments (home, work, school, or community) and adaptation of processes, including the application of ergonomic principles.
 - Assessment, design, fabrication, application, fitting, and training in seating and positioning, assistive technology, adaptive devices, and orthotic devices, and training in the use of prosthetic devices.
 - Assessment, recommendation, and training in techniques to enhance functional mobility, including management of wheelchairs and other mobility devices.
 - Low vision rehabilitation.
 - Driver rehabilitation and community mobility.
 - Management of feeding, eating, and swallowing to enable eating and feeding performance.
 - Application of physical agent modalities and use of a range of specific therapeutic procedures (such as wound care management, interventions to enhance sensory-perceptual and cognitive processing, and manual therapy) to enhance performance skills.
 - Facilitating the occupational performance of groups, populations, or organizations through the modification of environments and the adaptation of processes.

“Occupational therapy screening” means a brief process which is directed by an occupational therapist in order for the occupational therapist to render a decision as to whether the individual warrants further, in-depth evaluation and which includes:

1. Assessment of the medical and social history of an individual;
2. Observations related by that individual's caregivers; or
3. Observations or nonstandardized tests, or both, administered to an individual by the occupational therapist or an occupational therapy assistant under the direction of the occupational therapist.

Nothing in this definition shall be construed to prohibit licensed occupational therapists and occupational therapy assistants who work in preschools or school settings from providing short-term

interventions to children prior to an evaluation, not to exceed 16 sessions per concern per school year, in accordance with state and federal educational policy.

“*On site*” means:

1. To be continuously on site and present in the department or facility where the assistive personnel are performing services;
2. To be immediately available to assist the person being supervised in the services being performed; and
3. To provide continued direction of appropriate aspects of each treatment session in which a component of treatment is delegated to assistive personnel.

“*OT*” means occupational therapist.

“*OTA*” means occupational therapy assistant.

“*Reactivate*” or “*reactivation*” means the process as outlined in rule 206.18(17A,147,272C) by which an inactive license is restored to active status.

“*Reciprocal license*” means the issuance of an Iowa license to practice occupational therapy to an applicant who is currently licensed in another state which has a mutual agreement with the Iowa board of physical and occupational therapy 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.

[ARC 7644B, IAB 3/25/09, effective 4/29/09; ARC 0223C, IAB 7/25/12, effective 8/29/12]

645—206.2(147) Requirements for licensure. The following criteria shall apply to licensure:

206.2(1) The applicant shall complete a board-approved application. Application forms may be obtained from the board’s website (www.idph.iowa.gov/licensure) or directly from the board office, or the applicant may complete the application online at ibplicense.iowa.gov. All paper applications shall be sent to the Board of Physical and Occupational Therapy, Professional Licensure Division, Fifth Floor, Lucas State Office Building, Des Moines, Iowa 50319-0075.

206.2(2) The applicant shall complete the application form according to the instructions contained in the application. If the application is not completed according to the instructions, the application will not be reviewed by the board.

206.2(3) Each application shall be accompanied by the appropriate fees payable by check or money order to the Board of Physical and Occupational Therapy. The fees are nonrefundable.

206.2(4) No application will be considered by the board until official copies of academic transcripts sent directly from the school to the board have been received by the board.

206.2(5) The licensure examination score shall be sent directly from the examination service to the board to confirm a passing score on the examination.

206.2(6) Licensees who were issued their initial licenses within six months prior to the renewal date shall not be required to renew their licenses until the renewal date two years later.

206.2(7) Submitting complete application materials. An application for an occupational therapist or occupational therapy assistant license will be considered active for two years from the date the application is received. If the applicant does not submit all materials within this time period or if the applicant does not meet the requirements for the license, the application shall be considered incomplete. An applicant whose application is filed incomplete must submit a new application, supporting materials, and the application fee. The board shall destroy incomplete applications after two years.

[ARC 3445C, IAB 11/8/17, effective 12/13/17]

645—206.3(147) Limited permit to practice pending licensure. A limited permit holder who is applying for licensure in Iowa by taking the licensure examination for the first time and has never been licensed as an occupational therapist or occupational therapy assistant in any state, the District of Columbia, or another country must have completed the educational and experience requirements for licensure as an occupational therapist or occupational therapy assistant. The limited permit holder shall:

1. Make arrangements to take the examination and have the official results of the examination sent directly from the examination service to the board;
2. Apply for licensure on forms provided by the board. The applicant must include on the application form the name of the Iowa-licensed occupational therapist(s) who will provide supervision of the limited permit holder until the limited permit holder is licensed;
3. Practice only under the supervision of an Iowa-licensed OT for a period not to exceed six months from the date the application was received in the board office;
4. Submit to the board the name of the OT providing supervision within seven days after a change in supervision occurs; and
5. If the applicant fails the national examination, the limited permit holder must cease practicing immediately.

645—206.4(147) Applicant occupational therapist and occupational therapy assistant. Rescinded ARC 3445C, IAB 11/8/17, effective 12/13/17.

645—206.5(147) Practice of occupational therapy limited permit holders.

206.5(1) Occupational therapist limited permit holders may:

- a. Evaluate clients, plan treatment programs, and provide periodic reevaluations only under supervision of a licensed OT who shall bear full responsibility for care provided under the OT's supervision; and
- b. Perform the duties of the occupational therapist under the supervision of an Iowa-licensed occupational therapist, except for providing supervision to an occupational therapy assistant.

206.5(2) Occupational therapy assistants and limited permit holders shall:

- a. Follow the treatment plan written by the supervising OT outlining the elements that have been delegated; and
- b. Perform occupational therapy procedures delegated by the supervising OT as required in subrule 206.8(4).

[ARC 3445C, IAB 11/8/17, effective 12/13/17]

645—206.6(147) Examination requirements. The following criteria shall apply to the written examination(s):

206.6(1) The applicant for licensure as an occupational therapist shall have received a passing score on the licensure examination for occupational therapists. It is the responsibility of the applicant to make arrangements to take the examination and have the official results submitted directly from the examination service to the board of physical and occupational therapy.

206.6(2) The applicant for licensure as an occupational therapy assistant shall have received a passing score on the licensure examination for occupational therapy assistants. It is the responsibility of the applicant to make arrangements to take the examination and have the official results submitted directly from the examination service to the board of physical and occupational therapy.

645—206.7(147) Educational qualifications.

206.7(1) The applicant must present proof of meeting the following requirements for licensure as an occupational therapist or occupational therapy assistant:

a. *Occupational therapist.* The applicant for licensure as an occupational therapist shall have completed the requirements for a degree in occupational therapy in an occupational therapy program accredited by the Accreditation Council for Occupational Therapy Education of the American Occupational Therapy Association. The transcript shall show completion of a supervised fieldwork experience.

b. *Occupational therapy assistant.* The applicant for licensure as an occupational therapy assistant shall be a graduate of an educational program approved by the Accreditation Council for Occupational Therapy Education of the American Occupational Therapy Association. The transcript shall show completion of a supervised fieldwork experience.

206.7(2) Foreign-trained occupational therapists and occupational therapy assistants. To become eligible to take the licensure examination, internationally educated occupational therapists must meet NBCOT eligibility requirements and undergo prescreening based on the status of their occupational therapy educational programs.

645—206.8(148B) Supervision requirements.

206.8(1) Care rendered by unlicensed assistive personnel shall not be documented or charged as occupational therapy unless direct on-site supervision is provided by an OT or in-sight supervision is provided by an OTA.

206.8(2) Occupational therapist supervisor responsibilities. The supervisor shall:

a. Provide supervision to a licensed OTA, OT limited permit holder and OTA limited permit holder anytime occupational therapy services are rendered. Supervision may be provided on site or through the use of telecommunication or other technology.

b. Ensure that every licensed OTA, OT limited permit holder and OTA limited permit holder being supervised is aware of who the supervisor is and how the supervisor can be contacted anytime occupational therapy services are rendered.

c. Assume responsibility for all delegated tasks and shall not delegate a service which exceeds the expertise of the OTA or OTA limited permit holder.

d. Provide evaluation and development of a treatment plan for use by the OTA.

e. Ensure that the OTA, OT limited permit holder and OTA limited permit holder under the OT's supervision have current licenses to practice.

f. Ensure that the signature of an OTA on an occupational therapy treatment record indicates that the occupational therapy services were provided in accordance with the rules and regulations for practicing as an OTA.

206.8(3) The following are functions that only an occupational therapist may provide and that shall not be delegated to an OTA:

a. Interpretation of referrals;

b. Initial occupational therapy evaluation and reevaluations;

c. Identification, determination or modification of patient problems, goals, and care plans;

d. Final discharge evaluation and establishment of the discharge plan;

e. Assurance of the qualifications of all assistive personnel to perform assigned tasks through written documentation of their education or training that is maintained and available at all times;

f. Delegation of and instruction in the services to be rendered by the OTA including, but not limited to, specific tasks or procedures, precautions, special problems, and contraindicated procedures; and

g. Timely review of documentation, reexamination of the patient and revision of the plan when indicated.

206.8(4) Supervision of unlicensed assistive personnel. OTs are responsible for patient care provided by unlicensed assistive personnel under the OT's supervision. Unlicensed assistive personnel shall not provide independent patient care unless each of the following standards is satisfied:

a. The supervising OT shall physically participate in the patient's treatment or evaluation, or both, each treatment day;

b. The unlicensed assistive personnel shall provide independent patient care only while under the on-site supervision of the supervising OT;

c. Documentation made in occupational therapy records by unlicensed assistive personnel shall be cosigned by the supervising OT; and

d. The supervising OT shall provide periodic reevaluation of the performance of unlicensed assistive personnel in relation to the patient.

206.8(5) Minimum frequency of OT interaction. At a minimum, an OT must directly participate in treatment, either in person or through a telehealth visit, every twelfth visit for all patients and must document each visit. The occupational therapist shall participate at a higher frequency when the standard of care dictates.

206.8(6) Occupational therapy assistant responsibilities.*a.* The occupational therapy assistant:

- (1) Shall provide only those services for which the OTA has the necessary skills and shall consult the supervising occupational therapist if the procedures are believed not to be in the best interest of the patient;
 - (2) Shall gather data relating to the patient's disability during screening, but shall not interpret the patient information as it pertains to the plan of care;
 - (3) Shall communicate any change, or lack of change, which occurs in the patient's condition and which may need the assessment of the OT;
 - (4) Shall provide occupational therapy services only under the supervision of the occupational therapist;
 - (5) Shall provide treatment only after evaluation and development of a treatment plan by the occupational therapist;
 - (6) Shall refer inquiries that require interpretation of patient information to the occupational therapist;
 - (7) Shall be supervised by an occupational therapist, either on site or through the use of telecommunication or other technology, at all times when occupational therapy services are being rendered;
 - (8) May receive supervision from any number of occupational therapists; and
 - (9) Shall record on every patient chart the name of the OTA's supervisor for each treatment session.
- b.* The signature of an OTA on the occupational therapy treatment record indicates that occupational therapy services were provided in accordance with the rules and regulations for practicing as an OTA.

206.8(7) Unlicensed assistive personnel. Unlicensed assistive personnel may assist an OTA in providing patient care in the absence of an OT only if the OTA maintains in-sight supervision of the unlicensed assistive personnel and the OTA is primarily and significantly involved in that patient's care.

206.8(8) The occupational therapy limited permit holder may evaluate clients, plan treatment programs, and provide periodic reevaluations under supervision of a licensed occupational therapist who shall bear full responsibility for care provided under the occupational therapist's supervision.

[ARC 0223C, IAB 7/25/12, effective 8/29/12; ARC 3876C, IAB 7/4/18, effective 8/8/18]

645—206.9(147) Licensure by endorsement. An applicant who has been a licensed occupational therapist or occupational therapy assistant under the laws of another jurisdiction shall file an application for licensure by endorsement with the board office. The board may receive by endorsement any applicant from the District of Columbia, another state, territory, province or foreign country who:

1. Submits to the board a completed application;
2. Pays the licensure fee;
3. Shows evidence of licensure requirements in the jurisdiction in which the applicant has been licensed that are similar to those required in Iowa;
4. Submits official results from the appropriate professional examination sent directly from the examination service to the board;
5. Provides official copies of the academic transcripts sent directly from the school to the board;
6. Provides verification of license(s) from every jurisdiction in which the applicant has been licensed, sent directly from the jurisdiction(s) to the board office. Web-based verification may be substituted for verification direct from the jurisdiction's board office if it provides:
 - Licensee's name;
 - Date of initial licensure;
 - Current licensure status; and
 - Any disciplinary action taken against the license; and
7. Shows evidence of one of the following:
 - Completion of 30 hours for an occupational therapist and 15 hours for an occupational therapy assistant of board-approved continuing education during the immediately preceding two-year period;

- The practice of occupational therapy for a minimum of 2,080 hours during the immediately preceding two-year period as a licensed occupational therapist or occupational therapy assistant;
- Serving as a full-time equivalent faculty member teaching occupational therapy in an accredited school of occupational therapy for at least one of the immediately preceding two years; or
- Successfully passing the examination within a period of two years from the date of examination to the time application is completed for licensure.

Individuals who were issued their licenses by endorsement within six months of the license renewal date will not be required to renew their licenses until the next renewal two years later.

[ARC 0223C, IAB 7/25/12, effective 8/29/12; ARC 3445C, IAB 11/8/17, effective 12/13/17]

645—206.10(147) License renewal.

206.10(1) The biennial license renewal period for a license to practice as an occupational therapist or occupational therapy assistant shall begin on the sixteenth day of the birth month and end on the fifteenth day of the birth month 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.

206.10(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.

206.10(3) A licensee seeking renewal shall:

a. Meet the continuing education requirements of rule 645—207.2(272C) and the mandatory reporting requirements of subrule 206.12(4). A licensee whose license was reactivated during the current renewal compliance period may use continuing education earned during the compliance period for the first renewal following reactivation; and

b. Submit the completed renewal application and renewal fee before the license expiration date.

206.10(4) Mandatory reporter training requirements.

a. A licensee who in the scope of professional practice regularly examines, attends, counsels or treats children in Iowa shall indicate on the renewal application completion of two hours of training in child abuse identification and reporting in the previous five years or condition(s) for waiver of this requirement as identified in paragraph “e.”

b. A licensee who in the scope of professional practice regularly examines, attends, counsels or treats adults in Iowa shall indicate on the renewal application completion of two hours of training in dependent adult abuse identification and reporting in the previous five years or condition(s) for waiver of this requirement as identified in paragraph “e.”

c. A licensee who in the scope of professional practice regularly examines, attends, counsels or treats both adults and children in Iowa shall indicate on the renewal application completion of training in abuse identification and reporting for dependent adults and children in the previous five years or condition(s) for waiver of this requirement as identified in paragraph “e.”

Training may be completed through separate courses as identified in paragraphs “a” and “b” or in one combined two-hour course that includes curricula for identifying and reporting child abuse and dependent adult abuse. The course shall be a curriculum approved by the Iowa department of public health abuse education review panel.

d. The licensee shall maintain written documentation for five years after mandatory training as identified in paragraphs “a” to “c,” including program date(s), content, duration, and proof of participation.

e. The requirement for mandatory training for identifying and reporting child and dependent adult abuse shall be suspended if the board determines that suspension is in the public interest or that a person at the time of license renewal:

(1) Is engaged in active duty in the military service of this state or the United States.

(2) Holds a current waiver by the board based on evidence of significant hardship in complying with training requirements, including an exemption of continuing education requirements or extension of time in which to fulfill requirements due to a physical or mental disability or illness as identified in 645—Chapter 4.

f. The board may select licensees for audit of compliance with the requirements in paragraphs “a” to “e.”

206.10(5) Upon receiving the information required by this rule and the required fee, board staff shall administratively issue a two-year license and shall send the licensee a wallet card by regular mail. In the event the board receives adverse information on the renewal application, the board shall issue the renewal license but may refer the adverse information for further consideration or disciplinary investigation.

206.10(6) Persons licensed to practice as occupational therapists or occupational therapy assistants shall keep their renewal licenses displayed in a conspicuous public place at the primary site of practice.

206.10(7) Late renewal. The license shall become a late license 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 5.11(4). To renew a late license, the licensee shall complete the renewal requirements and submit the late fee within the grace period.

206.10(8) Inactive license. A licensee who fails to renew the license by the end of the grace period has an inactive license. A licensee whose license is inactive continues to hold the privilege of licensure in Iowa, but may not practice as an occupational therapist or occupational therapy assistant in Iowa until the license is reactivated. A licensee who practices as an occupational therapist or occupational therapy assistant 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 0223C, IAB 7/25/12, effective 8/29/12]

645—206.11(17A,147,272C) License reactivation. To apply for reactivation of an inactive license, a licensee shall:

206.11(1) Submit a reactivation application on a form provided by the board.

206.11(2) Pay the reactivation fee that is due as specified in 645—subrule 5.11(5).

206.11(3) Provide verification of current competence to practice occupational therapy by satisfying one of the following criteria:

a. If the license has been on inactive status for five years or less, an applicant must provide the following:

(1) Verification of the license(s) from every jurisdiction in which the applicant is or has been licensed and is or has been practicing during the time period the Iowa license was inactive, sent directly from the jurisdiction(s) to the board office. Web-based verification may be substituted for verification from a jurisdiction’s board office if the verification includes:

1. Licensee’s name;
2. Date of initial licensure;
3. Current licensure status; and
4. Any disciplinary action taken against the license; and

(2) Verification of completion of 15 hours of continuing education for an occupational therapy assistant and 30 hours of continuing education for an occupational therapist 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 30 hours of continuing education for an occupational therapy assistant and 60 hours of continuing education for an occupational therapist within two years of

application for reactivation; or evidence of successful completion of the professional examination required for initial licensure completed within one year prior to the submission of an application for reactivation.

[ARC 0223C, IAB 7/25/12, effective 8/29/12]

645—206.12(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 206.18(17A,147,272C) prior to practicing occupational therapy in this state.

[ARC 0223C, IAB 7/25/12, effective 8/29/12]

645—206.13(272C) Exemptions for inactive practitioners. Rescinded IAB 9/14/05, effective 10/19/05.

645—206.14(272C) Lapsed licenses. Rescinded IAB 9/14/05, effective 10/19/05.

645—206.15(147) Duplicate certificate or wallet card. Rescinded IAB 12/17/08, effective 1/21/09.

645—206.16(147) Reissued certificate or wallet card. Rescinded IAB 12/17/08, effective 1/21/09.

645—206.17(17A,147,272C) License denial. Rescinded IAB 12/17/08, effective 1/21/09.

These rules are intended to implement Iowa Code chapters 17A, 147, 148B and 272C.

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[Filed ARC 3876C (Notice ARC 3762C, IAB 4/25/18), IAB 7/4/18, effective 8/8/18]

[◊] Two or more ARCs

CHAPTER 4
TRAFFIC AND PARKING AT UNIVERSITIES
[Prior to 4/20/88, Regents, Board of[720]]

UNIVERSITY OF IOWA

681—4.1(262) Purpose. The purpose of these rules is to provide for the policing, control and regulation of traffic and of parking vehicles on the campus of the state University of Iowa.

681—4.2(262) Definitions. For the purpose of these rules, the following definitions shall apply unless the context clearly requires otherwise, and all other words shall have meaning according to their common usage.

“Bicycle” means any vehicle which has two or three wheels and fully operable pedals and which is a traditional bicycle designed solely to be pedaled by the rider. An electric/battery-powered bicycle designed not only to be pedaled by the rider but also propelled by an electric motor of less than 750 watts (one horsepower) may be treated as a bicycle and may be parked at bicycle racks.

“Director” means the director of parking and transportation at the university or any other person designated by the president of the university to perform any function or duty of the director hereunder.

“Employee” means any person regularly employed by the university who is not a student.

“Handrail” is any railing intended to provide physical support to a pedestrian.

“Immobilization” of a bicycle consists of restricting the bicycle’s use by detaining it at the point of infraction with a university locking device.

“Impoundment of a bicycle” consists of removing the owner’s locking device, transporting the bicycle to a university facility, and detaining it with a university locking device.

“In-line skates” means shoes which are attached to multiple wheels for the purpose of individual transportation.

“Motorcycle” means any vehicle which is self-propelled and has less than four wheels in contact with the ground.

“Motor vehicle” means any vehicle which is self-propelled and has four or more wheels in contact with the ground.

“Roller skates” means shoes which are attached to multiple wheels for the purpose of individual transportation.

“Skateboards” means any board or platform with attached wheels used for individual transportation.

“Street furniture” is any structure or accessory in a university pedestrian area or slow zone designed for the benefit of pedestrians. This includes, but is not limited to, benches, tables, lampposts, and trash receptacles.

“Student” means any person registered with the university for academic credit who is not employed by the university on a full-time salaried or equivalent basis.

“University” means the state University of Iowa.

“Vehicle” means any wheeled or treaded device used or designed for use as a means of transportation or conveyance of persons or property.

“Visitor” means any person who owns, operates or parks a vehicle on the university campus who is not a student or an employee.

[ARC 3877C, IAB 7/4/18, effective 8/8/18]

681—4.3(262) General traffic.

4.3(1) The director shall establish such rules governing the safe operation of all vehicles, including motor vehicles, motorcycles, skateboards, in-line skates, roller skates and bicycles as the director deems necessary. Such traffic rules shall be available for inspection during business hours at the office of the director and the state board of regents. Such traffic violations may also be charged and prosecuted as violations of Iowa Code chapter 321 and Iowa Code section 262.68.

4.3(2) The director shall erect speed limit signs in conformity with maps of the institutional roads and property of the university designating such speed limits as adopted by the state board of regents.

The maps will be available for inspection during business hours at the office of the director and the state board of regents.

4.3(3) The director is delegated authority to make temporary changes in traffic patterns, including establishment of one-way roads and road closures, where necessary because of construction or special events being held on university property.

4.3(4) The director is delegated authority to erect traffic control signs and devices, and to designate pedestrian crosswalks and bicycle lanes, as well as no bicycling and no skateboard, in-line skating and roller skating areas, bicycle dismount zones and pedestrian-only areas.

4.3(5) Pedestrians shall be given the right-of-way at all crosswalks or when in compliance with existing traffic controls.

4.3(6) Driving of vehicles, motor vehicles, and motorcycles on university property other than roads is prohibited, unless specific areas have been designated for such use by the director or special permission has been granted by the director for emergency conditions.

4.3(7) Driving of vehicles, motor vehicles, and motorcycles on parts of institutional roads marked as bicycle lanes is prohibited.

4.3(8) The director is delegated authority to have the university public safety department investigate accidents which occur on university property.

681—4.4(262) Registration. Motor vehicles and motorcycles shall be registered as follows:

4.4(1) *Students.* Every motor vehicle and motorcycle which is operated or maintained by a student on campus must be registered with the university and a registration decal must be displayed on the vehicle in the manner prescribed by the director. Any student who operates or maintains a motor vehicle or motorcycle on campus or who owns a vehicle which is so operated or maintained is responsible for the proper registration of such vehicle and the display of the registration decal thereon.

4.4(2) *Employees.* Motor vehicles and motorcycles owned or operated by employees may be registered with the university if the employee so desires, but registration of such vehicles is not required unless the employee is granted parking privileges on the campus. A registration decal may be issued for display on vehicles registered by employees.

4.4(3) *Procedure.* Applications for registration shall be submitted to the director in the manner the director prescribes. No student shall register any vehicle owned or actually maintained by another student. No fee shall be charged for registration without parking privileges.

4.4(4) *Bicycles.* Bicycle registration is optional.

a. To register a bicycle with the university, a current registration form is to be filled out at the parking and transportation offices. Required information includes current name of owner, address, social security number, description of the bicycle, and the bicycle manufacturer's identification number. Proof of name and address is required. Once the registration form is completed, a decal will be issued.

b. Bicycles may also be registered with the cities of Iowa City and Coralville. If these registrations are current and the decal is affixed to the bicycle, the university will accept them in lieu of a university registration.

c. Placement of registration decal. The registration process is completed when the registration decal is permanently and visibly affixed to the down- or seat-tube on the bicycle.

d. An official university bicycle registration decal is valid if the address and ownership given on the registration form are current. Change in ownership of a bicycle must be reported to the parking and transportation office. Proof of change in ownership is required.

681—4.5(262) Parking facilities. The director may set aside and designate certain areas of the university property for the parking of motor vehicles, motorcycles, and bicycles, and the use of any lot, ramp, or part of the parking facilities so established may be restricted to students, employees, or visitors. The director shall cause signs to be erected and maintained clearly identifying those areas of the university campus designated for vehicle parking, and any restrictions applicable thereto shall be conspicuously posted.

4.5(1) *Parking control devices.* Gates and other devices may be installed and maintained to control access to any parking facility.

4.5(2) *Parking meters.* Parking meters, toll houses, and other devices may be installed and maintained to regulate the use of any parking facility.

4.5(3) *Hours of operation.* Reasonable hours shall be established by the director for the normal operation of the parking facilities and a schedule of hours of operation shall be published and available for public inspection in the office of the director.

4.5(4) *Closing.* The director may temporarily close any parking facility for cleaning, maintenance or other university purpose, or may temporarily restrict or reassign the use of any facility as may be necessary or convenient. The director shall give advance notice of such temporary closing, restriction, or reassignment by posting or otherwise when practical.

4.5(5) *Restricted zones.* The director may designate areas of the campus as restricted zones, such as loading zones or service vehicle zones, and such restricted zones shall be conspicuously posted. No parking shall be permitted in such restricted zones except as authorized.

4.5(6) *No parking.* Motor vehicle and motorcycle parking on the campus shall be restricted to designated parking facilities, and no parking shall be permitted at any other place on the campus. Vehicles shall not be parked in such a manner as to block or obstruct sidewalks, crosswalks, driveways, roadways, or designated parking stalls. No parking is permitted in prohibited zones, such as in the vicinity of fire hydrants or fire lanes, and such zones shall be conspicuously posted or marked by painted curbs or other standard means. No parking is permitted on grass or other vegetation or in pedestrian areas.

4.5(7) *Motorcycle parking.* The director may designate areas of the parking facilities for motorcycle parking, and such areas shall be conspicuously posted. Motorcycles shall be parked only in areas designated for motorcycle parking, and no other vehicles shall be parked in such areas.

4.5(8) *Bicycle parking.* The director may install and maintain bicycle parking racks or designate other facilities for bicycle parking. Bicycles shall be parked only in bicycle racks or other facilities designated for bicycle parking.

4.5(9) *Violations.* Bicycles attached to, or rested against, trees, shrubs, handrails, handicapped parking meters, or limiting access to, or use of, any university facility may be impounded, the owners fined, or both. Bicycles parked inside a university building which is not designated for bicycle parking may be impounded or the owners fined, or both. Bicycles bearing proper registration decals which are attached to, or rested against, street furniture may be ticketed or immobilized and the owners fined. If the bicycles interfere with the use of the furniture, they may be impounded. Bicycles considered abandoned may be labeled for impending impoundment by placing impoundment tags on the bicycles. If the bicycles display the proper registration decals, an attempt will be made to contact the owners to remove the bicycles. If the bicycles do not display the proper registration decals, the owners have two weeks to contact the parking and transportation office from the time the bicycles are tagged until the bicycles may be impounded.

681—4.6(262) *Parking privileges.* Students and employees may be granted parking privileges on the campus in accordance with these rules and upon such other reasonable terms and conditions as may be established by the university.

4.6(1) *Students.* Students may be granted parking privileges in parking facilities designated for student use. Optional plans and facilities may be offered as determined by the director. Reasonable classifications may be established on the basis of a student's age, class, college or department, course load, proximity of the student's residence to the campus, physical disability, employment, the availability of facilities, or any other relevant criterion to determine the eligibility of students for parking privileges or any optional plan or facility.

4.6(2) *Employees.* Employees may be granted parking privileges in parking facilities designated for employee use. Optional plans and facilities may be offered as determined by the director. Reasonable classifications may be established on the basis of an employee's job classification, length of service, place of work or the nature thereof, physical disability, the availability of facilities, or any other relevant

criterion to determine the priority of employees for assignment of parking privileges or any optional plan or facility.

4.6(3) *Visitors.* Visitors may be granted parking privileges in parking facilities designated for visitor parking. Optional plans and facilities may be offered as determined by the director. Reasonable classifications may be established on the basis of the time, duration or purpose of the visit, physical disability, the availability of facilities, or any other relevant criterion to determine the eligibility of visitors for parking privileges or any optional plan or facility.

4.6(4) *Procedure.* Applications for parking privileges shall be submitted to the director in the manner the director prescribes. No student shall apply for parking privileges for any vehicle owned or actually maintained by another student. The director shall determine the eligibility and priority of each applicant for parking privileges within the classifications established in 4.6(1), 4.6(2) and 4.6(3) and shall make all parking assignments. A parking decal or other means of identification may be issued to each applicant who is granted parking privileges, and such decal or other identification must be displayed on the vehicle in the manner prescribed by the director. Parking privileges shall not be granted to a student and to an employee for the same vehicle, and a student parking decal and an employee parking decal shall not be displayed on the same vehicle.

4.6(5) *Parking fees.* The university may assess and collect from students, employees, and visitors reasonable fees or charges for parking privileges and the use of parking facilities. The amount of such fees and charges shall be established by the university and approved by the state board of regents, and a schedule of all parking fees and charges shall be published and available for inspection during normal business hours in the office of the director and in the office of the state board of regents. Parking fees and charges may be assessed and collected on an annual, semester, monthly, or hourly basis. Parking fees and charges may be added to student tuition bills and may by agreement be withheld from the salaries or wages of employees by payroll deduction. Parking fees and charges may be collected by means of parking meters or toll houses. Use of any parking facility constitutes an implied agreement to pay the prescribed fee or charge therefor.

4.6(6) *University business.* Special parking privileges may be granted for vehicles being used on official university business on the conditions and in the manner prescribed by the director.

4.6(7) *Responsibility.* Any person who owns or operates a vehicle which is parked on the campus or in whose name the vehicle is registered or to whom parking privileges have been granted is responsible for the proper parking of the vehicle at all times when it is on the campus and for all parking violations involving the vehicle.

4.6(8) *Liability.* Parking privileges granted hereunder constitute a license to use university parking facilities and do not constitute a lease of such facilities or a bailment of the vehicle by the university. Use of university parking facilities is at the owner's or visitor's risk, and the university shall not be liable or responsible for loss of or damage to any vehicle parked on the campus.

4.6(9) *Revocation.* Parking privileges on the campus may be revoked by the university for good cause at any time upon five days' written notice and refund of any advance payment of parking fees or charges on a pro rata basis for the revoked period.

681—4.7(262) *Violations.* Sanctions may be imposed for violation of traffic, registration and parking rules as follows:

4.7(1) *Notice of violations.* The university shall give written notice of all parking violations. Such notice may be given by means of a notice of parking violation placed conspicuously on the offending vehicle, and such notice shall constitute constructive notice of the violation to the owner and operator of the vehicle and to any person in whose name the vehicle is registered or parking privileges have been granted.

4.7(2) *Sanctions.* Reasonable monetary sanctions may be imposed upon students, employees, and visitors for violation of university traffic, vehicle registration or parking rules. The amount of such sanctions, not to exceed \$50 for each offense, shall be established by the university and approved by the state board of regents except sanctions established by statute will be imposed at the current statutory amount. A schedule of all sanctions for traffic violations, improper registration and parking shall be

published and available for public inspection during normal business hours in the office of the director and in the office of the state board of regents. Traffic, registration, and parking sanctions may be assessed against the owner or operator of the vehicle involved in each violation or against any person in whose name the vehicle is registered or parking privileges have been granted and charged to the person's university account. Registration and parking sanctions may be added to student tuition bills or may be deducted from student deposits or from the salaries or wages of employees or from other funds in the possession of the university.

4.7(3) *Impoundment and immobilization.* Any vehicle parked on the campus in violation of parking rules may be impounded, removed or immobilized. The university shall give written notice of impoundment to the owner of the vehicle or to the person in whose name the vehicle is registered or parking privileges have been granted. A reasonable fee may be charged for the cost of impoundment and storage, which fee must be paid prior to the release of the vehicle. Impounded vehicles which are not claimed within 60 days will be deemed abandoned property and may be sold under procedures set forth in Iowa Code chapter 579 and the proceeds of the sale will be applied to the payment of the costs of impoundment, storage and sale. The balance, if any, shall be sent to the owner.

a. Immobilization. Immobilized bicycles bearing proper registration decals may be claimed by proving ownership and payment of immobilization fees and any fines. Immobilized bicycles not bearing proper registration decals may be claimed by proving ownership, registering the bicycle under a valid name and address, and paying the appropriate fines and immobilization fees. Immobilization fees for first-time offenders may be waived after immobilized bicycles have been registered. Immobilized bicycles not reclaimed after two working days may be impounded.

b. Impoundment. Impounded bicycles bearing proper registration may be claimed by proving ownership and paying the impoundment fees and any fines. Impounded bicycles not bearing proper registration decals may be claimed by proving ownership, registering the bicycles under a valid name and address, and paying the appropriate fines and impoundment fees. Impoundment fees for first-time offenders may be waived after impounded bicycles have been registered. All impounded bicycles will be held for 60 days, during which time they may be claimed by the owners upon payment of all outstanding fines and charges. After 60 days, all unclaimed impounded bicycles will be deemed abandoned property and sold pursuant to Iowa law, and the proceeds applied to the costs of impoundment, storage, and sale. The balance, if any, shall be sent to the owner, if known.

4.7(4) *Administrative hearing.* Students and employees may request a hearing and administrative ruling concerning a controversy, based on the imposition of a sanction for a registration or parking violation, or an impoundment procedure, by the appropriate hearing body as set forth in the motor vehicle and bicycle regulations published by the university. Visitors may request the director to conduct a hearing and issue an administrative ruling in such cases.

681—4.8(262) Administration of rules. The president of the university shall be responsible for the proper administration of these rules. The president is authorized to establish procedures not inconsistent with these rules as may be reasonably necessary and convenient for the effective administration of presidential duties hereunder, and any procedure so established shall be published and available for public inspection during normal business hours in the office of the director and in the office of the state board of regents. The president may delegate presidential authority under these rules to the director or to any other person designated by the president to perform any function or duty hereunder.

Rules 681—4.1(262) to 681—4.8(262) are intended to implement Iowa Code section 262.69.

681—4.9 to 4.24 Reserved.

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IOWA STATE UNIVERSITY OF SCIENCE AND TECHNOLOGY

681—4.25(262) Purpose. The purpose of these rules is to provide for the policing, control and regulation of traffic and of parking vehicles on the campus of Iowa State University.

681—4.26(262) Definitions. For the purposes of these rules, the following definitions shall apply unless the context requires otherwise, and all other words shall have meaning according to their common usage.

“Bicycle” means any vehicle having two or three wheels and fully operable pedals which is either a traditional bicycle designed solely to be pedaled by the rider or an electric bicycle designed not only to be pedaled by the rider but also propelled by an electric motor of less than 750 watts (one horsepower).

“Campus” means all property under the control of the university.

“Employee” means any person regularly employed by the university who is not a student.

“Guest” means any person other than the person living at the designated residence hall.

“Manager” means the person(s) designated by the president of the university to perform any function or duty of the manager hereunder. At Iowa State University, that person is the director of public safety, who further delegates the duties and responsibilities to the manager of the parking division within the university’s department of public safety.

“Motorcycle” or *“moped”* or *“motorized bicycle”* means any vehicle which is self-propelled and has fewer than four wheels in contact with the ground and is not a bicycle or an electric bicycle. For purposes of these rules, a moped or motorized bicycle is considered a motorcycle.

“Motor vehicle” means any vehicle which is self-propelled and has four or more wheels in contact with the ground.

“Roller blades” means any frame or shoe with a single row of wheels that is used for gliding or skating. Roller blades are also known as in-line skates.

“Roller skates” means any frame or shoe with a pair of small wheels near the heel and near the toe that is used for gliding or skating.

“Skateboard” means a board with small wheels that is usually ridden by a person. For purposes of these rules, a nonmotorized scooter (a board with a handle) is considered a skateboard.

“Student” means any person registered with the university for academic credit who is not employed by the university on a full-time salaried or equivalent basis.

“University” means Iowa State University of science and technology.

“Vehicle” means any wheeled or treaded device used or designed for use as a means of transportation or conveyance of persons or property.

“Visitor” means any person who owns, operates or parks a vehicle on the university campus who is neither a student nor an employee.

[ARC 8874B, IAB 6/30/10, effective 8/4/10; ARC 0185C, IAB 6/27/12, effective 8/1/12]

681—4.27(262) General traffic.

4.27(1) These rules shall not apply to moving traffic violations on institutional roads and property of the university. Such violations will be charged and prosecuted as violations of Iowa Code chapters 262 and 321. All state of Iowa motor vehicle laws are in effect on campus.

4.27(2) The manager shall erect speed limit signs in conformity with maps of the institutional roads and property of the university designating such speed limits as adopted by the board of regents, state of Iowa. The maps will be available for inspection during business hours at the office of the manager and the board of regents, state of Iowa.

4.27(3) The manager is delegated authority to make temporary changes in traffic patterns, including establishment of one-way roads and road closures, where necessary because of construction or special events being held on campus.

4.27(4) The manager is delegated authority to erect traffic control signs and devices, and to designate pedestrian crosswalks and bicycle lanes. All vehicle operators must obey all signs directing traffic flow on campus.

4.27(5) Pedestrians shall be given the right-of-way at all crosswalks or when in compliance with existing traffic controls.

4.27(6) Driving of vehicles, motor vehicles, and motorcycles on university property other than roads is prohibited, unless specific areas have been designated for this use by the manager or special permission has been granted by the manager for emergency conditions.

4.27(7) Driving of vehicles, motor vehicles, and motorcycles in parts of institutional roads marked as bicycle lanes or on designated bicycle paths is prohibited.

4.27(8) Every person riding a bicycle on a street or highway on campus is granted all the privileges and is subject to all the regulations applicable to a driver of any motor vehicle on that street or highway and to the special regulations of this subrule. A bicycle rider on campus must:

a. Obey the instructions of official traffic control devices, signs and signals applicable to motor vehicles, unless otherwise directed by a peace officer or other authorized traffic director;

b. Obey the direction of any sign whenever authorized signs are erected indicating that no right, left or U-turn is permitted;

c. Obey the regulations applicable to pedestrians when the bicycle rider dismounts from the bicycle;

d. Yield the right-of-way to all vehicles approaching on a street whenever a rider is on a separate bicycle path that intersects the street;

e. Not use campus sidewalks except those specifically designated as bicycle paths;

f. Yield the right-of-way to any pedestrian in a designated crosswalk;

g. Not ride on lawns.

This subrule does not apply to peace officers of the university's department of public safety while they are acting within the scope of their regularly assigned duties.

4.27(9) Roller skates, roller blades and skateboards are permitted on campus sidewalks. Roller skates, roller blades and skateboards are not permitted on or in university structures or buildings, on stairways, sub-walks, elevated sidewalks, access ramps, steps, retaining walls, handrails or other architectural elements, on or in planting, grass or seeded areas, or where otherwise prohibited by sign, peace officer or other authorized traffic director. Any person on roller skates, roller blades or a skateboard must yield the right-of-way to any wheelchair or other mobility assistance device for the disabled, pedestrian or bicycle.

681—4.28(262) Registration. Motor vehicles, motorcycles, mopeds and bicycles shall be registered as follows:

4.28(1) *Students.* Any student who operates, maintains or owns a vehicle on university property is responsible for the proper registration of the vehicle and the display of the registration identification thereon in the manner prescribed by the manager. A student must register the vehicle within 48 hours of initial operation of the vehicle on campus.

4.28(2) *Employees.* Vehicles owned or operated by employees may be registered with the university if the employee so desires, but registration of these vehicles is not required unless the employee desires parking privileges on the campus. A registration identification shall be displayed on vehicles registered by employees in the manner prescribed by the manager.

4.28(3) *Visitors.* Vehicles owned or operated by visitors may be registered with the university if the visitor so desires, but registration of these vehicles is not required unless the visitor desires parking privileges on campus. A registration identification shall be displayed on registered vehicles by visitors in the manner prescribed by the manager.

4.28(4) *Bicycles.* Any person who rides, parks or propels a bicycle on any university property must display a bicycle identification sticker issued by Iowa State University.

4.28(5) *Procedure.* Applications for registration shall be submitted in the manner prescribed by the manager. No student shall register any vehicle owned or actually maintained by another student.

681—4.29(262) Parking facilities. The manager may set aside and designate certain areas of the campus as parking facilities for vehicles and the use of any part of the parking facilities so established

may be restricted to students, employees or visitors. The manager shall cause signs to be erected and maintained clearly identifying those areas of the campus designated for vehicle parking, and any restrictions applicable thereto shall be conspicuously posted.

4.29(1) *Parking control devices.* Gates and other devices may be installed and maintained to control access to any parking facility.

4.29(2) *Parking meters.* Parking meters, toll houses, and other devices may be installed and maintained to regulate the use of any parking facility.

4.29(3) *Hours of operation.* Reasonable hours shall be established for the normal operation of the parking facilities, and a schedule of hours of operation shall be published and available for public inspection in the office of the manager. Overnight parking is prohibited except in residence hall and vehicle storage parking facilities. Parking regulations remain in effect during semester breaks and seasonal holidays.

4.29(4) *Closing.* The manager may temporarily close any parking facility for cleaning, maintenance, or other university purpose, or may temporarily restrict or reassign the use of any facility as may be necessary or convenient. The manager shall give advance notice of such temporary closing, restriction, or reassignment by posting or otherwise when practical. No parking fees will be refunded during the temporary closing of a parking facility.

4.29(5) *Restricted areas.* The manager is delegated authority to restrict access to campus streets, parking lots and other facilities by means of gates or other barriers. Streets or portions of streets may be closed to vehicle traffic or limited to specific vehicles. Access to restricted areas is limited to established gate openings or designated entrances, and no other means of access is permitted. Moving or driving around authorized barriers is prohibited.

4.29(6) *Restricted zones.* The manager may designate areas of the campus as restricted zones, such as loading zones or service vehicle zones, and the restricted zones shall be conspicuously posted. No parking shall be permitted in restricted zones except as authorized.

4.29(7) *No parking.* Vehicle parking on the campus shall be restricted to designated parking facilities, and no parking shall be permitted at any other place on the campus.

a. Vehicles shall not be parked in such a manner as to block or obstruct sidewalks, crosswalks, driveways, roadways, or designated parking stalls.

b. No parking is permitted in prohibited zones, such as in the vicinity of fire lanes, and these zones shall be conspicuously posted or marked by painted curbs or other standard means.

c. Motor vehicles are not allowed in university buildings except:

- (1) Where a shop or garage is designated as a vehicle repair or storage area;
- (2) Where there is a designated vehicle loading area; or
- (3) Where there is a parking ramp or deck.

d. Illegal parking is parking in any place on campus other than those areas designated for parking.

e. Improper parking is parking incorrectly in designated parking areas. Improper parking includes, but is not limited to:

- (1) Parking in an area restricted by signs;
- (2) Parking without an appropriate permit;
- (3) Parking in an area designated for persons with disabilities;
- (4) Parking in a loading zone over the time limit; and
- (5) Parking over a stall marker line.

4.29(8) *Motorcycle and moped parking.* The manager may designate areas of the parking facilities for motorcycle parking, and these areas shall be conspicuously posted. Motorcycles shall be parked only in areas designated for motorcycle parking, and no other vehicles shall be parked in these areas. The university may require that a parking permit be displayed on all motorcycles and mopeds.

4.29(9) *Bicycle parking.* The manager may install and maintain bicycle parking racks or designate other facilities for bicycle parking. Bicycles shall be parked only in bicycle racks or other facilities designated for bicycle parking. Improperly or illegally parked and abandoned bicycles may be impounded. Locking devices may be cut and removed when necessary. Bicycles may not be taken inside university buildings except as approved by the manager.

681—4.30(262) Parking privileges. Students and employees may be granted parking privileges on the campus in accordance with these rules and upon reasonable terms and conditions as may be established by the manager. An application for parking privileges may be denied if the applicant has fines for parking violations that are unpaid and past the appeal date set by these rules.

4.30(1) Students. Students will be granted parking privileges in parking facilities designated for student use. Optional plans and facilities may be offered as established by the manager. Reasonable classifications may be established on the basis of a student's age, class, college or department, course load, proximity of residence to the campus, physical disability, employment, the availability of facilities, or any other relevant criterion to determine the eligibility of students for parking privileges or any optional plan or facility.

4.30(2) Employees. Employees will be granted parking privileges in parking facilities designated for employee use. Optional plans and facilities may be offered as established by the manager. Reasonable classifications may be established on the basis of an employee's job classification, length of service, place of work or the nature thereof, physical disability, the availability of facilities, or any other relevant criterion to determine the priority of employees for assignment of parking privileges or any optional plan or facility.

4.30(3) Visitors. Visitors may be granted parking privileges in parking facilities designated for visitor parking. Optional plans and facilities may be offered as established by the manager. Reasonable classifications may be established on the basis of the time, duration or purpose of visit, physical disability, the availability of facilities, or any other relevant criterion to determine the eligibility of visitors for parking privileges or any optional plan or facility.

4.30(4) Persons with disabilities. Persons with disabilities will be granted parking privileges in parking facilities designated for use by persons with disabilities. Persons must present a currently valid department of transportation parking permit for persons with disabilities to obtain the campus permit. Parking facilities designated for persons with disabilities shall be so regulated all hours of all days.

4.30(5) Procedure. Applications for parking privileges shall be submitted in the manner prescribed by the manager. No student shall apply for parking privileges for any vehicle owned or actually maintained by another student. The manager shall determine the eligibility and priority of each applicant for parking privileges within the classifications established in 4.30(1), 4.30(2) and 4.30(3) and shall make parking assignments. A parking permit will be issued to each applicant who is granted parking privileges, and the permit shall be displayed on the vehicle in the manner prescribed by the manager. Parking permits are not transferable. The unauthorized possession, use, alteration, forging or counterfeiting of a parking permit, or any portion thereof, is prohibited. Parking privileges will not be granted to a student and to an employee or visitor for the same vehicle, and a student parking permit and an employee or visitor parking permit shall not be displayed on the same vehicle. Temporary parking permits may be issued to accommodate special situations. The manager shall adopt a procedure to replace lost, stolen and destroyed parking permits and controlled access entry cards.

4.30(6) Parking fees. The university may assess and collect from students, employees, and visitors reasonable fees or charges for parking privileges and the use of parking facilities. The amount of these fees and charges shall be approved by the state board of regents. A schedule of all parking fees and charges shall be published and available for inspection during normal business hours in the office of the manager and in the office of the state board of regents. Parking fees and charges may be assessed and collected on an annual, semester, monthly, daily, or hourly basis. Parking fees and charges may be added to student tuition bills and may by agreement be withheld from the salaries or wages of employees by payroll deduction. Parking fees and charges may be collected by means of parking meters or toll houses. Use of any parking facility constitutes an implied agreement to pay the prescribed fee or charge therefor.

4.30(7) University business. Special parking privileges may be granted for vehicles being used on official university business on the conditions and in the manner prescribed by the manager.

4.30(8) Responsibility. Any person who maintains, operates, or owns a vehicle which is on the campus or in whose name the vehicle is registered or parking privileges have been granted is responsible for the proper parking of the vehicle at all times and for all parking violations involving the vehicle.

4.30(9) Liability. Parking privileges granted hereunder constitute a license to use university parking facilities and do not constitute a lease of the facilities or a bailment of the vehicle by the university. Use of university parking facilities is at the owner's or applicant's risk, and the university shall not be liable or responsible for loss of or damage to any vehicle parked on the campus.

4.30(10) Revocation. Parking privileges on the campus may be revoked by the manager for good cause at any time upon five days' written notice and refund of any advance payment of parking fees or charges on a pro rata basis for the revoked period.

[ARC 3877C, IAB 7/4/18, effective 8/8/18]

681—4.31(262) Violations. Sanctions may be imposed for violation of these parking rules as follows:

4.31(1) Notice of violations. The university shall give written notice of all parking violations. Such notice may be given by means of a notice of parking violation placed conspicuously on the offending vehicle, and the notice shall constitute constructive notice of the violation to the owner and operator of the vehicle and to any person in whose name the vehicle is registered or parking privileges have been granted.

4.31(2) Sanction. Reasonable monetary sanctions may be imposed for violation of these rules. The amount of the sanction approved by the board of regents, state of Iowa, is as follows:

<u>Offenses</u>	<u>Sanctions for Each Offense</u>
Altering, forging or counterfeiting any parking permit (4.30(5))	\$150
Unauthorized possession and use of a parking permit (4.30(5))	\$150
Failure to comply with signs regulating campus traffic flow (681—4.27(262))	\$30
Driving on campus walks or lawns (4.27(6), 4.27(8))	\$30
Driving on closed streets (4.27(3))	\$30
Driving on bike paths (4.27(7))	\$30
Access to restricted areas by means other than established gate openings (4.29(5))	\$30
Moving or driving around a barricade (4.29(5))	\$30
Improper use of gate card (681—4.29(262))	\$20
Illegal parking (4.29(7))	\$50
Improper parking (4.29(7))	\$25
Overtime parking at meters (4.29(2))	\$15
Parking without an appropriate permit in a reserved lot or space (681—4.29(262))	\$50
Improper affixing or failure to display a permit (681—4.28(262))	\$5
Failure to purchase a parking receipt (4.29(2))	\$15
Improper parking in a space or stall designated for persons with disabilities (681—4.29(262), 4.30(4))	\$200
Failure to display a current bicycle registration (4.28(4))	\$5
Bicycle improperly parked (4.29(9))	\$7.50
Improper use of roller skates, roller blades or skateboard (4.27(9))	\$25
All other violations	\$15

Violations that continue for more than one hour may receive additional sanctions.

Sanctions may be assessed against the owner or operator of the vehicle involved in each violation or against any person in whose name the vehicle is registered or parking privileges have been granted and may be charged to the violator's university account. Sanctions may be added to student tuition bills or may be deducted from student deposits or from the salaries or wages of employees or from other funds in the possession of the university.

4.31(3) Impoundment. Any vehicle parked on the campus in violation of these rules may be either impounded or removed, or both. A reasonable fee may be charged for the cost of impoundment and

storage, which fee must be paid prior to the release of the vehicle by the university or by contract with private operators. Impounded vehicles which are not claimed within 60 days will be deemed abandoned property and may be sold under procedures set forth in Iowa Code chapter 579, and the proceeds of the sale will be applied to the payment of the costs of impoundment, storage, sale, and amounts due the university. The balance, if any, shall be sent to the owner.

4.31(4) Appeal of sanction or impoundment decisions. A person may request a hearing and administrative ruling concerning a controversy, based on the imposition of a sanction for a registration or parking violation, or an impoundment procedure, by the appropriate university official or hearing body. A written request for a hearing and administrative ruling shall be made at the office of the university's department of public safety within ten business days of the imposition of the sanction. The manager is delegated the authority to establish a procedure, appoint an appropriate official or board, and to adopt forms and schedules to facilitate the provisions of this subrule.

4.31(5) Judicial review. Judicial review of an administrative ruling may be sought in an Iowa district court in accordance with the terms of the Iowa administrative procedure Act.

[ARC 7904B, IAB 7/1/09, effective 8/5/09; ARC 0185C, IAB 6/27/12, effective 8/1/12; ARC 1599C, IAB 9/3/14, effective 10/8/14; ARC 3877C, IAB 7/4/18, effective 8/8/18]

681—4.32(262) Administration of rules. The president of the university shall be responsible for the proper administration of these rules. The president is authorized to establish traffic and parking procedures not inconsistent with these rules as may be reasonably necessary and convenient for the effective administration of the duties hereunder, and any procedure so established shall be published and available for public inspection during the normal business hours in the office of the manager and the office of the board of regents, state of Iowa. The document in which such rules are published shall be known as the Department of Public Safety Parking Division Manual. The president may delegate the authority under these rules to the manager to perform any function or duty hereunder.

Rules 681—4.25(262) to 681—4.32(262) are intended to implement Iowa Code section 262.69.

681—4.33 to 4.65 Reserved.

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UNIVERSITY OF NORTHERN IOWA

681—4.66(262) Purpose. The purpose of these rules is to provide for the policing, control and regulation of parking of vehicles on the campus of the University of Northern Iowa.

681—4.67(262) Definitions. For the purpose of these rules, the following definitions shall apply unless the context clearly requires otherwise, and all other words shall have meaning according to their common usage.

“*Bicycle*” is any two-wheeled vehicle which is not self-propelled and which is designed to be pedaled by the rider.

“*Committee*” refers to the traffic and safety committee at the university.

“*Employee*” is any person regularly employed by the university who is not a student.

“*Motorcycle*” is any vehicle which is self-propelled and has less than four wheels in contact with the ground.

“*Motor vehicle*” is any vehicle which is self-propelled and has four or more wheels in contact with the ground.

“*Student*” is any person registered with the university for academic credit or for short courses or workshops for more than a one-week period.

“*Supervisor*” refers to the supervisor of security at the university or to any other person or persons designated by the president of the university to perform any function or duty of the supervisor hereunder.

“*University*” refers to the University of Northern Iowa, located in Cedar Falls, Iowa.

“*Vehicle*” is any wheeled device used or designed for use as a means of transportation or conveyance of persons or property.

“*Visitor*” is any person who owns, operates, or parks a vehicle on the university campus who is not a student or an employee.

681—4.68(262) Registration. Vehicles shall be registered as follows:

4.68(1) *Students.* Every motor vehicle and motorcycle which is operated or maintained by a student within Black Hawk County, Iowa, which may, at any time, use university parking facilities, must be registered with the university and a registration permit be displayed on the vehicle in the manner prescribed by the supervisor. Any student who operates or maintains a motor vehicle or motorcycle in Black Hawk County or who owns a vehicle which is so operated or maintained and which may, at any time, use university parking facilities, is responsible for the proper registration of such vehicle and the display of the registration permit thereon.

4.68(2) *Employees.* Motor vehicles and motorcycles owned or operated by employees may be registered with the university if the employee so desires, but registration of such vehicles is not required unless the employee desires parking privileges on the campus. A registration permit may be issued for display on vehicles registered by employees.

4.68(3) *Procedure.* Applications for registration shall be submitted to the supervisor in the manner prescribed by the supervisor. No student shall register any vehicle owned or actually maintained by another student.

681—4.69(262) Parking facilities. The university may set aside and designate certain areas of the campus for the parking of motor vehicles, motorcycles, and bicycles, and the use of any lot, ramp, or part of the parking facilities so established may be restricted to students, employees, or visitors. The supervisor shall cause signs to be erected and maintained clearly identifying those areas of the university campus designated for vehicle parking, and any restrictions applicable thereto shall be conspicuously posted.

4.69(1) *Parking control devices.* Gates and other devices may be installed and maintained to control access to any parking facility.

4.69(2) *Parking meters.* Parking meters, toll houses, and other devices may be installed and maintained to regulate the use of any parking facility.

4.69(3) *Hours of operation.* Reasonable hours shall be established for the normal operation of the parking facilities and a schedule of hours of operation shall be published and available for public inspection in the office of the supervisor.

4.69(4) *Closing.* The supervisor may temporarily close any parking facility for cleaning, maintenance, or other university purpose, or may temporarily restrict or reassign the use of any facility

as may be necessary or convenient. The supervisor shall give advance notice of such temporary closing, restriction, or reassignment by posting or otherwise when practical.

4.69(5) *Restricted zones.* The supervisor and committee may designate areas of the campus as restricted zones, such as loading zones or service vehicle zones, and such restricted zones shall be conspicuously posted. No parking shall be permitted in such restricted zones except as authorized.

4.69(6) *No parking.* Vehicle parking on the campus shall be restricted to designated parking facilities, and no parking shall be permitted at any other place on the campus. Vehicles shall not be parked in such a manner as to block or obstruct sidewalks, crosswalks, driveways, roadways, or designated parking stalls. No parking is permitted in prohibited zones, such as in the vicinity of fire hydrants or fire lanes, and such zones shall be conspicuously posted or marked by painted curbs or other standard means.

4.69(7) *Motorcycle parking.* The supervisor and committee may designate areas of the parking facilities for motorcycle parking, and such areas shall be conspicuously posted. Motorcycles shall be parked only in areas designated for motorcycle parking, and no other vehicles shall be parked in such areas.

4.69(8) *Bicycle parking.* The supervisor and committee may install and maintain bicycle parking racks or designate other facilities for bicycle parking. Bicycles shall be parked only in bicycle racks or other facilities designated for bicycle parking.

681—4.70(262) *Parking privileges.* Students and employees may be granted parking privileges on the campus in accordance with these rules and upon such reasonable terms and conditions as may be established by the university.

4.70(1) *Students.* Students may be granted parking privileges in parking facilities designated for student use. Optional plans and facilities may be offered as determined by the supervisor and committee. Reasonable classifications may be established on the basis of a student's age, class, college or department, course load, proximity of the student's residence to the campus, physical disability, employment, the availability of facilities, or any other relevant criterion to determine the eligibility of students for parking privileges or any optional plan or facility.

4.70(2) *Employees.* Employees may be granted parking privileges in parking facilities designated for employee use. Optional plans and facilities may be offered as determined by the supervisor and committee. Reasonable classifications may be established on the basis of an employee's job classification, length of service, place of work or the nature thereof, physical disability, the availability of facilities, or any other relevant criterion to determine the priority of employees for assignment of parking privileges or any optional plan or facility.

4.70(3) *Visitors.* Visitors may be granted parking privileges in parking facilities designated for visitor parking. Optional plans and facilities may be offered as determined by the supervisor and committee. Reasonable classifications may be established on the basis of the time, duration or purpose of the visit, physical disability, the availability of facilities, or any other relevant criterion to determine the eligibility of visitors for parking privileges or any optional plan or facility.

4.70(4) *Procedure.* Applications for parking privileges shall be submitted to the supervisor in the manner the supervisor prescribes. No student shall apply for parking privileges for any vehicle owned or actually maintained by another student. The supervisor shall determine the eligibility and priority of each applicant for parking privileges and shall make all parking assignments. A parking permit or other means of identification may be issued to each applicant who is granted parking privileges, and such permit or other identification must be displayed on the vehicle in the manner prescribed by the supervisor.

4.70(5) *Parking fees.* The university may assess and collect from students, employees, and visitors reasonable fees or charges for parking privileges and the use of parking facilities. The amount of such fees and charges shall be established by the university and approved by the state board of regents, and a schedule of all parking fees and charges shall be published and available for inspection during normal business hours in the office of the director and in the office of the state board of regents. Parking fees and charges may be assessed and collected on an annual, semester, monthly, or hourly basis. Parking fees and charges may be added to student tuition bills and may by agreement be withheld from the salaries

or wages of employees by payroll deduction. Parking fees and charges may be collected by means of parking meters or toll houses. Use of any parking facility constitutes an implied agreement to pay the prescribed fee or charge therefor.

4.70(6) *University business.* Special parking privileges may be granted for vehicles being used on official university business on the conditions and in the manner prescribed by supervisor and committee.

4.70(7) *Responsibility.* Any person who owns or operates a vehicle which is parked on the campus or in whose name the vehicle is registered or parking privileges have been granted is responsible for the proper parking of the vehicle at all times when it is on the campus and for all parking violations involving the vehicle.

4.70(8) *Liability.* Parking privileges granted hereunder constitute a license to use university parking facilities and do not constitute a lease of such facilities or a bailment of the vehicle by the university. Use of the university parking facilities is at the owner's or applicant's risk, and the university shall not be liable or responsible for loss of or damage to any vehicle parked on the campus.

4.70(9) *Revocation.* Parking privileges on the campus may be revoked by the university for good cause at any time upon five days' written notice and refund of any advance payment of parking fees or charges on a pro rata basis for the revoked period.

681—4.71(262) *Violations.* Sanctions may be imposed for violation of registration and parking rules as follows:

4.71(1) *Notice of violations.* The university shall give written notice of all parking or registration violations. Such notice may be given by means of a notice of parking violation placed conspicuously on the offending vehicle, and such notice shall constitute constructive notice of the violation to the owner and operator of the vehicle and to any person in whose name the vehicle is registered or parking privileges have been granted.

4.71(2) *Sanctions.* Reasonable monetary sanctions may be imposed upon students, employees, and visitors for violation of vehicle registration or parking rules. The amount of such sanctions, not to exceed \$50 for each offense, shall be established by the university and approved by the state board of regents except sanctions established by statute will be imposed at the current statutory amount. A schedule of all sanctions for improper registration and parking shall be published and available for public inspection during normal business hours in the office of the supervisor and in the office of the state board of regents. Registration and parking sanctions may be assessed against the owner or operator of the vehicle involved in each violation or against any person in whose name the vehicle is registered or parking privileges have been granted and charged to their university account. Registration and parking sanctions may be added to student tuition bills or may be deducted from student deposits or from the salaries or wages of employees or from other funds in the possession of the university.

4.71(3) *Impoundment.* Any vehicle parked on the campus in violation of parking or registration rules may be impounded and removed. The university shall give written notice of impoundment to the owner of the vehicle or to the person in whose name the vehicle is registered or parking privileges have been granted. A reasonable fee may be charged for the cost of impoundment and storage, which fee must be paid prior to the release of the vehicle. Impounded vehicles which are not claimed within 60 days will be deemed abandoned property and may be sold, under procedures set forth in Iowa Code chapter 579, and the proceeds of the sale will be applied to the payment of the costs of impoundment, storage and sale. The balance, if any, shall be sent to the owner.

4.71(4) *Hearing.* Students and employees may have a hearing on any registration or parking violation. A hearing request shall be submitted to the supervisor in writing within seven days after notice of the violation was given and shall state the grounds of the hearing request. The supervisor may allow additional time within which to request a hearing for good cause shown. Hearings shall be conducted by an impartial committee to be chosen in a manner approved by the president of the university. The person requesting said hearing shall be afforded the opportunity for an administrative hearing by the hearing committee and shall be given reasonable notice of the time and place of the hearing. The decision of the hearing committee shall be final and may be reviewed *de novo* by the district court as provided by law.

681—4.72(262) Effect of rules. These rules constitute a condition of registration as a student at the university and a condition of employment as an employee of the university. Registration as a student or acceptance of employment constitutes an acceptance of these rules and an agreement to pay all prescribed fees and monetary fines imposed in accordance with these rules.

681—4.73(262) Administration of rules. The president of the university shall be responsible for the proper administration of these rules. The president is authorized to establish procedures not inconsistent with these rules as may be reasonably necessary and convenient for the effective administration of presidential duties hereunder, and any procedure so established shall be published and available for public inspection during normal business hours in the office of the supervisor and in the office of the state board of regents. The president may delegate presidential authority under these rules to the supervisor or to any other person designated by the president to perform any function or duty hereunder.

Rules 681—4.66(262) to 681—4.73(262) are intended to implement Iowa Code section 262.69.

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TRANSPORTATION DEPARTMENT[761]

Rules transferred from agency number [820] to [761] to conform with the reorganization numbering scheme in general IAC Supp. 6/3/87.

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CHAPTER 161
HIGHWAY BRIDGE PROGRAM FOR CITIES AND COUNTIES

[Prior to 6/3/87, Transportation Department[820]—(06,Q) Ch 8]

761—161.1(307) Purpose. The purpose of these rules is to establish requirements for the counties' and cities' highway bridge program, in accordance with Iowa Code section 307.44.
[ARC 2425C, IAB 3/2/16, effective 4/6/16; ARC 3878C, IAB 7/4/18, effective 8/8/18]

761—161.2(307) Information. Information relating to this chapter may be obtained from the Office of Local Systems, Iowa Department of Transportation, 800 Lincoln Way, Ames, Iowa 50010; or on the department's website at www.iowadot.gov.
[ARC 2425C, IAB 3/2/16, effective 4/6/16; ARC 3878C, IAB 7/4/18, effective 8/8/18]

761—161.3(307) Source of funds. The Surface Transportation Block Grant Program established in 23 U.S.C. Section 133 provides for the use of federal funds to replace or rehabilitate public road bridges. The department, in consultation with county and city officials through their representative organizations, has dedicated a portion of these funds for replacement and rehabilitation of city and county bridges.
[ARC 2425C, IAB 3/2/16, effective 4/6/16; ARC 3878C, IAB 7/4/18, effective 8/8/18]

761—161.4(313) Swapping of funds. Surface Transportation Block Grant funds allocated to city and county road or bridge construction projects may be swapped with primary road funds in accordance with Iowa Code section 313.4(1).
[ARC 3878C, IAB 7/4/18, effective 8/8/18]

761—161.5(307) Administration of funds. The Highway Bridge Program funds shall be made available for obligation throughout the state on a fair and equitable basis. The department shall administer the program by dividing each fiscal year Highway Bridge Program apportionment into two separate funds: one for counties and one for incorporated cities. The amount allocated to each of the two funds shall be determined by the department after consultation with county and city officials through their representative organizations. This consultation shall precede any change in allocation.

161.5(1) The counties' share shall be administered by the department's office of local systems and shall be divided among the counties as determined by the department after consultation with county officials through their representative organizations.

161.5(2) The cities' share shall be administered by the department's office of local systems and shall be divided among the cities as determined by the department after consultation with city officials through their representative organizations.

[ARC 2425C, IAB 3/2/16, effective 4/6/16; ARC 3878C, IAB 7/4/18, effective 8/8/18]

These rules are intended to implement Iowa Code sections 307.44 and 313.4(1).

[Filed emergency 3/31/83—published 4/27/83, effective 4/1/83]

[Filed 5/11/87, Notice 3/11/87—published 6/3/87, effective 7/8/87]

[Filed 8/7/02, Notice 6/26/02—published 9/4/02, effective 10/9/02]

[Filed ARC 2425C (Notice ARC 2319C, IAB 12/23/15), IAB 3/2/16, effective 4/6/16]

[Filed ARC 3878C (Notice ARC 3777C, IAB 5/9/18), IAB 7/4/18, effective 8/8/18]

CHAPTER 162
SURFACE TRANSPORTATION BLOCK GRANT PROGRAM

761—162.1(307) Purpose. Federal authorization acts appropriate funds to states to support surface transportation investments. A portion of these funds are provided to the state of Iowa for the Surface Transportation Block Grant Program. The purpose of these rules is to establish requirements for the Surface Transportation Block Grant Program.

[ARC 2745C, IAB 10/12/16, effective 10/1/16; ARC 2843C, IAB 12/7/16, effective 1/11/17; ARC 3878C, IAB 7/4/18, effective 8/8/18]

761—162.2(307) Information. Information relating to this chapter may be obtained from the Office of Program Management, Iowa Department of Transportation, 800 Lincoln Way, Ames, Iowa 50010; telephone (515)239-1661; or on the department's website at www.iowadot.gov.

[ARC 2745C, IAB 10/12/16, effective 10/1/16; ARC 2843C, IAB 12/7/16, effective 1/11/17; ARC 3878C, IAB 7/4/18, effective 8/8/18]

761—162.3(307) Source of funds. The Surface Transportation Block Grant Program established in 23 U.S.C. Section 133 provides for the use of federal funds to preserve and improve the condition and performance of any federal-aid highway, bridge or tunnel project on any public road. Surface Transportation Block Grant funds may also be used on pedestrian and bicycle infrastructure and transit capital projects including intercity bus terminals.

[ARC 2745C, IAB 10/12/16, effective 10/1/16; ARC 2843C, IAB 12/7/16, effective 1/11/17; ARC 3878C, IAB 7/4/18, effective 8/8/18]

761—162.4(313) Swapping of funds. Surface Transportation Block Grant funds allocated to city and county road or bridge construction projects may be swapped with primary road funds in accordance with Iowa Code section 313.4(1).

[ARC 3878C, IAB 7/4/18, effective 8/8/18]

761—162.5(307) Administration of funds. Surface Transportation Block Grant funds are administered by the department and shall be made available for obligation throughout the state on a fair and equitable basis. The department, in consultation with city, county and local planning agency officials, through their representative organizations, shall allocate these funds to Iowa's transportation management areas, metropolitan planning organizations, regional planning affiliations, incorporated cities, counties and the department. Allocation of these funds shall be based upon a distribution methodology approved by the commission. The commission shall review and approve the distribution methodology upon passage of each federal authorization act. Funds allocated to cities and counties to support the Federal-Aid Highway Bridge Program shall be made in accordance with 761—Chapter 161. All allocations of the Surface Transportation Block Grant funds shall be made in accordance with the Federal Highway Administration's regulations and include the allocations of the Surface Transportation Program (STP) Set-Aside for transportation alternatives as established in 23 U.S.C. Section 133(h).

[ARC 2745C, IAB 10/12/16, effective 10/1/16; ARC 2843C, IAB 12/7/16, effective 1/11/17; ARC 3878C, IAB 7/4/18, effective 8/8/18]

These rules are intended to implement Iowa Code sections 307.44 and 313.4(1).

[Filed Emergency ARC 2745C, IAB 10/12/16, effective 10/1/16]

[Filed ARC 2843C (Notice ARC 2750C, IAB 10/12/16), IAB 12/7/16, effective 1/11/17]

[Filed ARC 3878C (Notice ARC 3777C, IAB 5/9/18), IAB 7/4/18, effective 8/8/18]

CHAPTER 174
REIMBURSABLE SERVICES AND SUPPLIES

[Prior to 6/3/87, Transportation Department[820]—(06,Q) Ch 9]

761—174.1(307) Purpose. The purpose of these rules is to list highway-related services and supplies that counties and cities may typically request from the department, in accordance with Iowa Code sections 17A.3 and 307.12.

[ARC 2425C, IAB 3/2/16, effective 4/6/16]

761—174.2(307) Contact information. Questions regarding this chapter may be directed to the Office of Local Systems, Iowa Department of Transportation, 800 Lincoln Way, Ames, Iowa 50010.

[ARC 2425C, IAB 3/2/16, effective 4/6/16]

761—174.3(307) Reimbursable services and supplies.

174.3(1) The department may require reimbursement for the services and supplies furnished. If an item to be reimbursed is for a farm-to-market project, the cost of the item will be charged to the county's farm-to-market road fund. The following list is not exhaustive:

a. Structural analysis: The department will provide an initial load-rating analysis for standard bridge types issued by the department. The department will provide a detailed field inspection of an existing structure to determine condition or load-carrying capacity.

b. Hydraulic analysis: The department will review structures in a detailed flood insurance study area, when a culvert will replace a bridge, and when a proposed structure is smaller than the existing structure.

c. Shop inspection: The department will assist with arranging inspection of steel fabrication at the assembly point to determine compliance with plans, specifications and approved shop drawings.

d. Physical testing: The department will provide specialized materials inspection, sampling, and testing when a project has federal funding or when requested for a project that has state assistance and involves work on a primary road. When requested for farm-to-market projects, limited specialized materials inspection, sampling, and testing will be provided.

e. Inspection supplies and equipment repairs: All inspection supplies furnished from warehouse stock shall be paid for by the receiving county or city and shall not be returned for credit. The cost of all equipment repairs performed for a county or city shall be charged to that county or city.

f. Manuals and publications: The department will provide manuals and publications on its website, www.iowadot.gov.

g. Office supplies.

h. Training: The department will provide training on various road subjects for county and city personnel.

i. Tabulation of bids: The department will publish the tabulation of bids for projects let through the department on its website, www.iowadot.gov.

j. Special traffic counts requested by a county or city.

174.3(2) Reserved.

[ARC 2425C, IAB 3/2/16, effective 4/6/16; ARC 3879C, IAB 7/4/18, effective 8/8/18]

These rules are intended to implement Iowa Code sections 17A.3 and 307.12.

[Filed 7/1/75]

[Filed 5/11/87, Notice 3/11/87—published 6/3/87, effective 7/8/87]

[Filed 8/7/02, Notice 6/26/02—published 9/4/02, effective 10/9/02]

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[Filed ARC 3879C (Notice ARC 3776C, IAB 5/9/18), IAB 7/4/18, effective 8/8/18]

AERONAUTICS
CHAPTER 700
AERONAUTICS ADMINISTRATION

761—700.1(328) Definitions. The definitions in Iowa Code section 328.1 and the following definitions shall apply to 761—Chapters 700 to 799.

“*FAA*” means the Federal Aviation Administration.

“*Sponsor*” means the person or governmental subdivision that has the authority for improving, maintaining and operating an aviation facility.

This rule is intended to implement Iowa Code section 328.1.

[ARC 1351C, IAB 3/5/14, effective 4/9/14]

761—700.2(17A) Information and forms. Program information, forms and application instructions are available on the department’s website at www.iowadot.gov. Requests for such materials or assistance may also be made by calling the office of aviation at (515)239-1048. Submission of application materials shall be made according to the annual application instructions included in the application materials. The office of aviation mailing address is: Office of Aviation, Iowa Department of Transportation, 800 Lincoln Way, Ames, Iowa 50010.

This rule is intended to implement Iowa Code section 17A.3.

[ARC 1351C, IAB 3/5/14, effective 4/9/14; ARC 3880C, IAB 7/4/18, effective 8/8/18]

761—700.3(17A) Hearing and appeal process. A person who has been aggrieved by a decision of the department and who is entitled to a hearing may contest the decision in accordance with 761—Chapter 13, Iowa Administrative Code.

This rule is intended to implement Iowa Code chapter 17A.

[Filed 9/2/87, Notice 7/15/87—published 9/23/87, effective 10/28/87]

[Filed 1/15/92, Notice 12/11/91—published 2/5/92, effective 3/11/92]

[Filed emergency 7/1/92—published 7/22/92, effective 7/27/92]

[Filed 12/17/03, Notice 11/12/03—published 1/7/04, effective 2/11/04]

[Filed ARC 1351C (Notice ARC 1270C, IAB 1/8/14), IAB 3/5/14, effective 4/9/14]

[Filed ARC 3880C (Notice ARC 3755C, IAB 4/25/18), IAB 7/4/18, effective 8/8/18]

CHAPTER 710
AIRPORT IMPROVEMENT PROGRAM
[Prior to 6/3/87, Transportation Department [820]—(04,B) Ch 1]

761—710.1(328) Purpose. These rules establish the procedures for a governmental subdivision to apply for state or federal funds for the improvement of airports and air navigation facilities.

This rule is intended to implement Iowa Code sections 328.12 and 330.13.

761—710.2(328) Definitions. The definitions in Iowa Code sections 328.1, 330.1, and 330A.2 apply to this chapter of rules.

This rule is intended to implement Iowa Code sections 328.1, 330.1, and 330A.2.

761—710.3(17A) Information and forms. Program information, forms and application instructions are available on the department's website at www.iowadot.gov. Requests for such materials or assistance may also be made by calling the office of aviation at (515)239-1048. Submission of application materials shall be made according to the annual application instructions included in the application materials. The office of aviation mailing address is: Office of Aviation, Iowa Department of Transportation, 800 Lincoln Way, Ames, Iowa 50010.

This rule is intended to implement Iowa Code section 17A.3.

[ARC 1351C, IAB 3/5/14, effective 4/9/14; ARC 3880C, IAB 7/4/18, effective 8/8/18]

761—710.4(330) Federal airport improvement funds.

710.4(1) Applicant eligibility. A governmental subdivision owning a public airport that is listed in the Federal Aviation Administration's (FAA) National Plan of Integrated Airport Systems (NPIAS) is eligible to apply for federal funds. The NPIAS published report is available at the FAA website: www.faa.gov/airports. An airport that receives federal primary commercial service entitlement funds is not required to submit preapplications.

710.4(2) Project eligibility. Projects must meet the FAA eligibility guidelines for federal airport improvement projects. Federal airport improvement program guidelines are available at the FAA website: www.faa.gov/airports.

710.4(3) Preapplication.

a. The department shall distribute preapplication instructions and forms annually to each eligible applicant.

b. The completed preapplication for federal airport improvement funds shall be submitted to the department according to the method and time frame specified in the annual application instructions.

710.4(4) Project prioritization.

a. The department shall review each completed preapplication for project eligibility and consistency with the state aviation system plan. The department shall review and prioritize projects based on the goals and objectives in the state aviation system plan.

b. The commission is responsible for approving the prioritization of the preapplications.

c. The department shall submit the preapplications with priorities identified to the FAA, and the FAA will contact the applicant directly concerning all subsequent action on the preapplication.

This rule is intended to implement Iowa Code section 330.13.

[ARC 1351C, IAB 3/5/14, effective 4/9/14]

761—710.5(328) State airport improvement funds.

710.5(1) Applicant eligibility. A governmental subdivision owning or establishing a public airport is eligible to apply to the department for state airport improvement funds.

710.5(2) Project eligibility and funding.

a. An airport improvement project must benefit and be accessible to the public.

b. Airport projects may include, but are not limited to: runway, taxiway, and apron surfaces; lighting and navigational aids; obstruction removal; grading, drainage, and surfacing airfield surfaces and protection areas; signage, security access control and lighting; planning; and other airport enhancements.

A project that involves airfield infrastructure shall comply with the airport master plan or airport layout plan as adopted by the governmental subdivision.

c. The department establishes the maximum percentage of state share of eligible projects. The department may annually set a maximum dollar amount per award. Funding criteria are included in application instructions provided to airport sponsors.

710.5(3) *Application for funding.*

a. The department shall make available the application instructions and forms to each publicly owned airport in Iowa. A complete application will include all materials identified in the annual application instructions.

b. Project applications shall be submitted to the department by the due date specified in the instructions.

c. Immediate safety enhancement project applications may be submitted at any time during the year to the department according to instructions that are part of the application form.

d. The department shall make available applications for special projects to all eligible airports. Airport sponsors shall submit applications for special projects to the department as specified in the application instructions.

710.5(4) *Review and approval.* The department shall review each completed application and evaluate the impact of the project on the aviation system considering the following factors: state system plan airport roles, goals and objectives; justification provided in the application; ability to enhance aeronautical activity for the airport and system; local participation; and multijurisdictional support of the airport. The department shall recommend projects to the transportation commission for approval. The commission is responsible for approving the projects to be funded.

710.5(5) *Project administration.*

a. After a project has been approved by the commission, the department shall enter into an agreement with the airport sponsor that specifies the responsibilities of the sponsor.

b. The agreement shall specify the amount of state funds, the contract period, and the responsibilities for project planning, development, and the payment process.

c. The department may inspect the improvement for compliance with the agreement and may audit all project costs incurred.

710.5(6) *Contract payments.*

a. Payments to the airport sponsor for eligible project costs shall be made on a cost reimbursement basis.

b. Engineering fees are an eligible project expense and shall be reimbursed in compliance with the agreement.

This rule is intended to implement Iowa Code chapter 328.

[ARC 1351C, IAB 3/5/14, effective 4/9/14]

[Filed 7/1/75]

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[Filed emergency 7/1/92—published 7/22/92, effective 7/27/92]

[Filed 3/10/94, Notice 1/5/94—published 3/30/94, effective 5/4/94]

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[Filed ARC 1351C (Notice ARC 1270C, IAB 1/8/14), IAB 3/5/14, effective 4/9/14]

[Filed ARC 3880C (Notice ARC 3755C, IAB 4/25/18), IAB 7/4/18, effective 8/8/18]

CHAPTER 715
AIR SERVICE DEVELOPMENT PROGRAM

761—715.1(328) Purpose. The purpose of the air service development program is to help commercial service airports sustain and enhance available air service options for the traveling public.
[ARC 1351C, IAB 3/5/14, effective 4/9/14]

761—715.2(328) Definitions. The definitions in Iowa Code section 328.1 and rule 761—700.1(328) shall apply to this chapter of rules.

761—715.3(328) Eligibility and funding.

715.3(1) Participation in the air service development program shall be limited to airports currently receiving scheduled air service and designated as commercial service airports in the Iowa aviation system plan.

715.3(2) The transportation commission shall establish annually:

a. The maximum amount of funds to be allocated to the air service development program for the program year.

b. The amount to be allocated to each airport for sustainment project activities.

c. The amount of funds that will be added to the enhancement fund pool.

715.3(3) Program information, instructions and application forms may be obtained from the department's website at www.iowadot.gov. Requests for such materials or assistance may also be made by calling the office of aviation at (515)239-1689. Submission of application materials shall be made according to the annual application instructions included in the application materials. The office of aviation mailing address is: Office of Aviation, Iowa Department of Transportation, 800 Lincoln Way, Ames, Iowa 50010.

715.3(4) Allocated program funds shall be available to each commercial service airport for the time period specified in the application instructions and in the agreement.

[ARC 1351C, IAB 3/5/14, effective 4/9/14; ARC 3880C, IAB 7/4/18, effective 8/8/18]

761—715.4(328) Eligible project activities. Activities that are eligible for reimbursement include, but are not limited to, the following:

715.4(1) Activities to sustain or improve air service, which include, but are not limited to, marketing, advocacy, educational efforts and leveraging local and federal funds in collection of data, studies or other efforts.

715.4(2) Service enhancement activities, which include, but are not limited to, market entry support, financial incentives and data analysis studies to help airports enhance service on new routes, provide for entry of a new carrier, or achieve an increase in seat capacity on existing routes.

[ARC 1351C, IAB 3/5/14, effective 4/9/14]

761—715.5(328) Ineligible project activities. Rescinded ARC 1351C, IAB 3/5/14, effective 4/9/14.

761—715.6(328) Project selection criteria. Sustainment projects at each commercial service airport that meet the eligibility criteria may be funded up to the limit of each airport's allocation. Enhancement project requests that meet program requirements may be funded if funding is available in the enhancement fund pool.

[ARC 1351C, IAB 3/5/14, effective 4/9/14]

761—715.7(328) Application. Completed applications shall be submitted to the department and include the information requested in the annual application instructions.

[ARC 1351C, IAB 3/5/14, effective 4/9/14]

761—715.8(328) Project administration.

715.8(1) Agreement. After a project application has been approved, the department shall enter into a project agreement with the airport sponsor that specifies the responsibilities of the sponsor. The

agreement shall specify the amount of state funds, the contract period, the payment process, and the responsibilities for project planning, development, and reporting. The department may inspect the improvement for compliance with the agreement and may audit all project costs.

715.8(2) Project payments. Payments to the airport sponsor for eligible project costs shall be made on a cost reimbursement basis.

[ARC 1351C, IAB 3/5/14, effective 4/9/14]

These rules are intended to implement Iowa Code section 328.12.

[Filed emergency 9/25/87—published 10/21/87, effective 9/25/87]

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[Filed ARC 1351C (Notice ARC 1270C, IAB 1/8/14), IAB 3/5/14, effective 4/9/14]

[Filed ARC 3880C (Notice ARC 3755C, IAB 4/25/18), IAB 7/4/18, effective 8/8/18]

CHAPTER 716
COMMERCIAL SERVICE VERTICAL INFRASTRUCTURE PROGRAM

761—716.1(328) Purpose. The purpose of the commercial air service vertical infrastructure program is to provide funding for improvements to the vertical infrastructure at Iowa's commercial air service airports. The source of funds is an appropriation from the Iowa general assembly.

761—716.2(328) Definitions. The definitions in Iowa Code section 328.1 and rule 761—700.1(328) apply to these rules. In addition:

“Vertical infrastructure” means the same as defined in Iowa Code section 8.57(5).
[ARC 1351C, IAB 3/5/14, effective 4/9/14; ARC 3880C, IAB 7/4/18, effective 8/8/18]

761—716.3(328) Information and forms. Program information, instructions, and forms are available on the department's website at www.iowadot.gov. Requests for such materials or assistance may also be made by calling the office of aviation at (515)239-1048. Submission of application materials shall be made according to the annual application instructions included in the application materials. The office of aviation mailing address is: Office of Aviation, Iowa Department of Transportation, 800 Lincoln Way, Ames, Iowa 50010.
[ARC 1351C, IAB 3/5/14, effective 4/9/14; ARC 3880C, IAB 7/4/18, effective 8/8/18]

761—716.4(328) Eligible airports. Eligible airports are those Iowa airports currently receiving scheduled commercial air service.

761—716.5(328) Eligible project activities. Activities that are eligible for reimbursement include, but are not limited to, the following:

716.5(1) Terminal building construction or renovation including associated design, land acquisition, grading and foundation work.

716.5(2) Hangar construction or renovation including associated design, land acquisition, grading and foundation work.

716.5(3) Maintenance facility building construction or renovation including, but not limited to, associated design, land acquisition, grading and foundation work.

761—716.6(328) Ineligible project activities. Rescinded IAB 1/7/04, effective 2/11/04.

761—716.7(328) Project application and review.

716.7(1) Each airport shall submit an application with the project or projects it intends to accomplish with the allocated funding. The completed application shall include the information and documents identified in the application instructions. The complete application shall be submitted to the department according to the annual application instructions.

716.7(2) The department shall review projects for eligibility and recommend projects and funding levels to the transportation commission. Funding criteria are included in application instructions provided to airport sponsors.

716.7(3) The transportation commission is responsible for approving the projects to be funded.
[ARC 1351C, IAB 3/5/14, effective 4/9/14]

761—716.8(328) Project administration.

716.8(1) Agreement. After the projects are approved by the commission, the department shall enter into an agreement with the airport sponsor that specifies the responsibilities of the sponsor. The agreement shall specify the amount of state funds, the contract period, the payment process, and the responsibilities for project planning, development, and reporting. The department may inspect the improvement for compliance with the agreement and may audit all project costs.

716.8(2) Payments. Payments to the airport sponsor for eligible project costs shall be made on a cost reimbursement basis. Engineering fees are an eligible project expense and shall be reimbursed in compliance with the agreement.

[ARC 1351C, IAB 3/5/14, effective 4/9/14]

These rules are intended to implement Iowa Code sections 8.57(5) and 328.12.

[Filed 10/28/98, Notice 8/26/98—published 11/18/98, effective 12/23/98]

[Filed 12/17/03, Notice 11/12/03—published 1/7/04, effective 2/11/04]

[Filed ARC 1351C (Notice ARC 1270C, IAB 1/8/14), IAB 3/5/14, effective 4/9/14]

[Filed ARC 3880C (Notice ARC 3755C, IAB 4/25/18), IAB 7/4/18, effective 8/8/18]

CHAPTER 717
GENERAL AVIATION VERTICAL INFRASTRUCTURE PROGRAM

761—717.1(328) Purpose. The purpose of the general aviation vertical infrastructure program is to provide funding for improvements to the vertical infrastructure at Iowa’s general aviation airports.
[ARC 1351C, IAB 3/5/14, effective 4/9/14]

761—717.2(328) Definitions. The definitions in Iowa Code section 328.1 and rule 761—700.1(328) apply to these rules. In addition:

“*Vertical infrastructure*” means the same as defined in Iowa Code section 8.57(5).
[ARC 1351C, IAB 3/5/14, effective 4/9/14; ARC 3880C, IAB 7/4/18, effective 8/8/18]

761—717.3(328) Information and forms. Program information, instructions, and application forms may be obtained from the department’s website at www.iowadot.gov. Requests for such materials or assistance may also be made by calling the office of aviation at (515)239-1048. Submission of application materials shall be made according to the annual application instructions included in the application materials. The office of aviation mailing address is: Office of Aviation, Iowa Department of Transportation, 800 Lincoln Way, Ames, Iowa 50010.
[ARC 1351C, IAB 3/5/14, effective 4/9/14; ARC 3880C, IAB 7/4/18, effective 8/8/18]

761—717.4(328) Applicant eligibility. An airport sponsor, as defined in rule 761—700.1(328), of a publicly owned general aviation airport is eligible to apply for funding.
[ARC 1351C, IAB 3/5/14, effective 4/9/14]

761—717.5(328) Eligible project activities. Activities that are eligible for reimbursement include, but are not limited to, the following:

717.5(1) Hangar renovation or construction including associated design, land acquisition, grading and foundation work.

717.5(2) Fuel facilities including associated design, land acquisition, grading and foundation work.

717.5(3) Terminal building renovation or construction including associated design, land acquisition, grading and foundation work.

717.5(4) Relocating an existing hangar, terminal building or fuel facility to correct violations of federal safety or design standards. Work shall include all associated design, land acquisition, grading and foundation work.

761—717.6(328) Ineligible project activities. Rescinded IAB 11/14/01, effective 12/19/01.

761—717.7(328) Funding. The department establishes the maximum percentage of state share of eligible projects. The department may annually set a maximum dollar amount per award. Funding criteria are included in application instructions provided to airport sponsors.
[ARC 1351C, IAB 3/5/14, effective 4/9/14]

761—717.8(328) Project priorities. The department shall consider the following in project selection: airport role and objectives defined in the state aviation system plan; demonstration of increased aeronautical activity; justification for the project; local participation; and multijurisdictional support of the airport.
[ARC 1351C, IAB 3/5/14, effective 4/9/14]

761—717.9(328) Project applications.

717.9(1) The department shall make available application instructions and forms to each publicly owned airport in Iowa. Project applications shall be submitted to the department as directed in the annual application instructions.

717.9(2) Each application shall include the information and forms identified in the annual application instructions.
[ARC 1351C, IAB 3/5/14, effective 4/9/14]

761—717.10(328) Review and approval. Department staff shall review project applications and submit recommendations to the transportation commission. The commission is responsible for approving the projects to be funded.

761—717.11(328) Project administration.

717.11(1) Agreement. After a project has been approved by the commission, the department shall enter into an agreement with the airport sponsor that specifies the responsibilities of the sponsor. The agreement shall specify the amount of state funds, the contract period, the payment process, and the responsibilities for project planning, development, and reporting. The department may inspect the improvement for compliance with the agreement and may audit all project costs.

717.11(2) Payments. Payments to the airport sponsor for eligible project costs shall be made on a cost reimbursement basis. Engineering fees are an eligible project expense and shall be reimbursed in compliance with the agreement.

[ARC 1351C, IAB 3/5/14, effective 4/9/14]

These rules are intended to implement Iowa Code sections 8.57(5) and 328.12.

[Filed 1/20/00, Notice 12/15/99—published 2/9/00, effective 3/15/00]

[Filed 10/24/01, Notice 9/19/01—published 11/14/01, effective 12/19/01]

[Filed 12/14/05, Notice 11/9/05—published 1/4/06, effective 2/8/06]

[Filed ARC 1351C (Notice ARC 1270C, IAB 1/8/14), IAB 3/5/14, effective 4/9/14]

[Filed ARC 3880C (Notice ARC 3755C, IAB 4/25/18), IAB 7/4/18, effective 8/8/18]

RAILROADS

CHAPTER 800

ITEMS OF GENERAL APPLICATION FOR RAILROADS

[Prior to 6/3/87, Transportation Department [820]—(10,A)Ch 1]

761—800.1(307) Definitions. The following terms when used in this division of rules shall have the following meanings:

Crossing. The point where the railroad tracks and highway meet at the same location.

Department. The state department of transportation.

Railroad. Persons who own rail facilities or who are responsible for their operation and maintenance.

This rule is intended to implement Iowa Code sections 307.1 and 307.26.

761—800.2(17A) Location and submission of documents. All documents concerning railroad matters which, according to statute or rule, must be submitted to the department shall be submitted to the following address: Office of Rail Transportation, Iowa Department of Transportation, 800 Lincoln Way, Ames, Iowa 50010.

This rule is intended to implement Iowa Code section 17A.3.

761—800.3(327C) Accounts. All railroads operating in Iowa, except those whose accounts are regulated by the Surface Transportation Board, shall maintain accounts using the generally accepted accounting principles of the financial standards accounting board. The accrual method of accounting shall be used.

This rule is intended to implement Iowa Code section 327C.42.

761—800.4(327C) Annual reports.

800.4(1) A railroad company submitting an annual report to the Surface Transportation Board under 49 CFR Part 1241 shall submit a copy of this report to the department on or before April 1 following the close of the calendar year. Included with this report shall be a “State Statistics” report which shall include the following: annual data on additions and deletions of mileage within the state; mileage operated within the state at the end of the year; railway operating revenues earned within the state; statistics on rail line operations within the state including locomotive unit-miles, car-miles and ton-miles; revenue freight carried within the state by commodity class; and a freight density map showing gross ton-miles for the railroad company’s system within the state.

800.4(2) A railroad company not required to submit an annual report to the Surface Transportation Board under 49 CFR Part 1241 shall submit an annual report to the department on Form 010030 on or before April 1 following the close of the calendar year.

This rule is intended to implement Iowa Code sections 327C.38 and 327C.41.

[ARC 3881C, IAB 7/4/18, effective 8/8/18]

761—800.5 to 800.14 Reserved.

761—800.15(327F) Train speed ordinances. An ordinance or resolution adopted by a political subdivision which relates to the speed of a train in an area within the jurisdiction of the political subdivision is subject to department approval according to the following procedure:

800.15(1) The political subdivision shall submit the ordinance/resolution to the department supported by information or reasons that justify its approval by the department.

800.15(2) The department shall notify the affected railroads.

800.15(3) The political subdivision and the affected railroads shall have 30 days in which to submit position papers to the department before the department issues an order approving or disapproving the ordinance/resolution.

800.15(4) The department shall issue an order approving or disapproving the ordinance/resolution in accordance with the following:

a. The department may approve the proposed ordinance/resolution only if the proposal satisfies the requirements of 49 U.S.C. 20106: (1) it is necessary to eliminate or reduce a local safety hazard; (2) it is not incompatible with a federal law, regulation or order; and (3) it does not unreasonably burden interstate commerce.

b. Generally, the department does not consider highway-railroad grade crossings or rail lines located near schools, residences, or commercial activities to be local safety hazards that can be remedied by train speed restrictions.

c. In making its decision, the department may also consider the following factors:

- (1) Traffic density and speed.
- (2) Accident frequency.
- (3) Causes of accidents.
- (4) Obstructions to visibility.
- (5) Traffic controls at crossings.
- (6) Population density.
- (7) Resulting burden on the rail transportation system.
- (8) Resulting benefit to residents of the political subdivision.

800.15(5) The department shall mail notice of its order approving or disapproving the ordinance/resolution by certified mail, return receipt requested, to the political subdivision and the affected railroads.

800.15(6) If the department issues an order approving the ordinance/resolution, it shall go into effect 25 days after the notice is mailed unless the order is contested pursuant to subrule 800.15(7).

800.15(7) Within 20 days after the notice is mailed, the political subdivision or an affected railroad may submit to the department a written statement contesting the department's order approving or disapproving the ordinance/resolution.

a. If the order is contested, 761—Chapter 13 applies.

b. If an order approving an ordinance/resolution is contested, the order shall be stayed pending the outcome of the contested case.

800.15(8) A submission to the department under this rule shall be deemed timely submitted if it is delivered or postmarked within the time period specified.

This rule is intended to implement Iowa Code section 327F.31 and 2002 Iowa Op.Att'yGen. _____ (#01-5-2).

761—800.16 to 800.19 Reserved.

761—800.20(327G) Removal of tracks from crossings.

800.20(1) 49 CFR Part 1152 contains the regulations governing the abandonment and discontinuance of railroad lines and rail transportation under 49 U.S.C. 10903 et seq. This part also contains the regulations and procedures for the acquisition or use of railroad rights-of-way proposed for abandonment for interim trail use and rail banking pursuant to 16 U.S.C. 1247(d).

For the purpose of this rule, this part is adopted as of October 1, 2017.

800.20(2) A railroad corporation or its successor in interest having received authority to remove its tracks from a rail line pursuant to abandonment or interim trail use under 49 CFR Part 1152 shall, at the same time it removes its tracks from the railroad rights-of-way, remove its tracks from the crossings of highways, streets and alleys along the rail line and restore the surface of these crossings. A crossing shall be restored in a manner specified by the agency having jurisdiction over the highway, street or alley at the crossing.

800.20(3) If a railroad corporation or its successor in interest fails to remove its tracks from and restore the surface of a crossing as specified in subrule 800.20(2), then the agency having jurisdiction over the highway, street or alley at the crossing may, at the expense of the railroad corporation or its

successor in interest, remove the tracks and restore the surface 120 days after the tracks adjacent to the crossing have been removed.

This rule is intended to implement Iowa Code section 327G.24.
[ARC 3881C, IAB 7/4/18, effective 8/8/18]

761—800.21(327G) Federal citations. Copies of the federal code or regulations cited in this chapter are available from the state law library or online at www.gpo.gov.

This rule is intended to implement Iowa Code section 327G.24.
[ARC 3881C, IAB 7/4/18, effective 8/8/18]

[Filed 8/24/82, Notice 7/7/82—published 9/15/82, effective 10/20/82]

[Filed 10/2/85, Notice 8/14/85—published 10/23/85, effective 11/27/85]

[Filed 5/11/87, Notice 3/11/87—published 6/3/87, effective 7/8/87]

[Filed 5/19/89, Notice 3/8/89—published 6/14/89, effective 7/19/89]

[Filed 8/8/90, Notice 6/27/90—published 9/5/90, effective 10/10/90]

[Filed 7/15/03, Notice 5/14/03—published 8/6/03, effective 9/10/03]

[Filed ARC 3881C (Notice ARC 3756C, IAB 4/25/18), IAB 7/4/18, effective 8/8/18]

CHAPTER 802
NOTIFICATION OF RAILROAD ACCIDENTS/INCIDENTS
[Prior to 6/3/87, Transportation Department [820]—(10,B)Ch 6]

761—802.1(327C) Written reports.

802.1(1) *When required.* A railroad filing with the Federal Railroad Administration any of the forms listed in subrule 802.1(2) shall, at the same time, file a copy with the department at the following address if the accident or incident occurred in Iowa: Office of Rail Transportation, Iowa Department of Transportation, 800 Lincoln Way, Ames, Iowa 50010.

802.1(2) *Forms.* This rule applies to the following Federal Railroad Administration forms:

FRA F 6180.54 — Rail Equipment Accident/Incident Report

FRA F 6180.57 — Rail-Highway Grade Crossing Accident/Incident Report

This rule is intended to implement Iowa Code section 327C.41.

[ARC 3882C, IAB 7/4/18, effective 8/8/18]

761—802.2(327C) Notification of railroad accidents/incidents.

802.2(1) *Accidents or incidents requiring notification.* Any accident/incident involving train movement which results in any of the following shall be reported within four hours of the accident/incident to the department:

- a. Fatality.
- b. Personal injury requiring hospitalization.
- c. Derailment of ten or more rail cars and locomotives.
- d. Derailment of any number of cars or locomotives when one or more are not upright.
- e. Derailment or other incident involving a railroad passenger train.
- f. Release or potential release of hazardous materials that presents a risk or potential risk to public safety including injury, fatality, evacuation or shelter-in-place of persons.
- g. Damage to public or private transportation infrastructure not owned by the involved railroad.

802.2(2) *Content of notice.* The notice of an accident/incident shall provide, at a minimum, the following information:

- a. Name of the railroad involved.
- b. Name and contact information of the individual calling to file the notice.
- c. Date and time the accident/incident occurred.
- d. Location of the accident/incident, described as accurately as possible, including the nearest city and the U.S. DOT crossing identification number or railroad milepost.
- e. Description of the accident/incident.
- f. Impact on motor vehicle travel, if known.
- g. Number of injuries and fatalities.
- h. Hazardous materials involved in the incident and actions taken in the event of a release.
- i. Number of rail cars derailed.

802.2(3) *Method of notification.* The notice shall be made to the department's traffic management center by telephone at (515)237-3300 (open year-round, 24 hours a day, including legal holidays).

This rule is intended to implement Iowa Code sections 327C.37 and 327C.41.

[ARC 3882C, IAB 7/4/18, effective 8/8/18]

[Filed 8/24/82, Notice 7/7/82—published 9/15/82, effective 10/20/82]

[Filed 10/2/85, Notice 8/14/85—published 10/23/85, effective 11/27/85]

[Filed 5/11/87, Notice 3/11/87—published 6/3/87, effective 7/8/87]

[Filed 8/26/88, Notice 7/13/88—published 9/21/88, effective 10/26/88]

[Filed 1/10/90, Notice 11/29/89—published 2/7/90, effective 3/14/90]

[Filed 1/15/92, Notice 12/11/91—published 2/5/92, effective 3/11/92]

[Filed 7/15/03, Notice 5/14/03—published 8/6/03, effective 9/10/03]

[Filed ARC 3882C (Notice ARC 3757C, IAB 4/25/18), IAB 7/4/18, effective 8/8/18]

CHAPTER 810
RAILROAD SAFETY STANDARDS
[Prior to 6/3/87, Transportation Department [820]—(10,B)Ch 1]

761—810.1(327C) Track safety standards.

810.1(1) Standards. The department adopts the railroad track safety standards contained in 49 CFR Part 213 (October 1, 2017).

810.1(2) Obtaining copies of regulations. Copies of the federal regulations are available from the state law library or online at www.gpo.gov.

This rule is intended to implement Iowa Code sections 307.26 and 327C.4.
[ARC 3881C, IAB 7/4/18, effective 8/8/18]

761—810.2(327C) Track inspection.

810.2(1) Credentials required. Authorized departmental employees shall be admitted to any railroad property to conduct safety inspections of the track and track structures and shall present state identification cards upon request.

810.2(2) Measurement tools and vehicles. Rescinded IAB 8/6/03, effective 9/10/03.

This rule is intended to implement Iowa Code section 327C.4.

761—810.3 Reserved.

761—810.4(327F) First aid and medical treatment for railroad employees.

810.4(1) Railroad employees who are injured in the course of employment shall have reasonable and adequate access to first aid or medical treatment. A railroad or railroad employee shall not:

a. Deny, delay or interfere with first aid or medical treatment for any railroad employee who is injured in the course of employment.

b. Discipline or threaten to discipline any railroad employee for requesting first aid or medical treatment when the employee is injured in the course of employment.

810.4(2) All railroads operating in the state must make reasonable efforts to have emergency first-aid kits available at locations where railroad employees perform their employment duties.

810.4(3) Nothing in this rule shall be construed to require a railroad or railroad employee to perform first aid or medical care.

This rule is intended to implement Iowa Code section 327F.38.

761—810.5(327F) Worker transportation motor vehicle equipment.

810.5(1) Heater requirement. Pursuant to Iowa Code subsection 327F.39(4), a motor vehicle used to transport railroad workers shall be equipped with a heating system that maintains a reasonable comfort level in the vehicle spaces where the workers are required to ride. The heating system shall comply with the safety standards established in 49 CFR 393.77, as adopted in rule 761—520.1(321).

810.5(2) Report procedure.

a. A person shall report an alleged violation in writing to the responsible railroad company at its corporate headquarters.

b. If within 30 days the railroad company does not respond or if the response is unsatisfactory, the person may report the alleged violation to the department at the following address: Office of Rail Transportation, Iowa Department of Transportation, 800 Lincoln Way, Ames, Iowa 50010.

c. The report shall include the date, time, weather conditions and all facts pertinent to the alleged violation. The report shall also include a copy of the railroad's response or, if the railroad failed to respond, proof of the date the report was submitted to the railroad.

d. The director of the office of rail transportation or the director's designee may request additional information from the person submitting the report, the railroad worker transportation company or the railroad.

e. The director of the office of rail transportation or the director's designee, which may include peace officers in the office of motor vehicle enforcement, may investigate the alleged violation.

f. The director of the office of rail transportation or the director's designee shall issue a decision within 20 days of receipt of the report or 20 days after receipt of the requested additional information. The decision may include any order as necessary to enforce the requirements of Iowa Code section 327F.39, as set forth in Iowa Code section 327F.39(6).

g. The department shall notify the person and the railroad of the decision.

h. The decision is final agency action.

This rule is intended to implement Iowa Code section 327F.39.
[ARC 3881C, IAB 7/4/18, effective 8/8/18]

761—810.6(327F) Worker transportation rest periods.

810.6(1) Requirements. A railroad worker transportation company and railroad worker transportation company driver shall comply with the rest period requirements of Iowa Code sections 321.449A and 327F.39(5).

810.6(2) Report procedure.

a. A person shall report an alleged violation in writing to the department at the following address: Office of Rail Transportation, Iowa Department of Transportation, 800 Lincoln Way, Ames, Iowa 50010.

b. The report shall include the date, time, circumstances and any evidence of an alleged violation, and the name and contact information of the driver employed by the railroad worker transportation company or the railroad worker transportation company alleged to require a driver to violate the provisions of Iowa Code section 321.449A or 327F.39(5).

c. The director of the office of rail transportation or the director's designee may request additional information from the driver, railroad worker transportation company or railroad.

d. The director of the office of rail transportation or the director's designee, which may include peace officers in the office of motor vehicle enforcement, may investigate the alleged violation.

e. The director of the office of rail transportation or the director's designee shall issue a decision within 60 days of receipt of the report or 60 days after receipt of the requested additional information. The decision may include any order as necessary to enforce the requirements of Iowa Code section 327F.39, as set forth in Iowa Code section 327F.39(6).

f. The department shall notify the driver and the railroad worker transportation company of the decision.

g. The decision is final agency action.

This rule is intended to implement Iowa Code sections 321.449A and 327F.39.
[ARC 3881C, IAB 7/4/18, effective 8/8/18]

[Filed 8/24/82, Notice 7/7/82—published 9/15/82, effective 10/20/82]

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[Filed 5/11/87, Notice 3/11/87—published 6/3/87, effective 7/8/87]

[Filed 8/26/88, Notice 7/13/88—published 9/21/88, effective 10/26/88]

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[Filed 7/15/03, Notice 5/14/03—published 8/6/03, effective 9/10/03]

[Filed 5/11/05, Notice 3/16/05—published 6/8/05, effective 7/13/05]

[Filed ARC 3881C (Notice ARC 3756C, IAB 4/25/18), IAB 7/4/18, effective 8/8/18]

CHAPTER 813
CLOSE-CLEARANCE WARNING SIGNS ALONG RAILROAD TRACKS

761—813.1(327F) Purpose and scope. This chapter implements Iowa Code section 327F.13. This statute requires the Iowa department of transportation (department) to implement the placement of close-clearance warning signs along railroad tracks where the close clearance between the tracks and an obstruction physically impedes a person who is lawfully riding the side of a train from clearing the obstruction. This chapter only applies when funds are available from the department to reimburse the owner for the cost of the close-clearance warning sign and installation.

[ARC 8202B, IAB 10/7/09, effective 11/11/09]

761—813.2(327F) Applicability. This chapter applies to railroad companies as well as industries, agricultural cooperatives or other entities that are owners of a railroad track, and it applies to individuals who are owners of a railroad track. This chapter does not apply to any railroad locations where locomotives are powered by overhead or suspended electric power.

[ARC 8202B, IAB 10/7/09, effective 11/11/09]

761—813.3(327F) Information. Information regarding this chapter is available from the Office of Rail Transportation, Iowa Department of Transportation, 800 Lincoln Way, Ames, Iowa 50010; telephone (515)239-1140.

[ARC 8202B, IAB 10/7/09, effective 11/11/09]

761—813.4(327F) Definitions.

“*Close clearance*” means a permanent or temporary situation where an obstruction near a railroad track physically impedes a person who is lawfully riding the side of a train from clearing the obstruction. Rule 761—813.5(327F) provides further detail on the dimensions that identify a close-clearance situation.

“*Obstruction*” means a building, machinery (other than equipment designed for operation on a railroad track when actually located on a railroad track), tree, brush or other object.

“*Owner*” means the railroad company, industry, agricultural cooperative, other entity, or individual that holds a fee simple title, easement, leasehold, contract to purchase, license, or other legal or equitable interest or right in the railroad track, and is in primary possession and control of the railroad track.

“*Tangent track*” means a track segment without any curves.

[ARC 8202B, IAB 10/7/09, effective 11/11/09]

761—813.5(327F) Close-clearance dimensions.

813.5(1) Close clearance for tangent track is a location along the railroad track where there is an obstruction that falls within the following dimensions: starting at the centerline of track at top of rail and extending 5 feet both sides horizontally and level therewith, thence upward vertically 15 inches, thence upward diagonally to a point 4 feet above top of rail and 8 feet laterally from centerline of track, thence vertically to a point 20 feet above top of rail, thence diagonally to a point 6 feet from centerline of track and 22 feet above top of rail, thence horizontally to centerline of track. Vertical clearance shall be 18 feet above top of rail at the entrance to and inside buildings. On curved track, clearances on each side of the track centerline shall be increased 1½ inches per degree of curvature. (See Figure 1.)

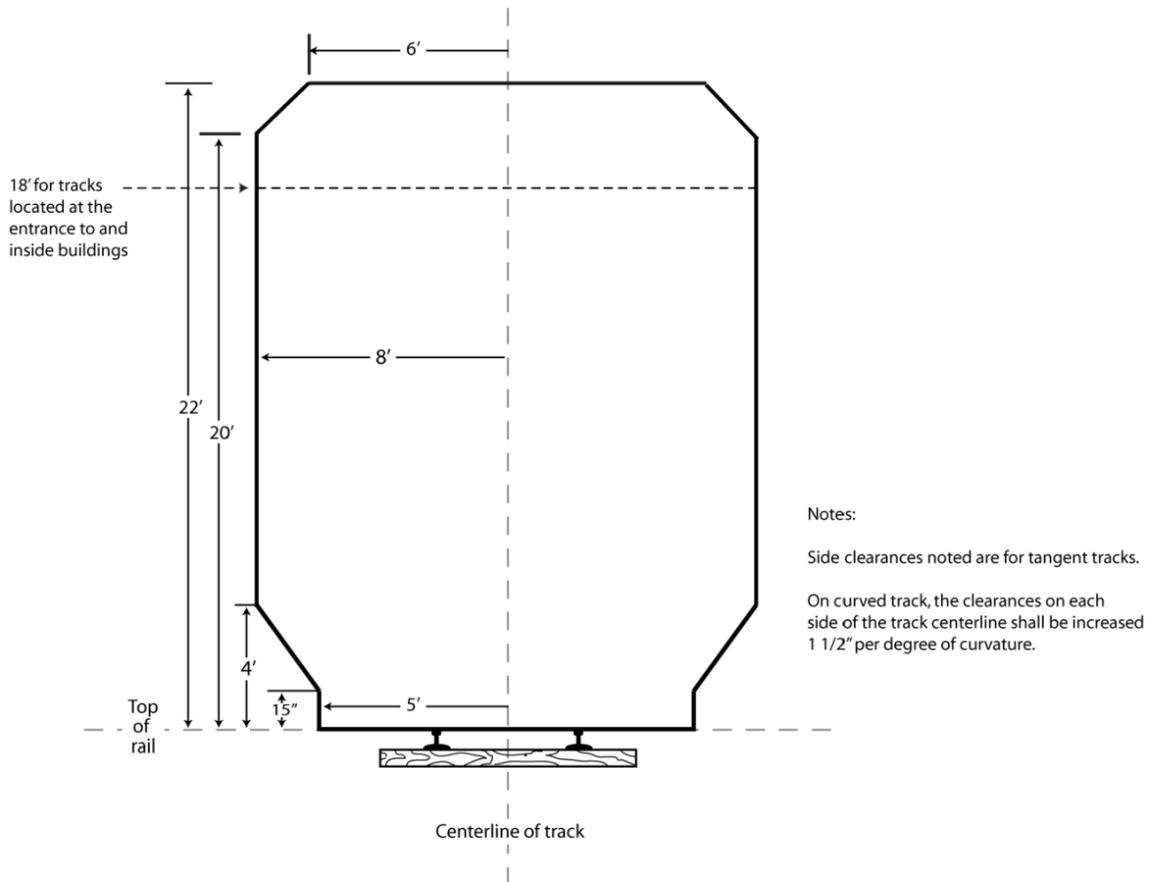


Figure 1

813.5(2) Reserved.

[ARC 8202B, IAB 10/7/09, effective 11/11/09]

761—813.6(327F) Signing requirements.

813.6(1) A close-clearance warning sign or signs are required at all locations where there is close clearance. It is the responsibility of the owner to ensure that all close-clearance locations have warning signs.

813.6(2) If an obstruction creating a close-clearance situation is a temporary or nonpermanent obstruction, in lieu of signing the owner may meet the requirements of this rule by opting to remove the obstruction or remove the track from service until the obstruction is removed.

813.6(3) A close-clearance warning sign shall be placed in a location that provides adequate notice to a person who is lawfully riding the side of a train so that the person may prepare for the close clearance.

813.6(4) A close-clearance warning sign shall comply with the following requirements. A warning sign shall:

- a. Include the words "no clearance." The letters must be black on a white reflective background and be a minimum of 3 inches high.
- b. Be a vertical sign not less than 42 inches in height and 4 inches in width.
- c. Be placed at least 1 foot off the ground or on the obstruction and within 3 feet of the close-clearance location or on the obstruction. Signs shall be located on both sides of the obstruction so as to be visible from both directions.
- d. Not be within 8 feet of the centerline of the tracks.

813.6(5) In the event that the placement of the close-clearance warning sign according to paragraph 813.6(4) "c" or 813.6(4) "d" does not provide adequate notice for a person who is lawfully riding the side of a train to prepare for the close clearance (such as a curve or other sight obstruction), an additional sign

reading “no clearance ahead” shall be placed in a location that provides adequate notice to the person who is lawfully riding the side of the train so that the person may prepare for the close clearance. Depending on the particular environment that makes an additional no clearance ahead sign necessary, a no clearance ahead sign may be required on one or on both sides of the obstruction so as to be visible from both directions.

813.6(6) In the event that the physical environment prevents the placement of a warning sign in accordance with paragraph 813.6(4)“c” or 813.6(4)“d,” the sign shall be placed in a highly visible location that is clearly indicative of the point of close clearance. An alternative size and shape of sign may be used if there is no location available where a standard size and shape sign may be used. Any alternative sign must clearly be identifiable as an indicator of the close-clearance situation.

813.6(7) In limited situations where multiple instances of insufficient clearance occur within a confined area or over a distance, and where posting of multiple warning signs could on its own be a safety hazard, or where multiple signs would create a confusing environment making it difficult to discern the areas that lack clearance, a sign reading “no clearance ahead” may be posted in lieu of multiple signs.

813.6(8) A line or other marker shall be maintained at a distance of 8 feet from the centerline of the track on all platforms, excluding passenger platforms, to indicate the space along the edge of such platform that shall be kept clear of merchandise, material, or other articles that could create a temporary close-clearance situation.

813.6(9) Placement of a warning sign does not relieve the owner from any duties required under Iowa Code chapter 317 or Iowa Code section 327F.27.
[ARC 8202B, IAB 10/7/09, effective 11/11/09]

761—813.7 and 813.8 Reserved.

761—813.9(327F) Enforcement.

813.9(1) If the owner is provided written notice by an employee, a person working on or near the tracks, or a railroad inspector that a location is in need of a close-clearance warning sign, the owner shall investigate and, if warranted, ensure the placement of a warning sign or signs within 30 calendar days of notification. If a close-clearance warning sign is not warranted, the owner shall inform the person who provided notice, in writing within 30 calendar days, that a sign is not warranted and shall explain why the location does not need a close-clearance warning sign.

813.9(2) If the owner fails to respond to a written notice by an employee or another person working on or near the tracks, or if the employee or other person disagrees with the owner’s determination that a warning sign is not warranted, the employee or other person may notify the department. The department shall investigate and make a determination if the location warrants the placement of a close-clearance warning sign.

a. If the department determines a close-clearance warning sign is warranted, the department shall notify the owner in writing. The owner shall have 14 calendar days from the date of the notification to install the proper warning sign. Failure to install the close-clearance warning sign is evidence that the owner is in violation of Iowa Code section 327F.13.

b. The owner, an employee or a person working on or near the tracks may contest the determination. If the determination is contested, 761—Chapter 13 applies.

[ARC 8202B, IAB 10/7/09, effective 11/11/09]

761—813.10(327F) Reimbursement.

813.10(1) The owner may request reimbursement from the department for up to \$100 per sign for the cost and installation of the close clearance or no clearance ahead warning sign.

813.10(2) To be reimbursed, the owner shall complete Form 291303, “Close-Clearance Warning Sign Certification,” and submit the form to the office of rail transportation. The owner must certify that the warning sign complies with the requirements in rule 761—813.6(327F) and provide proof of purchase.

813.10(3) The department may inspect, at any time, the sign installation to confirm that the warning sign meets the minimum requirements in rule 761—813.6(327F).

813.10(4) Form 291303 is available on the department's website at www.iowadot.gov or from the office of rail transportation.

[ARC 8202B, IAB 10/7/09, effective 11/11/09; ARC 3881C, IAB 7/4/18, effective 8/8/18]

These rules are intended to implement Iowa Code section 327F.13.

[Filed ARC 8202B (Notice ARC 7885B, IAB 7/1/09), IAB 10/7/09, effective 11/11/09]

[Filed ARC 3881C (Notice ARC 3756C, IAB 4/25/18), IAB 7/4/18, effective 8/8/18]

CHAPTER 822
RAILROAD REVOLVING LOAN AND GRANT FUND PROGRAM
[Prior to 7/1/09, see 765—Ch 5]

761—822.1(327H) Introduction and purpose. The railroad revolving loan and grant fund program provides funding in the form of loans and grants for railroad-related improvement projects. The purpose of the program is to spur economic development and job growth and provide benefits to Iowa through economic benefits derived from railroad transportation system or service improvements. The railroad revolving loan and grant fund is established in Iowa Code section 327H.20A and is under the control of the department.

[ARC 7909B, IAB 7/1/09, effective 7/1/09; ARC 3883C, IAB 7/4/18, effective 8/8/18]

761—822.2(327H) Definitions.

“*Rail facilities*” includes railroad main lines, branch lines, switching yards, sidings, rail connections, transload yards, intermodal yards, highway grade separations, railroad bridges, railroad scales and other railroad infrastructure.

“*Rail port*” means a commercial or industrial development that has the potential to provide rail service to multiple users through shared rail infrastructure, including transload or intermodal yards.

[ARC 7909B, IAB 7/1/09, effective 7/1/09; ARC 3883C, IAB 7/4/18, effective 8/8/18]

761—822.3(327H) Information. Program information and application forms are available on the department’s website at www.iowadot.gov. Completed applications shall be submitted as directed in the application materials. Assistance may be obtained at the following address: Office of Rail Transportation, Iowa Department of Transportation, 800 Lincoln Way, Ames, Iowa 50010; telephone (515)239-1066.

[ARC 7909B, IAB 7/1/09, effective 7/1/09; ARC 3883C, IAB 7/4/18, effective 8/8/18]

761—822.4(327H) Purpose of program. Rescinded ARC 3883C, IAB 7/4/18, effective 8/8/18.

761—822.5(327H) Funding.

822.5(1) The transportation commission is responsible for determining the projects to be funded and the amount of funding for each project.

822.5(2) The minimum amount of matching funds required of an applicant is 20 percent of the project cost.

822.5(3) Rescinded IAB 7/1/09, effective 7/1/09.

[ARC 7909B, IAB 7/1/09, effective 7/1/09]

761—822.6(327H) Project criteria. Rescinded ARC 3883C, IAB 7/4/18, effective 8/8/18.

761—822.7(327H) Applicant eligibility. A railroad company, railroad user, city, county, metropolitan planning organization, regional planning affiliation, or any other entity with an interest in a rail transportation improvement is eligible to apply for funding. The applicant shall be fiscally responsible for any awarded loans or grants. Joint applications are allowed and encouraged, but joint applications shall designate one entity that shall be fiscally responsible for any awarded loans or grants.

[ARC 7909B, IAB 7/1/09, effective 7/1/09; ARC 3883C, IAB 7/4/18, effective 8/8/18]

761—822.8(327H) Eligible and ineligible project costs.

822.8(1) Eligible costs. Activities or items eligible for funding include, but are not limited to, the following:

- a. Modernization, upgrading or reconstruction of existing rail facilities or rail ports.
- b. Construction of new rail facilities or rail ports.
- c. Railroad bridge and culvert modernization, replacement or removal.
- d. Right-of-way acquisition costs.
- e. Feasibility studies or planning studies for proposed projects that are otherwise eligible.

f. Loan development costs that a Class II or III railroad may have in obtaining a loan for a project that would have otherwise qualified under this chapter.

822.8(2) Ineligible costs.

a. The following activities or items are ineligible for funding:

- (1) Contract administration.
- (2) Freight car or locomotive lease, purchase or repair.
- (3) Refinancing of a completed project that would have otherwise qualified under this chapter.
- (4) Facilities solely used for historical or tourist railroad activities.
- (5) Capital or operating costs associated with passenger rail, commuter rail or public transit.
- (6) Acquisition or capital costs associated with recreational trails.

b. The following costs are ineligible unless the costs are part of a larger construction award under this program:

- (1) Design and engineering.
- (2) Environmental studies.
- (3) At-grade crossing surface repair or replacement.
- (4) Signals, gates or other crossing protection.

822.8(3) Advance eligibility exemption. No part of a project may be under construction prior to a signed and executed agreement. Certain preliminary costs may be eligible for an advance eligibility exemption, if the exemption is requested in writing and granted by the department in writing. If granted, an exemption will permit a specified expenditure by the applicant without jeopardizing the project's eligibility for future funding approval. Granting an exemption shall not imply or guarantee that the department will fund a subsequent application. An advance eligibility exemption must be requested and approved prior to the expenditure; any cost incurred before a written exemption is granted will be ineligible for reimbursement.

[ARC 7909B, IAB 7/1/09, effective 7/1/09; ARC 3883C, IAB 7/4/18, effective 8/8/18]

761—822.9 Reserved.

761—822.10(327H) Project application.

822.10(1) Submission. Applications may be submitted at any time and will be held until the next evaluation cycle.

a. A notice of funding availability will be published on the department's website when funding is available. The notice will include the approximate amount of funding available and a deadline for consideration of applications.

b. An applicant shall submit the appropriate application on the prescribed forms either electronically to the email address included in the application or to the address in rule 761—822.3(327H).

c. If an application is incomplete, department staff shall return the application to the applicant to be resubmitted when it is complete.

d. An application may be withdrawn at any time after submission.

822.10(2) Contents of application. Each application shall contain the following:

a. The applicant's name, address, telephone number, facsimile number and email address (if available) and the name of a designated contact person for the project.

b. A detailed description of the project proposed for funding, including a location map and a project plan or drawing.

c. The justification for the project, including the following information:

- (1) The need for and purpose of the project.
- (2) Specific information demonstrating that the proposed project will provide benefits to Iowa in terms of direct economic development and job growth or retention or through economic transportation or other benefits derived from railroad transportation system or service improvements. Benefits are to be quantified whenever possible.

d. An itemized estimate of all project or planning study costs and the proposed match or cost sharing based on the requested funding. A detailed financial plan to explain the funding for the entire project should be included, along with any associated development costs.

e. A time schedule for the completion of the project.

f. The total amount of loan and grant funds requested.

g. If loan funds are requested, a detailed description of the applicant's ability to repay the loan. Department staff may require the applicant to provide audited financial statements for the past two years plus a current balance sheet and profit/loss statement for the entity that is to repay the loan. If the entity that is to repay the loan is a new entity, the applicant shall, instead, provide a pro forma balance sheet and pro forma profit/loss statement.

h. If requested by department staff, endorsement of the project by a local government(s) that will be affected by the project and a description of how the project will impact the local government's transportation and economic development plans.

i. If the project is a new or expanded development, a letter from the serving railroad(s) indicating that the railroad(s) will serve the planned development.

[ARC 7909B, IAB 7/1/09, effective 7/1/09; ARC 3883C, IAB 7/4/18, effective 8/8/18]

761—822.11(327H) Project evaluation and approval.

822.11(1) Staff review. Department staff shall review the contents of each application and request any additional information necessary to understand the scope and benefits of a project. Projects involving job creation which do not meet 100 percent of the annual laborshed wage rate for their area will not be considered. Department staff may visit the project site and may require the applicant to verify the information in the application. After department staff determines that the application is complete, the staff shall develop a funding recommendation and shall schedule the project for submission to the transportation commission for approval.

822.11(2) Commission evaluation. The transportation commission shall be responsible for selecting and determining the funding for each project, subject to the availability of railroad revolving loan and grant funds. The transportation commission may fund all or part of a project and may make funding dependent upon the applicant's adherence to a time schedule or fulfillment of specified conditions, including job creation commitments.

822.11(3) Commission approval. In making its decision to fund a project, the transportation commission may consider the railroad transportation service benefits of the project, the economic development benefits of the project, the applicant's total capital investment, the number of direct and indirect jobs to be created or retained by the project, the financing requested, an analysis of public benefits versus public costs, and other potential impacts or benefits of the project.

[ARC 7909B, IAB 7/1/09, effective 7/1/09; ARC 3883C, IAB 7/4/18, effective 8/8/18]

761—822.12(327H) Award acceptance. After the transportation commission approves the project, department staff shall notify the applicant of the amount of the award. The applicant shall either accept or reject the award in writing within 45 days.

[ARC 3883C, IAB 7/4/18, effective 8/8/18]

761—822.13(327H) Project agreement and administration.

822.13(1) Agreement. After the applicant has accepted the award for a project, department staff shall negotiate and execute an agreement with the applicant. Department staff shall administer the agreement.

a. The agreement shall specify the scope of the project, the approved funding level, and other conditions for project funding.

b. As applicable, the agreement shall address responsibilities for consultant selection, project design, right-of-way acquisition, contracting, construction and materials inspection; documentation required for reimbursement of project costs; loan repayment terms; audit requirements; and maintenance of the completed project.

c. The applicant shall execute the agreement within 180 days following the acceptance of the award. The applicant may request an extension, and department staff may approve an extension for

good cause. Failure to execute an agreement within the specified time may result in forfeiture of the award.

822.13(2) *Reimbursement.* The applicant will be reimbursed for eligible project costs in accordance with the agreement.

822.13(3) *Audits.*

a. Prior to execution of the agreement, department staff may perform a preaudit evaluation of the applicant or others as defined in the agreement. A preaudit evaluation typically includes an examination of accounting methods to determine the applicant's ability to segregate and accumulate costs to be charged against the project, and an analysis of costs factors to ensure their propriety and allowability.

b. Department staff may conduct a final audit of all project costs.

822.13(4) *Remedies for noncompliance with project agreement.* The commission may revoke a funding commitment, require repayment of funds loaned or granted or take both actions when the applicant has not fulfilled the terms of the project agreement.

[ARC 7909B, IAB 7/1/09, effective 7/1/09; ARC 3883C, IAB 7/4/18, effective 8/8/18]

These rules are intended to implement Iowa Code section 327H.20A.

[Filed 11/15/05, Notice 9/28/05—published 12/7/05, effective 1/11/06]

[Filed Emergency ARC 7909B, IAB 7/1/09, effective 7/1/09]

[Filed ARC 3883C (Notice ARC 3759C, IAB 4/25/18), IAB 7/4/18, effective 8/8/18]

CHAPTER 8
SUBSTANTIVE AND INTERPRETIVE RULES

[Prior to 9/24/86 see Industrial Commissioner[500]]

[Prior to 1/29/97 see Industrial Services Division[343]]

[Prior to 7/29/98 see Industrial Services Division[873]Ch 8]

876—8.1(85) Transportation expense. Transportation expense as provided in Iowa Code sections 85.27 and 85.39 shall include but not be limited to the following:

1. The cost of public transportation if tendered by the employer or insurance carrier.
2. All mileage incident to the use of a private auto. The per-mile rate for use of a private auto from August 1, 2005, through June 30, 2006, shall be 40.5 cents. For annual periods beginning July 1, 2006, and thereafter, the per-mile rate shall be the rate allowed by the Internal Revenue Service for the business standard mileage rate in effect on July 1 of each year.
3. Meals and lodging if reasonably incident to the examination.
4. Taxi fares or other forms of local transportation if incident to the use of public transportation.
5. Ambulance service or other special means of transportation if deemed necessary by competent medical evidence or by agreement of the parties.

Transportation expense in the form of reimbursement for mileage which is incurred in the course of treatment or an examination, except under Iowa Code section 85.39, shall be payable at such time as 50 miles or more have accumulated or upon completion of medical care, whichever occurs first. Reimbursement for mileage incurred under Iowa Code section 85.39 shall be paid within a reasonable time after the examination.

The workers' compensation commissioner or a deputy commissioner may order transportation expense to be paid in advance of an examination or treatment. The parties may agree to the advance payment of transportation expense.

This rule is intended to implement Iowa Code sections 85.27 and 85.39.

876—8.2(85) Overtime. The word "overtime" as used in Iowa Code section 85.61 means amounts due in excess of the straight time rate for overtime hours worked. Such excess amounts shall not be considered in determining gross weekly wages within Iowa Code section 85.36. Overtime hours at the straight time rate are included in determining gross weekly earnings.

This rule is intended to implement Iowa Code sections 85.36 and 85.61.

876—8.3 Rescinded, effective July 1, 1982.

876—8.4(85) Salary in lieu of compensation. The excess payment made by an employer in lieu of compensation which exceeds the applicable weekly compensation rate shall not be construed as advance payment with respect to either future temporary disability, healing period, permanent partial disability, permanent total disability or death.

This rule is intended to implement Iowa Code sections 85.31, 85.34, 85.36, 85.37 and 85.61.

876—8.5(85) Appliances. Appliances are defined as hearing aids, corrective lenses, orthodontic devices, dentures, orthopedic braces, or any other artificial device used to provide function or for therapeutic purposes.

Appliances which are for the correction of a condition resulting from an injury or appliances which are damaged or made unusable as a result of an injury or avoidance of an injury are compensable under Iowa Code section 85.27.

876—8.6(85,85A) Calendar days—decimal equivalent. Weekly compensation benefits payable under Iowa Code chapters 85 and 85A are based upon a seven-day calendar week. Each day of weekly compensation benefits due may be paid by multiplying the employee's weekly compensation benefit rate by the decimal equivalents of the number of days as follows:

1 day	=	.143	×	weekly rate
2 days	=	.286	×	weekly rate
3 days	=	.429	×	weekly rate
4 days	=	.571	×	weekly rate
5 days	=	.714	×	weekly rate
6 days	=	.857	×	weekly rate

This rule is intended to implement Iowa Code sections 85.31, 85.33 and 85.34.

876—8.7(86) Short paper. All filings before the workers' compensation commissioner shall be on white paper measuring 8½ inches by 11 inches.

This rule is intended to implement Iowa Code section 86.18.

876—8.8(85,17A) Payroll tax tables. Tables for determining payroll taxes to be used for the period July 1, 2018, through June 30, 2019, are the tables in effect on July 1, 2018, for computation of:

1. Federal income tax withholding according to the percentage method of withholding for weekly payroll period. (Internal Revenue Service, Employer's Supplemental Tax Guide, Publication 15-A [2018].)

2. Iowa Withholding Tax Guide. (Iowa Department of Revenue Iowa Withholding Tax Rate Tables [Effective April 1, 2006].)

3. Social Security and Medicare withholding (FICA) at the rate of 7.65 percent. (Internal Revenue Service, Circular E, Employer's Tax Guide, Publication 15 [2018].)

This rule is intended to implement Iowa Code section 85.61(6).

[ARC 7947B, IAB 7/15/09, effective 7/1/09; ARC 8943B, IAB 7/28/10, effective 7/1/10; ARC 9586B, IAB 6/29/11, effective 7/1/11; ARC 0222C, IAB 7/25/12, effective 7/1/12; ARC 0835C, IAB 7/10/13, effective 6/30/13; ARC 1517C, IAB 7/9/14, effective 7/1/14; ARC 2611C, IAB 7/6/16, effective 7/1/16; ARC 3044C, IAB 4/26/17, effective 5/31/17; ARC 3884C, IAB 7/4/18, effective 8/8/18]

876—8.9(85,86) Exchange of records. Whether or not a contested case has been commenced, upon the written request of an employee or the representative of an employee who has alleged an injury arising out of and in the course of employment, an employer or insurance carrier shall provide the claimant a copy of all records and reports in its possession generated by a medical provider.

Whether or not a contested case has been commenced, upon the written request of the employer or insurance carrier against which an employee has alleged an injury arising out of and in the course of employment, the employee shall provide the employer or insurance carrier with a patient's waiver. See rules 876—3.1(17A) and 876—4.6(85,86,17A) for the waiver form used in contested cases. Claimant shall cooperate with the employer and insurance carrier to provide patients' waivers in other forms and to update patients' waivers where requested by a medical practitioner or institution.

A medical provider or its agent shall furnish an employer or insurance carrier copies of the initial as well as final clinical assessment without cost when the assessments are requested as supporting documentation to determine liability or for payment of a medical provider's bill for medical services. When requested, a medical provider or its agent shall furnish a legible duplicate of additional records or reports. Except as otherwise provided in this rule, the amount to be paid for furnishing duplicates of records or reports shall be the actual expense to prepare duplicates not to exceed: \$20 for 1 to 20 pages; \$20 plus \$1 per page for 21 to 30 pages; \$30 plus \$.50 per page for 31 to 100 pages; \$65 plus \$.25 per page for 101 to 200 pages; \$90 plus \$.10 per page for more than 200 pages, and the actual expense of postage. No other expenses shall be allowed.

EXAMPLE 1. For 7 pages of records the amount to be paid for furnishing duplicates shall not exceed \$20.

EXAMPLE 2. For 28 pages of records the amount to be paid for furnishing duplicates shall not exceed \$28 (\$20 plus (8 times \$1)).

EXAMPLE 3. For 41 pages of records the amount to be paid for furnishing duplicates shall not exceed \$35.50 (\$30 plus (11 times \$.50)).

EXAMPLE 4. For 127 pages of records the amount to be paid for furnishing duplicates shall not exceed \$71.75 (\$65 plus (27 times \$.25)).

EXAMPLE 5. For 210 pages of records the amount to be paid for furnishing duplicates shall not exceed \$91 (\$90 plus (10 times \$.10)).

This rule is intended to implement Iowa Code sections 85.27, 85.31, 85.33 to 85.37, 85.39, 85.61, 86.8, 86.10, 86.18 and 86.39.

876—8.10(85B) Apportionment of age-related loss for occupational hearing loss claims.

8.10(1) Effective date. This rule is effective for claims for occupational hearing loss filed on or after July 1, 1998.

8.10(2) Purpose. The purposes of this rule are to adopt tables and the method for calculating age-related hearing loss and to adopt a worksheet for apportionment of age-related hearing loss for occupational hearing loss claims.

8.10(3) Table. In 1972 the National Institute for Occupational Safety and Health (NIOSH) published the Criteria for a Recommended Standard: Occupational Exposure to Noise (NIOSH Publication No.73-11001). Table B-1, page I-16, provides the Age Corrections Values to be Used for Age Correction of Initial Baseline Audiograms for Males and Table B-2, page I-17, provides the Age Corrections Values to be Used for Age Correction of Initial Baseline Audiograms for Females. These NIOSH tables are used to calculate the correction value for age for males and females for 500, 1000, 2000 and 3000 hertz.

For example, the age correction for a male 21 years of age is 10 decibels at 500 hertz, 5 decibels at 1000 hertz, 3 decibels at 2000 hertz and 4 decibels at 3000 hertz. The correction for age is 5.50 decibels (the sum of 10+5+3+4 divided by 4).

The following table is to be used to determine an employee's age-related change in hearing level during the period of employment. To determine the age-related change in hearing level in decibels during the period of employment, subtract the value shown in the table for the employee's age at the beginning of employment from the value shown in the table for the employee's age on the date of injury.

NOTE: This table should not be used to compute standard threshold shift as required by rules of the Occupational Safety and Health Administration or Iowa occupational safety and health administration.

<u>Age in Years</u>	<u>Correction in dB</u>	
	<u>Males</u>	<u>Females</u>
20 or younger	5.50	7.25
21	5.50	7.75
22	5.50	7.75
23	5.50	8.00
24	5.75	8.00
25	6.00	8.25
26	6.25	8.50
27	6.50	8.75
28	6.75	8.75
29	6.75	8.75
30	6.75	9.00
31	7.25	9.25
32	7.50	9.50
33	7.50	9.75
34	7.75	9.75
35	8.00	10.00
36	8.25	10.25
37	8.75	10.25

<u>Age in Years</u>	<u>Correction in dB</u>	
	<u>Males</u>	<u>Females</u>
38	8.75	10.50
39	9.00	11.00
40	9.00	11.00
41	9.25	11.25
42	10.00	11.50
43	10.25	11.75
44	10.25	12.00
45	10.50	12.25
46	10.75	12.50
47	11.00	12.50
48	11.50	13.00
49	12.00	13.25
50	12.25	13.50
51	12.25	13.75
52	12.75	13.75
53	13.25	14.25
54	13.50	14.50
55	14.00	15.00
56	14.25	15.00
57	14.50	15.25
58	15.25	15.75
59	15.50	16.00
60 or older	16.00	16.25

8.10(4) Apportionment. The apportionment of age-related hearing loss shall be made by reducing the total binaural percentage hearing loss as calculated pursuant to Iowa Code section 85B.9(3) by the same percentage as the decibels of age-related change in hearing level occurring during the period of employment bears to the total decibel hearing level in each ear.

Age-related hearing loss is apportioned using the results of the audiogram determined to be the proper audiogram for measurement of the employee's hearing loss on the date of injury by using the following steps:

1. Separately for each ear, compute the average of the employee's decibel hearing levels at 500, 1000, 2000, and 3000 hertz for that ear.
2. Separately for each ear, compute the percentage loss for each ear.
3. Compute the employee's age-related change in hearing level in decibels during the period of employment using the table in subrule 8.10(3).
4. Separately for each ear, divide the result of step 3 by the result of step 1 to compute the age-correction factor for that ear.
5. Separately for each ear, multiply the total percentage hearing loss in that ear calculated pursuant to Iowa Code section 85B.9 by the age-correction factor for that ear.
6. Separately for each ear, subtract the result obtained in step 5 from the total percentage hearing loss in that ear to obtain the age-corrected hearing loss for that ear.
7. Multiply the age-corrected hearing loss in the better ear as calculated in step 6 by 5 and add the percentage hearing loss in the worse ear.
8. Divide the result obtained in step 7 by 6 to obtain the age-corrected binaural percentage hearing loss.

8.10(5) Worksheet. The following worksheet is used to calculate the percentage of age-corrected binaural hearing loss.

APPORTIONMENT OF PERCENT HEARING LOSS FOR AGE		
Left Ear <u>Hearing Level</u>	Frequency <u>in Hertz</u>	Right Ear <u>Hearing Level</u>
1. _____	500	_____
2. _____	1000	_____
3. _____	2000	_____
4. _____	3000	_____
5. _____	total of lines 1 through 4	_____
divide by 4	(divide the "total" by 4)	divide by 4
6. _____	equals average equals	_____
minus 25	subtract "low fence"	minus 25
7. _____	equals "Excess"	_____
multiply by 1.5	multiply % factor	multiply by 1.5
8. _____	equals % loss each ear	_____
(% loss left ear)		(% loss right ear)
9. Age on date of injury	_____	
10. Age at beginning of employment	_____	
11. _____	correction for age on date of injury in dB from table minus	
12. _____	correction for age at beginning of employment in dB from table equals	
13. _____	age-related change in hearing level during employment in dB	
<u>LEFT EAR</u>		<u>RIGHT EAR</u>
Divide age-related change in hearing level from line 13 by average hearing level from line 6		
To obtain		
14. _____	age correction factor	_____
multiply % loss from line 8 by age-correction factor from line 14		
To obtain		
15. _____	deduction for age-correction	_____
subtract line 15 from line 8		
To obtain		
16. _____	age-corrected percent hearing loss	_____
<u>BINAURAL PERCENTAGE LOSS</u>		
17. _____	% loss better ear (smaller amount) from line 16, multiplied by 5 plus	

18. _____ % loss worse ear (larger amount)
from line 16
19. _____ equals
divided
by 6
equals
20. _____ % age-corrected binaural hearing loss

This rule is intended to implement Iowa Code sections 85B.9A and 86.8.

876—8.11(85) Offer of suitable work. The employer shall communicate an offer of temporary work to the employee in writing, including the details of lodging, meals, and transportation. With each offer of temporary work, the employer shall notify the employee in writing that:

1. If the employee refuses the offer of temporary work, the employee shall communicate the refusal and the reason for the refusal to the employer in writing;

2. During the period of refusal, the employee will not be compensated with temporary partial, temporary total, or healing period benefits unless the work refused is not suitable; and

3. Failure to communicate the reason for the refusal to the employer in writing precludes the employee from raising suitability of the work as the reason for the refusal until such time as the reason for the refusal is communicated in writing to the employer.

This rule is intended to implement Iowa Code section 85.33.

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[◇] Two or more ARCs

¹ Effective date of 343—8.9(85,86), second unnumbered paragraph, delayed 70 days by the Administrative Rules Review Committee at its meeting held February 13, 1995; delay lifted by this Committee May 9, 1995.