

*State of Iowa*

**Iowa**  
**Administrative**  
**Code**  
**Supplement**

Biweekly  
September 25, 2019



---

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

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

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

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

# INSTRUCTIONS

## FOR UPDATING THE

# IOWA ADMINISTRATIVE CODE

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

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

### **Insurance Division[191]**

Replace Chapter 103

### **Human Services Department[441]**

Replace Chapters 78 and 79

### **Dental Board[650]**

Replace Analysis

Replace Chapter 10

Replace Chapter 15

Replace Chapter 20

Remove Reserved Chapters 23 and 24 and Chapter 25

Insert Chapter 23, Reserved Chapter 24, and Chapter 25

### **Revenue Department[701]**

Replace Analysis

Replace Chapter 46

Replace Chapter 225



CHAPTER 103  
RESIDENTIAL AND MOTOR VEHICLE SERVICE CONTRACTS

[Prior to 9/28/16, see 191—Ch 54]

**191—103.1(523C) Purpose.** The purpose of this chapter is to administer Iowa Code chapter 523C as amended by 2019 Iowa Acts, Senate File 619, relating to service contracts and service companies. [ARC 2729C, IAB 9/28/16, effective 11/2/16; ARC 4495C, IAB 6/19/19, effective 5/20/19; ARC 4677C, IAB 9/25/19, effective 10/30/19]

**191—103.2(523C) Definitions.** The definitions in Iowa Code section 523C.1 as amended by 2019 Iowa Acts, Senate File 619, section 1, are incorporated by this reference. In addition, the following definitions shall apply to this chapter.

“*Division*” means the Iowa insurance division, supervised by the commissioner pursuant to Iowa Code section 505.8, in the division’s performance of the duties of the commissioner under Iowa Code chapter 523C as amended by 2019 Iowa Acts, Senate File 619.

“*Division’s website*” means the website of the Iowa insurance division, [iid.iowa.gov](http://iid.iowa.gov).

“*Residential customer*,” as used in the definition of “residential service contract” in Iowa Code section 523C.1 as amended by 2019 Iowa Acts, Senate File 619, section 1, means any person (whether or not the person is the owner of the residential property) who purchases a residential service contract relating to a residential property.

“*Residential property*” means any single- or multiple-unit structure, including a house, townhouse, condominium, mobile home, or other habitable structure, which is used primarily for residential purposes.

“*Service contract holder*” means the original purchaser of a service contract or the successor in interest or transferee entitled to services under the contract.

“*Structural components*,” as used in the definition of “residential service contract” in Iowa Code section 523C.1 as amended by 2019 Iowa Acts, Senate File 619, section 1, means the roof, foundation, basement, walls, ceiling or floors of a residential property.

[ARC 2729C, IAB 9/28/16, effective 11/2/16; ARC 4495C, IAB 6/19/19, effective 5/20/19; ARC 4677C, IAB 9/25/19, effective 10/30/19]

**191—103.3(523C) Filings of forms, contracts and other items.** If Iowa Code chapter 523C as amended by 2019 Iowa Acts, Senate File 619, or this chapter requires an item to be filed with the division, the applicable item shall be filed with the division’s securities and regulated industries bureau, regardless of whether the applicable item has already been filed elsewhere within the division.

[ARC 4495C, IAB 6/19/19, effective 5/20/19; ARC 4677C, IAB 9/25/19, effective 10/30/19]

**191—103.4(523C) Forms and instructions.** Instructions for license applications, fees, forms and other filings, and copies of all required forms are available on the division’s website.

[ARC 2729C, IAB 9/28/16, effective 11/2/16; ARC 4495C, IAB 6/19/19, effective 5/20/19; ARC 4677C, IAB 9/25/19, effective 10/30/19]

**191—103.5(523C) Financial security deposits.**

**103.5(1)** For purposes of Iowa Code section 523C.5(2) “*b*” as enacted by 2019 Iowa Acts, Senate File 619, section 5, “placing in trust with the commissioner” means filing a surety bond with the commissioner or creating a financial or custodial account in a manner acceptable to the commissioner.

**103.5(2)** Requirements for surety bonds.

*a.* A surety bond filed with the commissioner as a financial security deposit pursuant to Iowa Code section 523C.5(2) “*b*” as enacted by 2019 Iowa Acts, Senate File 619, section 5, shall be in the form directed by the division and as available on the division’s website.

*b.* A surety bond filed with the commissioner as a financial security deposit pursuant to Iowa Code section 523C.5(2) “*b*” as enacted by 2019 Iowa Acts, Senate File 619, section 5, shall cover service contracts still outstanding that predate the effective date of the surety bond and any service contracts executed during the surety bond’s period of coverage except service contracts that have been rescinded or fulfilled or that are secured by another bond.

c. No suit or action shall be commenced by a surety bond claimant later than one year after the expiration date of the surety bond.

d. The surety bond shall, in the event of the service company's failure to perform under the service contract or otherwise, either reimburse or pay on behalf of the service company any covered amounts that the service company is legally obligated to pay under the service contract.

e. The surety bond is for the benefit of and subject to recovery by any Iowa service contract holder sustaining actionable injury due to the failure of the service company to perform its obligations under a service contract. A holder of a service contract issued in this state may, in the event of nonperformance of the contract by the service company, maintain an action and file a claim against the surety bond filed. The surety's liability shall extend to all service contracts issued by the service company and outstanding in this state, provided, however, that the surety's aggregate liability shall not exceed the penal sum of the bond.

f. The surety bond cannot be canceled by the surety except upon written notice of cancellation by the surety to the commissioner by certified mail, and not prior to the expiration of 60 days after receipt of the notice by the commissioner.

g. A service company shall maintain an adequate surety bond and shall continuously monitor the surety amount to assure its adequacy.

[ARC 4495C, IAB 6/19/19, effective 5/20/19; ARC 4677C, IAB 9/25/19, effective 10/30/19]

### **191—103.6(523C) Prohibited acts or practices.**

**103.6(1) *Defamation.*** A service company is prohibited from, directly or indirectly, doing, or aiding, abetting or encouraging, the following: the making, publishing, disseminating, or circulating of any oral or written statement, or of any pamphlet, circular, article or literature which is false or maliciously critical as to the financial condition of any person and which is calculated to injure that person.

**103.6(2) *Boycott, coercion, and intimidation.*** A service company is prohibited from entering into any agreement to commit, or by any concerted action committing, any act of boycott, coercion, or intimidation resulting in or tending to result in unreasonable restraint of, or monopoly in, the service contract industry.

**103.6(3) *False statements.*** A service company is prohibited from knowingly filing with any supervisory or other public official, or knowingly making or causing directly or indirectly to be made, published, disseminated, circulated, delivered to any person, or placed before the public, any false material statement of fact as to the financial condition of a person.

**103.6(4) *False entries.*** A service company is prohibited from knowingly making any false entry of a material fact in any book, report or statement of any person and from knowingly omitting to make a true entry of any material fact pertaining to the business of that person in any book, report or statement of that person.

**103.6(5) *Misrepresentation, false advertising, and unfair practices.***

a. A service company shall not:

(1) Use in its name, contracts, or literature, any of the words "insurance," "casualty," "surety," "mutual," or any other words descriptive of the insurance, casualty or surety business or deceptively similar to the name or description of any insurance or surety corporation, or any other service company. This subparagraph does not apply to a service company also licensed as an insurance company.

(2) Represent or imply in any manner that the service company has been sponsored or recommended, or that the service company's abilities or qualifications have in any respect been passed upon, by the division or by the state of Iowa. Nothing in this subrule prohibits a statement, other than in a paid advertisement, that a person has received a license, if the statement is true in fact and if the effect of the license's issuance is not misrepresented.

(3) Without the written consent of the customer, knowingly charge for duplication of coverage or duties required by state or federal law, or duplication of a warranty expressly issued by a manufacturer or seller of a product or any implied warranty enforceable against the lessor, seller or manufacturer of a product.

(4) Make, permit or cause any false or misleading statements, either oral or written, in connection with the sale, offer to sell or advertisement of a service contract.

(5) Permit or cause the omission of any material statement that, under the circumstances, should have been made in connection with the sale, offer to sell, or advertisement of a service contract, in order that other statements also made in connection with the sale, offer to sell or advertisement of a service contract would not be misleading.

(6) Make, permit or cause any false or misleading statements, either oral or written, about the benefits or services available under the service contract.

(7) Make, permit or cause any statement or practice which has the effect of creating or maintaining a fraud.

(8) Cause, directly or indirectly, to be made, published, disseminated, circulated, or placed before the public in a newspaper, magazine or other publication, or in the form of a notice, circular, pamphlet, letter or poster, or over any radio or television station, or in any other way, an advertisement, announcement or statement containing any assertion, representation, or statement with respect to the service contract industry or with respect to any service company which is untrue, deceptive or misleading.

(9) Require the use of used parts in the repair of a motor vehicle covered by a motor vehicle service contract unless the service company has obtained prior written authorization by the vehicle owner or unless all of the following are true regarding any rebuilt parts:

1. The parts have been dismantled and reconstructed as necessary.
2. All of the internal and external parts have been cleaned and made free from rust and corrosion.
3. All impaired, defective, or substantially worn parts have been restored to a sound condition or replaced with new, rebuilt, or unimpaired used parts.
4. All rewinding or machining or other necessary operations have been performed.
5. The rebuilt parts have been put in working condition, using, as minimum standards, the manufacturer's performance specifications in existence when the parts were originally manufactured if those specifications are publicly available.

*b.* Rescinded IAB 6/19/19, effective 5/20/19.

[ARC 2729C, IAB 9/28/16, effective 11/2/16; ARC 4495C, IAB 6/19/19, effective 5/20/19; ARC 4677C, IAB 9/25/19, effective 10/30/19]

#### **191—103.7(523C) Service company licenses.**

**103.7(1)** Service company licenses shall not be transferable. A service company which sells its business shall cancel its service company license, and the purchaser of the business shall apply for a new service license under the purchaser's name.

**103.7(2)** A service company licensed or registered with the division on April 1, 2019, in accordance with Iowa Code chapter 516E or 523C shall be deemed licensed with the insurance division under Iowa Code chapter 523C as amended by 2019 Iowa Acts, Senate File 619, until August 31, 2019, without any additional application or filing.

[ARC 2729C, IAB 9/28/16, effective 11/2/16; ARC 4495C, IAB 6/19/19, effective 5/20/19; ARC 4677C, IAB 9/25/19, effective 10/30/19]

#### **191—103.8(523C) Annual form filing.** Rescinded ARC 4495C, IAB 6/19/19, effective 5/20/19.

#### **191—103.9(523C) Financial statements and calculation of net worth.**

**103.9(1)** All financial statements, including balance statements, filed pursuant to or prepared for purposes of Iowa Code chapter 523C as amended by 2019 Iowa Acts, Senate File 619, or this chapter shall be prepared in accordance with generally accepted accounting principles and certified by an independent certified public accountant.

**103.9(2)** For purposes of Iowa Code section 523C.5 as enacted by 2019 Iowa Acts, Senate File 619, section 5, "net worth" means the excess of all assets over liabilities, and any required reserves shall be treated as a liability rather than as an asset.

[ARC 2729C, IAB 9/28/16, effective 11/2/16; ARC 4495C, IAB 6/19/19, effective 5/20/19; ARC 4677C, IAB 9/25/19, effective 10/30/19]

**191—103.10(523C) Records.**

**103.10(1)** All licensed service companies shall keep accurate accounts, books, and records concerning transactions regulated under Iowa Code chapter 523C as amended by 2019 Iowa Acts, Senate File 619.

**103.10(2)** A licensed service company's accounts, books, and records shall include:

- a. Copies of all service contracts;
- b. The name and address of each service contract holder; and
- c. The dates and amounts of all receipts and expenditures related to all service contracts.

**103.10(3)** A licensed service company shall retain all required accounts, books, and records pertaining to each service contract for at least two years after the expiration of the specified period of time.

**103.10(4)** All licensed service companies shall make all accounts, books, and records concerning transactions regulated under Iowa Code chapter 523C as amended by 2019 Iowa Acts, Senate File 619, available to the division for the purpose of examination.

**103.10(5)** A licensed service company discontinuing business in this state shall maintain its records until it furnishes the division satisfactory proof that it has discharged all obligations to service contract holders in this state.

[ARC 2729C, IAB 9/28/16, effective 11/2/16; ARC 4495C, IAB 6/19/19, effective 5/20/19; ARC 4677C, IAB 9/25/19, effective 10/30/19]

**191—103.11 to 103.14 Reserved.**

**191—103.15(523C) Violations.** Failure to comply with this chapter or with Iowa Code chapter 523C as amended by 2019 Iowa Acts, Senate File 619, shall be deemed a violation which shall subject a person or entity to the procedures and penalties set forth in Iowa Code chapter 523C as amended by 2019 Iowa Acts, Senate File 619.

[ARC 2729C, IAB 9/28/16, effective 11/2/16; ARC 4495C, IAB 6/19/19, effective 5/20/19; ARC 4677C, IAB 9/25/19, effective 10/30/19]

These rules are intended to implement Iowa Code chapter 523C as amended by 2019 Iowa Acts, Senate File 619.

[Filed ARC 2729C (Notice ARC 2666C, IAB 8/3/16), IAB 9/28/16, effective 11/2/16]

[Filed Emergency ARC 4495C, IAB 6/19/19, effective 5/20/19]

[Filed ARC 4677C (Notice ARC 4496C, IAB 6/19/19), IAB 9/25/19, effective 10/30/19]

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.

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

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

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

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

Decubitus equipment.

Dialysis equipment.

Diaphragm (contraceptive device).

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

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

Heat/cold application device.

Hospital bed and accessories.

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

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

Lymphedema pump.

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

Neuromuscular stimulator.

Oximeter.

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

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

Phototherapy bilirubin light.

Protective helmet.

Seat lift chair.

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

Traction equipment.

Ventilator.

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

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

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

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

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

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

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

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

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

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

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

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

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

1. Lap belt or safety belt;

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

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

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

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

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

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

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

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

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

(9) Tracheotomy tubes.

(10) Vibrotactile aids. Vibrotactile aids are payable only once in a four-year period unless the original aid is broken beyond repair or lost. (Cross reference 78.28(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, subject to the requirements of 78.10(2)"d."

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

[ARC 7548B, IAB 2/11/09, effective 4/1/09; ARC 8344B, IAB 12/2/09, effective 12/1/09; ARC 8643B, IAB 4/7/10, effective 3/11/10; ARC 8714B, IAB 5/5/10, effective 5/1/10; ARC 8993B, IAB 8/11/10, effective 10/1/10; ARC 9256B, IAB 12/1/10, effective 1/1/11; ARC 0632C, IAB 3/6/13, effective 5/1/13; ARC 0823C, IAB 7/10/13, effective 9/1/13; ARC 1151C, IAB 10/30/13, effective 1/1/14; ARC 4575C, IAB 7/31/19, effective 9/4/19]

**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, subject to the requirements of 78.10(2)“d.”

**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; ARC 4575C, IAB 7/31/19, effective 9/4/19]

**441—78.29(249A) Behavioral health services.** Payment shall be made for medically necessary behavioral health services provided by a participating marital and family therapist, independent social worker, master social worker, mental health counselor, or certified alcohol and drug counselor within the practitioner’s scope of practice pursuant to state law and subject to the limitations and exclusions set forth in this rule.

**78.29(1) Limitations.**

a. An assessment and a treatment plan are required.

b. Services provided by a licensed master social worker must be provided under the supervision of an independent social worker qualified to participate in the Medicaid program.

**78.29(2) Exclusions.** Payment will not be approved for the following services:

- a. Services provided in a medical institution.
- b. Services performed without relationship to a specific condition, risk factor, symptom, or complaint.
- c. Services provided for nonspecific conditions of distress such as job dissatisfaction or general unhappiness.
- d. Sensitivity training, marriage enrichment, assertiveness training, and growth groups or marathons.

**78.29(3) Payment.**

- a. Payment shall be made only for time spent in face-to-face consultation with the member.
- b. A unit of service is 15 minutes. Time spent with members shall be rounded to the quarter hour, where applicable.

This rule is intended to implement Iowa Code section 249A.4.  
[ARC 9649B, IAB 8/10/11, effective 8/1/11]

**441—78.30(249A) Birth centers.** Payment will be made for prenatal, delivery, and postnatal services.

**78.30(1) Risk assessment.** Risk assessment, using Form 470-2942, Medicaid Prenatal Risk Assessment, shall be completed at the initial visit during a Medicaid member's pregnancy.

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

**78.30(2) Vaccines.** In order to be paid for the administration of a vaccine covered under the Vaccines for Children (VFC) Program, a birth center must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

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

**441—78.31(249A) Hospital outpatient services.**

**78.31(1) Covered hospital outpatient services.** Payment will be approved only for the following outpatient hospital services and medical services when provided on the licensed premises of the hospital or pursuant to subrule 78.31(5). Hospitals with alternate sites approved by the department of inspections and appeals are acceptable sites. All outpatient services listed in paragraphs "g" to "m" are subject to a random sample retrospective review for medical necessity by the IME medical services unit. All services may also be subject to a more intensive retrospective review if abuse is suspected. Services in paragraphs "a" to "f" shall be provided in hospitals on an outpatient basis and are subject to no further limitations except medical necessity of the service.

Services listed in paragraphs "g" to "m" shall be provided by hospitals on an outpatient basis and must be certified by the department before payment may be made. Other limitations apply to these services.

- a. Emergency service.
- b. Outpatient surgery.
- c. Laboratory, X-ray and other diagnostic services.
- d. General or family medicine.
- e. Follow-up or after-care specialty clinics.
- f. Physical medicine and rehabilitation.
- g. Alcoholism and substance abuse.
- h. Eating disorders.
- i. Cardiac rehabilitation.
- j. Mental health.
- k. Pain management.
- l. Diabetic education.
- m. Pulmonary rehabilitation.
- n. Nutritional counseling for persons aged 20 and under.

**78.31(2) Requirements for all outpatient services.**

*a. Need for service.* It must be clearly established that the service meets a documented need in the area served by the hospital. There must be documentation of studies completed, consultations with other health care facilities and health care professionals in the area, community leaders, and organizations to determine the need for the service and to tailor the service to meet that particular need.

*b. Professional direction.* All outpatient services must be provided by or at the direction and under the supervision of a medical doctor or osteopathic physician except for mental health services which may be provided by or at the direction and under the supervision of a medical doctor, osteopathic physician, or certified health service provider in psychology.

*c. Goals and objectives.* The goals and objectives of the program must be clearly stated. Paragraphs “d” and “f” and the organization and administration of the program must clearly contribute to the fulfillment of the stated goals and objectives.

*d. Treatment modalities used.* The service must employ multiple treatment modalities and professional disciplines. The modalities and disciplines employed must be clearly related to the condition or disease being treated.

*e. Criteria for selection and continuing treatment of patients.* The condition or disease which is proposed to be treated must be clearly stated. Any indications for treatment or contraindications for treatment must be set forth together with criteria for determining the continued medical necessity of treatment.

*f. Length of program.* There must be established parameters that limit the program either in terms of its overall length or in terms of number of visits, etc.

*g. Monitoring of services.* The services provided by the program must be monitored and evaluated to determine the degree to which patients are receiving accurate assessments and effective treatment.

The monitoring of the services must be an ongoing plan and systematic process to identify problems in patient care or opportunities to improve patient care.

The monitoring and evaluation of the services are based on the use of clinical indicators that reflect those components of patient care important to quality.

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

**78.31(3) Application for certification.** Hospital outpatient programs listed in subrule 78.31(1), paragraphs “g” to “m,” must submit an application to the Iowa Medicaid enterprise provider services unit for certification before payment will be made. The provider services unit will review the application against the requirements for the specific type of outpatient service and notify the provider whether certification has been approved.

Applications will consist of a narrative providing the following information:

*a.* Documented need for the program including studies, needs assessments, and consultations with other health care professionals.

*b.* Goals and objectives of the program.

*c.* Organization and staffing including how the program fits with the rest of the hospital, the number of staff, staff credentials, and the staff’s relationship to the program, e.g., hospital employee, contractual consultant.

*d.* Policies and procedures including admission criteria, patient assessment, treatment plan, discharge plan and postdischarge services, and the scope of services provided, including treatment modalities.

*e.* Any accreditations or other types of approvals from national or state organizations.

*f.* The physical facility and any equipment to be utilized, and whether the facility is part of the hospital license.

**78.31(4) Requirements for specific types of service.**

*a.* Alcoholism and substance abuse.

(1) Approval by joint commission or substance abuse commission. In addition to certification by the department, alcoholism and substance abuse programs must also be approved by either the joint commission on the accreditation of hospitals or the Iowa substance abuse commission.

(2) General characteristics. The services must be designed to identify and respond to the biological, psychological and social antecedents, influences and consequences associated with the recipient's dependence.

These needed services must be provided either directly by the facility or through referral, consultation or contractual arrangements or agreements.

Special treatment needs of recipients by reason of age, gender, sexual orientation, or ethnic origin are evaluated and services for children and adolescents (as well as adults, if applicable) address the special needs of these age groups, including but not limited to, learning problems in education, family involvement, developmental status, nutrition, and recreational and leisure activities.

(3) Diagnostic and treatment staff. Each person who provides diagnostic or treatment services shall be determined to be competent to provide the services by reason of education, training, and experience.

Professional disciplines which must be represented on the diagnostic and treatment staff, either through employment by the facility (full-time or part-time), contract or referral, are a physician (M.D. or D.O.), a licensed psychologist and a substance abuse counselor certified by the Iowa board of substance abuse certification. Psychiatric consultation must be available and the number of staff should be appropriate to the patient load of the facility.

(4) Initial assessment. A comprehensive assessment of the biological, psychological, social, and spiritual orientation of the patient must be conducted which shall include:

A history of the use of alcohol and other drugs including age of onset, duration, patterns, and consequences of use; use of alcohol and drugs by family members and types of and responses to previous treatment.

A comprehensive medical history and physical examination including the history of physical problems associated with dependence.

Appropriate laboratory screening tests based on findings of the history and physical examination and tests for communicable diseases when indicated.

Any history of physical abuse.

A systematic mental status examination with special emphasis on immediate recall and recent and remote memory.

A determination of current and past psychiatric and psychological abnormality.

A determination of any degree of danger to self or others.

The family's history of alcoholism and other drug dependencies.

The patient's educational level, vocational status, and job performance history.

The patient's social support networks, including family and peer relationships.

The patient's perception of the patient's strengths, problem areas, and dependencies.

The patient's leisure, recreational, or vocational interests and hobbies.

The patient's ability to participate with peers and in programs and social activities.

Interview of family members and significant others as available with the patient's written or verbal permission.

Legal problems, if applicable.

(5) Admission criteria. Both of the first two criteria and one additional criterion from the following list must be present for a patient to be accepted for treatment.

Alcohol or drugs taken in greater amounts over a longer period than the person intended.

Two or more unsuccessful efforts to cut down or control use of alcohol or drugs.

Continued alcohol or drug use despite knowledge of having a persistent or recurrent family, social, occupational, psychological, or physical problem that is caused or exacerbated by the use of alcohol or drugs.

Marked tolerance: the need for markedly increased amounts of alcohol or drugs (i.e., at least a 50 percent increase) in order to achieve intoxication or desired effect or markedly diminished effect with continued use of same amount.

Characteristic withdrawal symptoms.

Alcohol or drugs taken often to relieve or avoid withdrawal symptoms.

(6) Plan of treatment. For each patient there is a written comprehensive and individualized description of treatment to be undertaken. The treatment plan is based on the problems and needs identified in the assessment and specifies the regular times at which the plan will be reassessed.

The patient's perception of needs and, when appropriate and available, the family's perception of the patient's needs shall be documented.

The patient's participation in the development of the treatment plan is sought and documented.

Each patient is reassessed to determine current clinical problems, needs, and responses to treatment. Changes in treatment are documented.

(7) Discharge plan. For each patient before discharge, a plan for discharge is designed to provide appropriate continuity of care which meets the following requirements:

The plan for continuing care must describe and facilitate the transfer of the patient and the responsibility for the patient's continuing care to another phase or modality of the program, other programs, agencies, persons or to the patient and the patient's personal support system.

The plan is in accordance with the patient's reassessed needs at the time of transfer.

The plan is developed in collaboration with the patient and, as appropriate and available, with the patient's written verbal permission with family members.

The plan is implemented in a manner acceptable to the patient and the need for confidentiality.

Implementation of the plan includes timely and direct communication with and transfer of information to the other programs, agencies, or persons who will be providing continuing care.

(8) Restrictions and limitations on payment. Medicaid will reimburse for a maximum of 28 treatment days. Payment beyond 28 days is made when documentation indicates that the patient has not reached an exit level.

If an individual has completed all or part of the basic 28-day program, a repeat of the program will be reimbursed with justification. The program will include an aftercare component meeting weekly for at least one year without charge.

*b.* Eating disorders.

(1) General characteristics. Eating disorders are characterized by gross disturbances in eating behavior. Eating disorders include anorexia nervosa or bulimia nervosa. Compulsive overeaters are not approved for this program.

(2) Diagnostic and treatment staff. Each person who provides diagnostic or treatment services shall be determined to be competent to provide the services by reason of education, training, and experience.

Professional disciplines which must be represented on the diagnostic and treatment staff, either through employment by a facility (full-time or part-time), contract or referral, are a physician (M.D. or D.O.), a licensed psychologist, a counselor with a master's or bachelor's degree and experience, a dietitian with a bachelor's degree and registered dietitian's certificate, and a licensed occupational therapist. The number of staff should be appropriate to the patient load of the facility.

(3) Initial assessment. A comprehensive assessment of the biological, psychological, social, and family orientation of the patient must be conducted. The assessment must include a weight history and a history of the patient's eating and dieting behavior, including binge eating, onset, patterns, and consequences. The assessment shall include the following:

A family history as well as self-assessment regarding chronic dieting, obesity, anorexia, bulimia, drug abuse, alcohol problems, depression, hospitalization for psychiatric reasons, and threatened or attempted suicide.

A history of purging behavior including frequency and history of vomiting, use of laxatives, history and frequency of use of diuretics, history and frequency of use of diet pills, ipecac, or any other weight control measures, and frequency of eating normal meals without vomiting.

A history of exercise behavior, including type, frequency, and duration.

A complete history of current alcohol and other drug use.

Any suicidal thoughts or attempts.

Sexual history, including sexual preference and activity. Sexual interest currently as compared to prior to the eating disorder is needed.

History of experiencing physical or sexual (incest or rape) abuse.

History of other counseling experiences.

Appropriate psychological assessment, including psychological orientation to the above questions.

A medical history, including a physical examination, covering the information listed in subparagraph (4) below.

Appropriate laboratory screening tests based on findings of the history and physical examination and tests for communicable diseases when indicated.

The patient's social support networks, including family and peer relationships.

The patient's educational level, vocational status, and job or school performance history, as appropriate.

The patient's leisure, recreational, or vocational interests and hobbies.

The patient's ability to participate with peers and programs and social activities.

Interview of family members and significant others as available with the patient's written or verbal permission as appropriate.

Legal problems, if applicable.

(4) Admission criteria. In order to be accepted for treatment, the patient shall meet the diagnostic criteria for anorexia nervosa or bulimia nervosa as established by the current version of the DSM (Diagnostic and Statistical Manual of Mental Disorders) published by the American Psychiatric Association.

In addition to the diagnostic criteria, the need for treatment will be determined by a demonstrable loss of control of eating behaviors and the failure of the patient in recent attempts at voluntary self-control of the problem. Demonstrable impairment, dysfunction, disruption or harm of physical health, emotional health (e.g., significant depression withdrawal, isolation, suicidal ideas), vocational or educational functioning, or interpersonal functioning (e.g., loss of relationships, legal difficulties) shall have occurred.

The need for treatment may be further substantiated by substance abuse, out-of-control spending, incidence of stealing to support habit, or compulsive gambling.

The symptoms shall have been present for at least six months and three of the following criteria must be present:

Medical criteria including endocrine and metabolic factors (e.g., amenorrhea, menstrual irregularities, decreased reflexes, cold intolerance, hypercarotenemia, parotid gland enlargement, lower respiration rate, hair loss, abnormal cholesterol or triglyceride levels).

Other cardiovascular factors including hypotension, hypertension, arrhythmia, ipecac poisoning, fainting, or bradycardia.

Renal considerations including diuretic abuse, dehydration, elevated BUN, renal calculi, edema, or hypokalemia.

Gastrointestinal factors including sore throats, Mallory-Weiss tears, decreased gastric emptying, constipation, abnormal liver enzymes, rectal bleeding, laxative abuse, or esophagitis.

Hematologic considerations including anemia, leukopenia, or thrombocytopenia.

Ear, nose, and throat factors including headaches or dizziness.

Skin considerations including lanugo or dry skin.

Aspiration pneumonia, a pulmonary factor.

The presence of severe symptoms and complications as evaluated and documented by the medical director may require a period of hospitalization to establish physical or emotional stability.

(5) Plan of treatment. For each patient there is a written comprehensive and individualized description of treatment to be undertaken. The treatment plan is based on problems and needs identified in the assessment and specifies the regular times at which the plan will be reassessed.

The patient's perceptions of needs and, when appropriate and available, the family's perceptions of the patient's needs shall be documented.

The patient's participation in the development of the treatment plans is sought and documented.

Each patient is reassessed to determine current clinical problems, needs, and responses to treatment. Changes in treatment are documented.

(6) Discharge plan. Plans for discharge shall meet the requirements for discharge plans for alcohol and substance abuse patients in subrule 78.31(3), paragraph "a," subparagraph (6).

(7) Restriction and limitations on payment. Medicaid will pay for a maximum of 30 days of a structured outpatient treatment program. Payment beyond 30 days is made when documentation indicates that the patient has not reached an exit level.

Eating disorder programs will include an aftercare component meeting weekly for at least one year without charge.

Family counseling groups held in conjunction with the eating disorders program will be part of the overall treatment charge.

c. Cardiac rehabilitation.

(1) General characteristics. Cardiac rehabilitation programs shall provide a supportive educational environment in which to facilitate behavior change with respect to the accepted cardiac risk factors, initiate prescribed exercise as a mode of facilitating the return of the patient to everyday activities by improving cardiovascular functional capacity and work performance, and promote a long-term commitment to lifestyle changes that could positively affect the course of the cardiovascular disease process.

(2) Treatment staff. Professional disciplines who must be represented on the treatment staff, either by employment by the facility (full-time or part-time), contract or referral, are as follows:

At least one physician responsible for responding to emergencies must be physically present in the hospital when patients are receiving cardiac rehabilitation services. The physician must be trained and certified at least to the level of basic life support.

A medical consultant shall oversee the policies and procedures of the outpatient cardiac rehabilitation area. The director shall meet with the cardiac rehabilitation staff on a regular basis to review exercise prescriptions and any concerns of the team.

A cardiac rehabilitation nurse shall carry out the exercise prescription after assessment of the patient. The nurse shall be able to interpret cardiac dysrhythmia and be able to initiate emergency action if necessary. The nurse shall assess and implement a plan of care for cardiac risk factor modification. The nurse shall have at least one year of experience in a coronary care unit.

A physical therapist shall offer expertise in unusual exercise prescriptions where a patient has an unusual exercise problem.

A dietitian shall assess the dietary needs of persons and appropriately instruct them on their prescribed diets.

A social worker shall provide counseling as appropriate and facilitate a spouse support group. A licensed occupational therapist shall be available as necessary.

(3) Admission criteria. Candidates for the program must be referred by the attending physician. The following conditions are eligible for the program:

Postmyocardial infarction (within three months postdischarge).

Postcardiac surgery (within three months postdischarge).

Poststreptokinase.

Postpercutaneous transluminal angioplasty (within three months postdischarge).

Patient with severe angina being treated medically because of client or doctor preference or inoperable cardiac disease.

(4) Physical environment and equipment. A cardiac rehabilitation unit must be an autonomous physical unit specifically equipped with the necessary telemetry monitoring equipment, exercise equipment, and appropriate equipment and supplies for cardiopulmonary resuscitation (CPR). The exercise equipment must have the capacity to measure the intensity, speed, and length of the exercises. The equipment must be periodically inspected and maintained in accordance with the hospital's preventive maintenance program.

(5) Medical records. Medical records for each cardiac rehabilitation patient shall consist of at least the following:

Referral form.  
Physician's orders.  
Laboratory reports.  
Electrocardiogram reports.  
History and physical examination.  
Angiogram report, if applicable.  
Operative report, if applicable.  
Preadmission interview.  
Exercise prescription.  
Rehabilitation plan, including participant's goals.  
Documentation for exercise sessions and progress notes.  
Nurse's progress reports.  
Discharge instructions.

(6) Discharge plan. The patient will be discharged from the program when the physician, staff, and patient agree that the work level is functional for them and little benefit could be derived from further continuation of the program, dysrhythmia disturbances are resolved, and appropriate cardiovascular response to exercise is accomplished.

(7) Monitoring of services. The program should be monitored by the hospital on a periodic basis using measuring criteria for evaluating cardiac rehabilitation services provided.

(8) Restrictions and limitations. Payment will be made for a maximum of three visits per week for a period of 12 weeks. Payment beyond 12 weeks is made when documentation indicates that the patient has not reached an exit level.

*d.* Mental health.

(1) General characteristics. To be covered, mental health services must be prescribed by a physician or certified health service provider in psychology, provided under an individualized treatment plan and reasonable and necessary for the diagnosis or treatment of the patient's condition. This means the services must be for the purpose of diagnostic study or the services must reasonably be expected to improve the patient's condition.

(2) Individualized treatment plan. The individualized written plan of treatment shall be established by a physician or certified health service provider in psychology after any needed consultation with appropriate staff members. The plan must state the type, amount, frequency and duration of the services to be furnished and indicate the diagnoses and anticipated goals. (A plan is not required if only a few brief services will be furnished.)

(3) Supervision and evaluation. Services must be supervised and periodically evaluated by a physician, certified health service provider in psychology, or both within the scopes of their respective practices if clinically indicated to determine the extent to which treatment goals are being realized. The evaluation must be based on periodic consultation and conference with therapists and staff. The physician or certified health service provider in psychology must also provide supervision and direction to any therapist involved in the patient's treatment and see the patient periodically to evaluate the course of treatment and to determine the extent to which treatment goals are being realized and whether changes in direction or services are required.

(4) Reasonable expectation of improvement. Services must be for the purpose of diagnostic study or reasonably be expected to improve the patient's condition. The treatment must at a minimum be designed to reduce or control the patient's psychiatric or psychological symptoms so as to prevent relapse or hospitalization and improve or maintain the patient's level of functioning.

It is not necessary that a course of therapy have as its goal restoration of the patient to the level of functioning exhibited prior to the onset of the illness although this may be appropriate for some patients. For many other patients, particularly those with long-term chronic conditions, control of symptoms and maintenance of a functional level to avoid further deterioration or hospitalization is an acceptable expectation of improvement. "Improvement" in this context is measured by comparing the effect of continuing versus discontinuing treatment. Where there is a reasonable expectation that if

treatment services were withdrawn, the patient's condition would deteriorate, relapse further, or require hospitalization, this criterion would be met.

(5) Diagnostic and treatment staff. Each person who provides diagnostic or treatment services shall be determined to be competent to provide the services by reason of education, training, and experience. The number of the above staff employed by the facility must be appropriate to the facility's patient load. The staff may be employees of the hospital, on contract, or the service may be provided through referral.

The diagnostic and treatment staff shall consist of a physician, a psychologist, social workers or counselors meeting the requirements for "mental health professionals" as set forth in rule 441—33.1(225C,230A).

(6) Initial assessment. A comprehensive assessment of the biological, psychological, social, and spiritual orientation of the patient must be conducted, which shall include:

A history of the mental health problem, including age of onset, duration, patterns of symptoms, consequences of symptoms, and responses to previous treatment.

A comprehensive clinical history, including the history of physical problems associated with the mental health problem. Appropriate referral for physical examination for determination of any communicable diseases.

Any history of physical abuse.

A systematic mental health examination, with special emphasis on any change in cognitive, social or emotional functioning.

A determination of current and past psychiatric and psychological abnormality.

A determination of any degree of danger to self or others.

The family's history of mental health problems.

The patient's educational level, vocational status, and job performance history.

The patient's social support network, including family and peer relationship.

The patient's perception of the patient's strengths, problem areas, and dependencies.

The patient's leisure, recreational or vocational interests and hobbies.

The patient's ability to participate with peers in programs and social activities.

Interview of family members and significant others, as available, with the patient's written or verbal permission.

Legal problems if applicable.

(7) Covered services. Services covered for the treatment of psychiatric conditions are:

1. Individual and group therapy with physicians, psychologists, social workers, counselors, or psychiatric nurses.

2. Occupational therapy services if the services require the skills of a qualified occupational therapist and must be performed by or under the supervision of a licensed occupational therapist or by an occupational therapy assistant.

3. Drugs and biologicals furnished to outpatients for therapeutic purposes only if they are of the type which cannot be self-administered and are not "covered Part D drugs" as defined by 42 U.S.C. Section 1395w-102(e)(1)-(2) for a "Part D eligible individual" as defined in 42 U.S.C. Section 1395w-101(a)(3)(A), including an individual who is not enrolled in a Part D plan.

4. Activity therapies which are individualized and essential for the treatment of the patient's condition. The treatment plan must clearly justify the need for each particular therapy utilized and explain how it fits into the patient's treatment.

5. Family counseling services are covered only if the primary purpose of the counseling is the treatment of the patient's condition.

6. Partial hospitalization and day treatment services to reduce or control a person's psychiatric or psychological symptoms so as to prevent relapse or hospitalization, improve or maintain the person's level of functioning and minimize regression. These services include all psychiatric services needed by the patient during the day.

Partial hospitalization services means an active treatment program that provides intensive and structured support that assists persons during periods of acute psychiatric or psychological distress or during transition periods, generally following acute inpatient hospitalization episodes.

Service components may include individual and group therapy, reality orientation, stress management and medication management.

Services are provided for a period for four to eight hours per day.

Day treatment services means structured, long-term services designed to assist in restoring, maintaining or increasing levels of functioning, minimizing regression and preventing hospitalization.

Service components include training in independent functioning skills necessary for self-care, emotional stability and psychosocial interactions, and training in medication management.

Services are structured with an emphasis on program variation according to individual need.

Services are provided for a period of three to five hours per day, three or four times per week.

7. Partial hospitalization and day treatment for persons aged 20 or under. Payment to a hospital will be approved for day treatment services for persons aged 20 or under if the hospital is certified by the department for hospital outpatient mental health services. All conditions for the day treatment program for persons aged 20 or under as outlined in subrule 78.16(7) for community mental health centers shall apply to hospitals. All conditions of the day treatment program for persons aged 20 or under as outlined in subrule 78.16(7) for community mental health centers shall be applicable for the partial hospitalization program for persons aged 20 or under with the exception that the maximum hours shall be 25 hours per week.

(8) Restrictions and limitations on coverage. The following are generally not covered except as indicated:

Activity therapies, group activities, or other services and programs which are primarily recreational or diversional in nature. Outpatient psychiatric day treatment programs that consist entirely of activity therapies are not covered.

Geriatric day-care programs, which provide social and recreational activities to older persons who need some supervision during the day while other family members are away from home. These programs are not covered because they are not considered reasonable and necessary for a diagnosed psychiatric disorder.

Vocational training. While occupational therapy may include vocational and prevocational assessment of training, when the services are related solely to specific employment opportunities, work skills, or work setting, they are not covered.

(9) Frequency and duration of services. There are no specific limits on the length of time that services may be covered. There are many factors that affect the outcome of treatment. Among them are the nature of the illness, prior history, the goals of treatment, and the patient's response. As long as the evidence shows that the patient continues to show improvement in accordance with the individualized treatment plan and the frequency of services is within acceptable norms of medical practice, coverage will be continued.

(10) Documentation requirements. The provider shall develop and maintain sufficient written documentation to support each medical or remedial therapy, service, activity, or session for which billing is made. All outpatient mental health services shall include:

1. The specific services rendered.
2. The date and actual time the services were rendered.
3. Who rendered the services.
4. The setting in which the services were rendered.
5. The amount of time it took to deliver the services.
6. The relationship of the services to the treatment regimen described in the plan of care.
7. Updates describing the patient's progress.

For services that are not specifically included in the patient's treatment plan, a detailed explanation of how the services being billed relate to the treatment regimen and objectives contained in the patient's plan of care and the reason for the departure from the plan shall be given.

*e.* Pain management.

(1) Approval by commission on accreditation of rehabilitation facilities. In addition to certification by the department, pain management programs must also be approved by the commission on accreditation of rehabilitation facilities (CARF).

(2) General characteristics. A chronic pain management program shall provide coordinated, goal-oriented, interdisciplinary team services to reduce pain, improve quality of life, and decrease dependence on the health care system for persons with pain which interferes with physical, psychosocial, and vocational functioning.

(3) Treatment staff. Each person who provides treatment services shall be determined to be competent to provide the services by reason of education, training, and experience. Professional disciplines which must be represented on the treatment staff, either through employment by the facility (full-time or part-time), contract or referral, are a physician (M.D. or D.O.), a registered nurse, a licensed physical therapist and a licensed clinical psychologist or psychiatrist. The number of staff should be appropriate to the patient load of the facility.

(4) Admission criteria. Candidates for the program shall meet the following guidelines:

The person must have had adequate medical evaluation and treatment in the months preceding admission to the program including an orthopedic or neurological consultation if the problem is back pain or a neurological evaluation if the underlying problem is headaches.

The person must be free of any underlying psychosis or severe neurosis.

The person cannot be toxic on any addictive drugs.

The person must be capable of self-care; including being able to get to meals and to perform activities of daily living.

(5) Plan of treatment. For each patient there is a written comprehensive and individualized description of treatment to be undertaken. The treatment plan is based on the problems and needs identified in the assessment and specifies the times at which the plan will be reassessed.

The patient's perception of needs and, when appropriate and available, the family's perception of the patient's needs shall be documented.

The patient's participation in the development of the treatment plan is sought and documented.

Each patient is reassessed to determine current clinical problems, needs, and responses to treatment. Changes in treatment are documented.

(6) Discharge plan. For each patient before discharge, a plan for discharge is designed to provide appropriate continuity of care which meets the following requirements:

The plan for continuing care must describe and facilitate the transfer of the patient and the responsibility for the patient's continuing care to another phase or modality of the program, other programs, agencies, persons or to the patient and the patient's personal support system.

The plan is in accordance with the patient's reassessed needs at the time of transfer.

The plan is developed in collaboration with the patient and, as appropriate and available, with the patient's written verbal permission with the family members.

The plan is implemented in a manner acceptable to the patient and the need for confidentiality.

Implementation of the plan includes timely and direct communication with and transfer of information to the other programs, agencies, or persons who will be providing continuing care.

(7) Restrictions and limitations on payment. Medicaid will pay for a maximum of three weeks of a structured outpatient treatment program. When documentation indicates that the patient has not reached an exit level, coverage may be extended an extra week.

A repeat of the entire program for any patient will be covered only if a different disease process is causing the pain or a significant change in life situation can be demonstrated.

*f.* Diabetic education.

(1) Certification by department of public health. In addition to certification by the department for Medicaid, diabetic education programs must also be certified by the department of public health. (See department of public health rules 641—Chapter 9.)

(2) General characteristics. An outpatient diabetes self-management education program shall provide instruction which will enable people with diabetes and their families to understand the diabetes disease process and the daily management of diabetes. People with diabetes must learn to balance their special diet and exercise requirements with drug therapy (insulin or oral agents). They must learn self-care techniques such as monitoring their own blood glucose. And often, they must learn to

self-treat insulin reactions, protect feet that are numb and have seriously compromised circulation, and accommodate their regimen to changes in blood glucose because of stress or infections.

(3) Program staff. Each person who provides services shall be determined to be competent to provide the services by reason of education, training and experience. Professional disciplines which must be represented on the staff, either through employment by the facility (full-time or part-time), contract or referral, are a physician (M.D. or D.O.), a registered nurse, a registered dietitian and a licensed pharmacist. The number of staff should be appropriate to the patient load of the facility.

(4) Admission criteria. Candidates for the program shall meet the following guidelines:

The person must have Type I or Type II diabetes.

The person must be referred by the attending physician.

The person shall demonstrate an ability to follow through with self-management.

(5) Health assessment. An individualized and documented assessment of needs shall be developed with the patient's participation. Follow-up assessments, planning and identification of problems shall be provided.

(6) Restrictions and limitations on payment. Medicaid will pay for a diabetic self-management education program. Diabetic education programs will include follow-up assessments at 3 and 12 months without charge. A complete diabetic education program is payable once in the lifetime of a recipient.

g. Pulmonary rehabilitation.

(1) General characteristics. Pulmonary rehabilitation is an individually tailored, multidisciplinary program through which accurate diagnosis, therapy, emotional support, and education stabilizes or reverses both the physio- and psychopathology of pulmonary diseases and attempts to return the patient to the highest possible functional capacity allowed by the pulmonary handicap and overall life situation.

(2) Diagnostic and treatment staff. Each person who provides diagnostic or treatment services shall be determined to be competent to provide the services by reason of education, training, and experience.

Professional disciplines which must be represented by the diagnostic and treatment staff, either through employment by the facility (full-time or part-time), contract, or referral, are a physician (doctor of medicine or osteopathy), a respiratory therapist, a licensed physical therapist, and a registered nurse.

(3) Initial assessment. A comprehensive assessment must occur initially, including:

A diagnostic workup which entails proper identification of the patient's specific respiratory ailment, appropriate pulmonary function studies, a chest radiograph, an electrocardiogram and, when indicated, arterial blood gas measurements at rest and during exercise, sputum analysis and blood theophylline measurements.

Behavioral considerations include emotional screening assessments and treatment or counseling when required, estimating the patient's learning skills and adjusting the program to the patient's ability, assessing family and social support, potential employment skills, employment opportunities, and community resources.

(4) Admission criteria. Criteria include a patient's being diagnosed and symptomatic of chronic obstructive pulmonary disease (COPD), having cardiac stability, social, family, and financial resources, ability to tolerate periods of sitting time; and being a nonsmoker for six months, or if a smoker, willingness to quit and a physician's order to participate anyway.

Factors which would make a person ineligible include acute or chronic illness that may interfere with rehabilitation, any illness or disease state that affects comprehension or retention of information, a strong history of medical noncompliance, unstable cardiac or cardiovascular problems, and orthopedic difficulties that would prohibit exercise.

(5) Plan of treatment. Individualized long- and short-term goals will be developed for each patient. The treatment goals will be based on the problems and needs identified in the assessment and specify the regular times at which the plan will be reassessed.

The patients and their families need to help determine and fully understand the goals, so that they realistically approach the treatment phase.

Patients are reassessed to determine current clinical problems, needs, and responses to treatment. Changes in treatment are documented.

Components of pulmonary rehabilitation to be included are physical therapy and relaxation techniques, exercise conditioning or physical conditioning for those with exercise limitations, respiratory therapy, education, an emphasis on the importance of smoking cessation, and nutritional information.

(6) Discharge plan. Ongoing care will generally be the responsibility of the primary care physician. Periodic reassessment will be conducted to evaluate progress and allow for educational reinforcement.

(7) Restrictions and limitations on payment. Medicaid will pay for a maximum of 25 treatment days. Payment beyond 25 days is made when documentation indicates that the patient has not reached an exit level.

*h.* Nutritional counseling. Payment will be made for persons aged 20 and under for nutritional counseling provided by a licensed dietitian employed by or under contract with a hospital for a nutritional problem or condition of a degree of severity that nutritional counseling beyond that normally expected as part of the standard medical management is warranted. For persons eligible for the WIC program, a WIC referral is required. Medical necessity for nutritional counseling services exceeding those available through WIC shall be documented.

**78.31(5)** *Services rendered by advanced registered nurse practitioners certified in family, pediatric, or psychiatric mental health specialties and employed by a hospital.* Rescinded IAB 10/15/03, effective 12/1/03.

This rule is intended to implement Iowa Code section 249A.4.  
[ARC 0065C, IAB 4/4/12, effective 6/1/12; ARC 2164C, IAB 9/30/15, effective 10/1/15; ARC 2361C, IAB 1/6/16, effective 1/1/16]

**441—78.32(249A) Area education agencies.** Payment will be made for physical therapy, occupational therapy, psychological evaluations and counseling, psychotherapy, speech-language therapy, and audiological, nursing, and vision services provided by an area education agency (AEA). Services shall be provided directly by the AEA or through contractual arrangement with the AEA.

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

**441—78.33(249A) Case management services.** Payment will be approved for targeted case management services that are provided pursuant to 441—Chapter 90 to:

1. Members who are 18 years of age or over and have a primary diagnosis of intellectual disability, developmental disabilities, or chronic mental illness as defined in rule 441—90.1(249A).

2. Members who are under 18 years of age and are receiving services under the HCBS intellectual disability waiver or children's mental health waiver.

This rule is intended to implement Iowa Code section 249A.4.  
[ARC 9403B, IAB 3/9/11, effective 5/1/11; ARC 9588B, IAB 6/29/11, effective 9/1/11; ARC 0848C, IAB 7/24/13, effective 7/1/13; ARC 1051C, IAB 10/2/13, effective 11/6/13; ARC 2361C, IAB 1/6/16, effective 1/1/16]

**441—78.34(249A) HCBS ill and handicapped waiver services.** Payment will be approved for the following services to members eligible for HCBS ill and handicapped waiver services as established in 441—Chapter 83 and as identified in the member's service plan. Effective March 17, 2022, payment shall only be made for services provided in integrated, community-based settings that support full access of members receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.

**78.34(1) Homemaker services.** Homemaker services are those services provided when the member lives alone or when the person who usually performs these functions for the member needs assistance with performing the functions. A unit of service is 15 minutes. Components of the service must be directly related to the care of the member and may include only the following:

*a.* Essential shopping: shopping for basic need items such as food, clothing or personal care items, or drugs.

*b.* Limited housecleaning: maintenance cleaning such as vacuuming, dusting, scrubbing floors, defrosting refrigerators, cleaning stoves, cleaning medical equipment, washing and mending clothes, washing personal items used by the member, and washing dishes.

*c.* Meal preparation: planning and preparing balanced meals.

**78.34(2) Home health services.** Home health services are personal or direct care services provided to the client which are not payable under Medicaid as set forth in rule 441—78.9(249A). A unit of service is a visit.

*a.* Components of the service include, but are not limited to:

- (1) Observation and reporting of physical or emotional needs.
- (2) Helping a client with bath, shampoo, or oral hygiene.
- (3) Helping a client with toileting.
- (4) Helping a client in and out of bed and with ambulation.
- (5) Helping a client reestablish activities of daily living.
- (6) Assisting with oral medications ordered by the physician which are ordinarily self-administered.
- (7) Performing incidental household services which are essential to the client's health care at home and are necessary to prevent or postpone institutionalization in order to complete a full unit of service.
- (8) Accompaniment to medical services or transport to and from school.

*b.* In some cases, a nurse may provide home health services if the health of the client is such that the agency is unable to place an aide in that situation due to limitations by state law or in the event that the agency's Medicare certification requirements prohibit the aide from providing the service. It is not permitted for the convenience of the provider.

*c.* Skilled nursing care is not covered.

**78.34(3) Adult day care services.** Adult day care services provide an organized program of supportive care in a group environment to persons who need a degree of supervision and assistance on a regular or intermittent basis in a day care center. A unit of service is 15 minutes (up to four units per day), a half day (1.25 to 4 hours per day), a full day (4.25 to 8 hours per day), or an extended day (8.25 to 12 hours per day). Components of the service include health-related care, social services, and other related support services.

**78.34(4) Nursing care services.** Nursing care services are services which are included in the plan of treatment approved by the physician and which are provided by licensed nurses to consumers in the home and community. The services shall be reasonable and necessary to the treatment of an illness or injury and include all nursing tasks recognized by the Iowa board of nursing. A unit of service is a visit.

**78.34(5) Respite care services.** Respite care services are services provided to the member that give temporary relief to the usual caregiver and provide all the necessary care that the usual caregiver would provide during that period. The purpose of respite care is to enable the member to remain in the member's current living situation.

*a.* Services provided outside the member's home shall not be reimbursable if the living unit where respite is provided is reserved for another person on a temporary leave of absence.

*b.* Member-to-staff ratios shall be appropriate to the individual needs of the member as determined by the member's interdisciplinary team.

*c.* A unit of service is 15 minutes.

*d.* Respite care is not to be provided to members during the hours in which the usual caregiver is employed except when the member is attending a 24-hour residential camp. Respite care shall not be used as a substitute for a child's day care. Respite cannot be provided to a member whose usual caregiver is a consumer-directed attendant care provider for the member.

*e.* The interdisciplinary team shall determine if the member will receive basic individual respite, specialized respite, or group respite as defined in 441—Chapter 83.

*f.* A maximum of 14 consecutive days of 24-hour respite care may be reimbursed.

*g.* Respite services provided for a period exceeding 24 consecutive hours to three or more individuals who require nursing care because of a mental or physical condition must be provided by a health care facility licensed as described in Iowa Code chapter 135C.

*h.* Respite services shall not be provided simultaneously with other residential, nursing, or home health aide services provided through the medical assistance program.

**78.34(6) *Counseling services.*** Counseling services are face-to-face mental health services provided to the member and caregiver by a mental health professional as defined in rule 441—24.1(225C) to facilitate home management of the member and prevent institutionalization. Counseling services are nonpsychiatric services necessary for the management of depression, assistance with the grief process, alleviation of psychosocial isolation and support in coping with a disability or illness, including terminal illness. Counseling services may be provided both for the purpose of training the member's family or other caregiver to provide care and for the purpose of helping the member and those caring for the member to adjust to the member's disability or terminal condition. Counseling services may be provided to the member's caregiver only when included in the case plan for the member.

Payment will be made for individual and group counseling. A unit of individual counseling for the waiver member or the waiver member and the member's caregiver is 15 minutes. A unit of group counseling is 15 minutes. Payment for group counseling is based on the group rate divided by six, or, if the number of persons who comprise the group exceeds six, the actual number of persons who comprise the group.

**78.34(7) *Consumer-directed attendant care service.*** Consumer-directed attendant care services are service activities performed by a person to help a member with self-care tasks which the member would typically do independently if the member were otherwise able. Covered service activities are limited to the nonskilled activities listed in paragraph 78.34(7) "f" and the skilled activities listed in paragraph 78.34(7) "g." Covered service activities must be essential to the health, safety, and welfare of the member. Services may be provided in the absence of a parent or guardian if the parent or guardian has given advance direction for the service provision.

*a. Service planning.*

(1) The member, parent, guardian, or attorney in fact under a durable power of attorney for health care shall:

1. Select the individual or agency that will provide the components of the attendant care services.
2. Determine with the selected provider what components of attendant care services the provider shall perform, subject to confirmation by the service worker or case manager that those components are consistent with the assessment and are authorized covered services.

3. Complete, sign, and date Form 470-3372, HCBS Consumer-Directed Attendant Care Agreement, to indicate the frequency, scope, and duration of services (a description of each service component and the time agreed on for that component). The case manager or service worker and provider shall also sign the agreement.

4. Submit the completed agreement to the service worker or case manager. The agreement shall be part of the member's service plan and shall be kept in the member's records, in the provider's records, and in the service worker's or case manager's records. Any service component that is not listed in the agreement shall not be payable.

(2) Whenever a legal representative acts as a provider of consumer-directed attendant care as allowed by 441—paragraph 79.9(7) "b," the following shall apply:

1. The payment rate for the legal representative must be based on the skill level of the legal representative and may not exceed the median statewide reimbursement rate for the service unless the higher rate receives prior approval from the department;

2. The legal representative may not be paid for more than 40 hours of service per week; and

3. A contingency plan must be established in the member's service plan to ensure service delivery in the event the legal representative is unable to provide services due to illness or other unexpected event.

*b. Supervision of skilled services.* Skilled consumer-directed attendant care services shall be provided under the supervision of a licensed nurse or licensed therapist working under the direction of a physician. The licensed nurse or therapist shall:

- (1) Retain accountability for actions that are delegated.

- (2) Ensure appropriate assessment, planning, implementation, and evaluation.

- (3) Make on-site supervisory visits every two weeks with the service provider present.

*c. Service documentation.* The consumer-directed attendant care provider must complete Form 470-4389, Consumer-Directed Attendant Care (CDAC) Service Record, for each day of service. Any service component that is not documented in accordance with rule 441—79.3(249A) shall not be payable.

*d. Role of guardian or attorney.* If the member has a guardian or attorney in fact under a durable power of attorney for health care:

(1) The service worker's or case manager's service plan shall address how consumer-directed attendant care services will be monitored to ensure that the member's needs are being adequately met. If the guardian or attorney in fact is the service provider, the service plan shall address how the service worker or case manager shall oversee service provision.

(2) The guardian or attorney in fact shall sign the claim form in place of the member, indicating that the service has been provided as presented on the claim.

*e. Service units and billing.* A unit of service is 15 minutes provided by an individual or agency. Each service shall be billed in whole units.

*f. Nonskilled services.* Covered nonskilled service activities are limited to help with the following activities:

(1) Dressing.

(2) Bathing, shampooing, hygiene, and grooming.

(3) Access to and from bed or a wheelchair, transferring, ambulation, and mobility in general.

(4) Toileting, including bowel, bladder, and catheter assistance (emptying the catheter bag, collecting a specimen, and cleaning the external area around the catheter).

(5) Meal preparation, cooking, and assistance with feeding, not including the cost of meals themselves. Meal preparation and cooking shall be provided only in the member's home.

(6) Housekeeping, laundry, and shopping essential to the member's health care at home.

(7) Taking medications ordinarily self-administered, including those ordered by a physician or other qualified health care provider.

(8) Minor wound care.

(9) Going to or returning from a place of employment and job-related tasks while the member is on the job site. Transportation for the member and assistance with understanding or performing the essential job functions are not included in consumer-directed attendant care services.

(10) Tasks, such as financial management and scheduling, that require cognitive or physical assistance.

(11) Communication essential to the health and welfare of the member, through interpreting and reading services and use of assistive devices for communication.

(12) Using transportation essential to the health and welfare of the member. The cost of the transportation is not included.

*g. Skilled services.* Covered skilled service activities are limited to help with the following activities:

(1) Tube feedings of members unable to eat solid foods.

(2) Intravenous therapy administered by a registered nurse.

(3) Parenteral injections required more than once a week.

(4) Catheterizations, continuing care of indwelling catheters with supervision of irrigations, and changing of Foley catheters when required.

(5) Respiratory care including inhalation therapy and tracheotomy care or tracheotomy care and ventilator.

(6) Care of decubiti and other ulcerated areas, noting and reporting to the nurse or therapist.

(7) Rehabilitation services including, but not limited to, bowel and bladder training, range of motion exercises, ambulation training, restorative nursing services, respiratory care and breathing programs, reality orientation, reminiscing therapy, remotivation, behavior modification, and reteaching of the activities of daily living.

(8) Colostomy care.

(9) Care of uncontrolled medical conditions, such as brittle diabetes, and comfort care of terminal conditions.

(10) Postsurgical nursing care.

(11) Monitoring medications requiring close supervision because of fluctuating physical or psychological conditions, e.g., antihypertensives, digitalis preparations, mood-altering or psychotropic drugs, or narcotics.

(12) Preparing and monitoring response to therapeutic diets.

(13) Recording and reporting of changes in vital signs to the nurse or therapist.

*h. Excluded services and costs.* Services, activities, costs and time that are not covered as consumer-directed attendant care include the following (not an exclusive list):

(1) Any activity related to supervising a member. Only direct services are billable.

(2) Any activity that the member is able to perform.

(3) Costs of food.

(4) Costs for the supervision of skilled services by the nurse or therapist. The supervising nurse or therapist may be paid from private insurance, Medicare, or other third-party payment sources, or may be paid as another Medicaid service, including early and periodic screening, diagnosis and treatment services.

(5) Exercise that does not require skilled services.

(6) Parenting or child care for or on behalf of the member.

(7) Reminders and cueing.

(8) Services provided simultaneously with any other similar service regardless of funding source, including other waiver services and state supplementary assistance in-home health-related care services.

(9) Transportation costs.

(10) Wait times for any activity.

**78.34(8)** *Interim medical monitoring and treatment services.* Interim medical monitoring and treatment (IMMT) services are monitoring and treatment of a medical nature for children or adults whose medical needs make alternative care unavailable, inadequate, or insufficient. IMMT services are not intended to provide day care but to supplement available resources. Services must be ordered by a physician.

*a.* Need for service. The member must be currently receiving home health agency services under rule 441—78.9(249A) and require medical assessment, medical monitoring, and regular medical intervention or intervention in a medical emergency during those services. The service worker or case manager must identify the need for IMMT services after evaluating the member's living environment, family and natural supports, ability to perform activities of daily living, and health care needs. The services must be needed:

(1) To allow the member's usual caregivers to be employed,

(2) During a search for employment by a usual caregiver,

(3) To allow for academic or vocational training of a usual caregiver,

(4) Due to the hospitalization of a usual caregiver for treatment for physical or mental illness, or

(5) Due to the death of a usual caregiver.

*b.* Service requirements. Interim medical monitoring and treatment services shall:

(1) Provide experiences for each member's social, emotional, intellectual, and physical development;

(2) Include comprehensive developmental care and any special services for a member with special needs; and

(3) Include medical assessment, medical monitoring, and medical intervention as needed on a regular or emergency basis. Medical intervention means the ability to assess the situation and contact the appropriate medical professional, not the direct application of medical care.

*c.* Interim medical monitoring and treatment services may include supervision while the member is being transported to and from school.

*d.* Limitations.

(1) A maximum of 12 hours of service is available per day.

(2) Covered services do not include a complete nutritional regimen.

(3) Interim medical monitoring and treatment services may not duplicate any regular Medicaid or waiver services provided under the state plan. Services under the state plan, including home health agency services under rule 441—78.9(249A), must be exhausted before IMMT services are accessed.

(4) Interim medical monitoring and treatment services shall be provided in the following settings that are approved by the department as integrated, community-based settings: the member's home; a registered child development home; a licensed child care center, residential care facility, or adult day care facility; or during the time when the member is being transported to and from school.

(5) The member-to-staff ratio shall not be more than six members to one staff person.

(6) The parent or guardian of the member shall be responsible for the usual and customary nonmedical cost of day care during the time in which the member is receiving IMMT services. Medical care necessary for monitoring and treatment is an allowable IMMT cost. If the cost of care goes above the usual and customary cost of day care services due to the member's medical condition, the costs above the usual and customary cost shall be covered as IMMT services.

*e.* A unit of service is 15 minutes.

**78.34(9) Home and vehicle modification.** Covered home or vehicle modifications are physical modifications to the member's home or vehicle that directly address the member's medical or remedial need. Covered modifications must be necessary to provide for the health, welfare, or safety of the member and enable the member to function with greater independence in the home or vehicle.

*a.* Modifications that are necessary or desirable without regard to the member's medical or remedial need and that would be expected to increase the fair market value of the home or vehicle, such as furnaces, fencing, or adding square footage to the residence, are excluded except as specifically included below. Purchasing or leasing of a motorized vehicle is excluded. Home and vehicle repairs are also excluded.

*b.* Only the following modifications are covered:

(1) Kitchen counters, sink space, cabinets, special adaptations to refrigerators, stoves, and ovens.  
 (2) Bathtubs and toilets to accommodate transfer, special handles and hoses for shower heads, water faucet controls, and accessible showers and sink areas.

(3) Grab bars and handrails.

(4) Turnaround space adaptations.

(5) Ramps, lifts, and door, hall and window widening.

(6) Fire safety alarm equipment specific for disability.

(7) Voice-activated, sound-activated, light-activated, motion-activated, and electronic devices directly related to the member's disability.

(8) Vehicle lifts, driver-specific adaptations, remote-start systems, including such modifications already installed in a vehicle.

(9) Keyless entry systems.

(10) Automatic opening device for home or vehicle door.

(11) Special door and window locks.

(12) Specialized doorknobs and handles.

(13) Plexiglas replacement for glass windows.

(14) Modification of existing stairs to widen, lower, raise or enclose open stairs.

(15) Motion detectors.

(16) Low-pile carpeting or slip-resistant flooring.

(17) Telecommunications device for the deaf.

(18) Exterior hard-surface pathways.

(19) New door opening.

(20) Pocket doors.

(21) Installation or relocation of controls, outlets, switches.

(22) Air conditioning and air filtering if medically necessary.

(23) Heightening of existing garage door opening to accommodate modified van.

(24) Bath chairs.

*c.* A unit of service is the completion of needed modifications or adaptations.

d. All modifications and adaptations shall be provided in accordance with applicable federal, state, and local building and vehicle codes.

e. Services shall be performed following prior department approval of the modification as specified in 441—subrule 79.1(17) and a binding contract between the provider and the member.

f. All contracts for home or vehicle modification shall be awarded through competitive bidding. The contract shall include the scope of work to be performed, the time involved, supplies needed, the cost, diagrams of the project whenever applicable, and an assurance that the provider has liability and workers' compensation coverage and the applicable permit and license.

g. Service payment shall be made to the enrolled home or vehicle modification provider. If applicable, payment will be forwarded to the subcontracting agency by the enrolled home or vehicle modification provider following completion of the approved modifications. Payment of up to \$6,366.64 per year may be made to certified providers upon satisfactory completion of the service.

h. Services shall be included in the member's service plan and shall exceed the Medicaid state plan services.

**78.34(10)** *Personal emergency response or portable locator system.*

a. A personal emergency response system is an electronic device that transmits a signal to a central monitoring station to summon assistance in the event of an emergency.

(1) The required components of the system are:

1. An in-home medical communications transceiver.
2. A remote, portable activator.
3. A central monitoring station with backup systems staffed by trained attendants at all times.
4. Current data files at the central monitoring station containing response protocols and personal, medical, and emergency information for each member.

(2) The service shall be identified in the member's service plan.

(3) A unit of service is a one-time installation fee or one month of service.

(4) Maximum units per state fiscal year shall be the initial installation and 12 months of service.

b. A portable locator system is an electronic device that transmits a signal to a monitoring device. The system allows a member to access assistance in the event of an emergency and allows law enforcement or the monitoring system provider to locate a member who is unable to request help or to activate a system independently. The member must be unable to access assistance in an emergency situation due to the member's age or disability.

(1) The required components of the portable locator system are:

1. A portable communications transceiver or transmitter to be worn or carried by the member.
2. Monitoring by the provider at a central location with response protocols and personal, medical, and emergency information for each member as applicable.

(2) The service shall be identified in the member's service plan.

(3) Payable units of service are purchase of equipment, an installation or set-up fee, and monthly fees.

(4) Maximum units per state fiscal year shall be one equipment purchase, one installation or set-up fee, and 12 months of service.

**78.34(11)** *Home-delivered meals.* Home-delivered meals are meals prepared elsewhere and delivered to a member at the member's residence.

a. Each meal shall ensure the member receives a minimum of one-third of the daily recommended dietary allowance as established by the Food and Nutrition Board of the National Research Council of the National Academy of Sciences. The meal may also be a liquid supplement that meets the minimum one-third standard.

b. When a restaurant provides the home-delivered meal, the member is required to have a nutritional consultation. The nutritional consultation includes contact with the restaurant to explain the dietary needs of the member and what constitutes the minimum one-third daily dietary allowance.

c. A unit of service is a meal (morning, noon, evening, or liquid supplement). Any maximum combination of any two meals (morning, noon, evening, or liquid supplement) is allowed per day.

Duplication of a meal in any one day is not allowed. The number of approved meals (morning, noon, evening, or liquid supplement) is contained in the member's service plan.

*d.* The number of meals delivered for any morning, noon, evening, or liquid supplement meal cannot exceed the number of calendar days in a calendar month; nor can the number of delivered meals exceed the number of authorized days in a month. Meals billed in excess of the calendar days in a calendar month and those billed in excess of the number of authorized days in a month are subject to recoupment or denial of payment.

**78.34(12) Nutritional counseling.** Nutritional counseling services may be provided for a nutritional problem or condition of such a degree of severity that nutritional counseling beyond that normally expected as part of the standard medical management is warranted. A unit of service is 15 minutes.

**78.34(13) Consumer choices option.** The consumer choices option (CCO) provides a member with a flexible monthly individual budget that is based on the member's service needs. With the individual budget, the member shall have the authority to purchase goods and services to meet the member's assessed needs and may choose to employ providers of services and supports. The services, supports, and items that are purchased with an individual budget must be directly related to a member's assessed need or goal established in the member's service plan. The consumer choices option is available to any member receiving the AIDS/HIV, brain injury, elderly, health and disability, intellectual disability, or physical disability waiver programs who has the ability and desire to perform all budget authority tasks identified in paragraph 78.34(13) "g" and employer authority tasks identified in paragraph 78.34(13) "h," or who delegates the budget or employer authority tasks identified in paragraph 78.34(13) "i." Components of this service are set forth below.

*a. Agreement.* As a condition of participating in the consumer choices option, a member shall sign Form 470-4289, HCBS Consumer Choices Informed Consent and Risk Agreement, to document that the member has been informed of the responsibilities and risks of electing the consumer choices option.

*b. Individual budget amount.* A monthly individual budget amount shall be established for each member based on the assessed needs of the member and based on the services and supports authorized in the member's service plan. The member shall be informed of the individual budget amount during the development of the service plan.

(1) Services that may be included in determining the individual budget amount for a member in the HCBS health and disability waiver are:

1. Consumer-directed attendant care (unskilled).
2. Home and vehicle modification.
3. Home-delivered meals.
4. Homemaker service.
5. Basic individual respite care.

(2) Services that may be included in determining the individual budget amount for a member in the HCBS elderly waiver are:

1. Assistive devices.
2. Chore service.
3. Consumer-directed attendant care (unskilled).
4. Home and vehicle modification.
5. Home-delivered meals.
6. Homemaker service.
7. Basic individual respite care.
8. Senior companion.
9. Transportation.

(3) Services that may be included in determining the individual budget amount for a member in the HCBS AIDS/HIV waiver are:

1. Consumer-directed attendant care (unskilled).
2. Home-delivered meals.
3. Homemaker service.
4. Basic individual respite care.

(4) Services that may be included in determining the individual budget amount for a member in the HCBS intellectual disability waiver are:

1. Consumer-directed attendant care (unskilled).
2. Day habilitation.
3. Home and vehicle modification.
4. Prevocational services.
5. Basic individual respite care.
6. Supported community living.
7. Supported employment.
8. Transportation.

(5) Services that may be included in determining the individual budget amount for a member in the HCBS brain injury waiver are:

1. Consumer-directed attendant care (unskilled).
2. Home and vehicle modification.
3. Prevocational services.
4. Basic individual respite care.
5. Specialized medical equipment.
6. Supported community living.
7. Supported employment.
8. Transportation.

(6) Services that may be included in determining the individual budget amount for a member in the HCBS physical disability waiver are:

1. Consumer-directed attendant care (unskilled).
2. Home and vehicle modification.
3. Specialized medical equipment.
4. Transportation.

(7) The department shall determine an average unit cost for each service listed in subparagraphs 78.34(13)“b”(1) to (6) based on actual unit costs from the previous fiscal year plus a cost-of-living adjustment.

(8) In aggregate, costs for individual budget services shall not exceed the current costs of waiver program services. In order to maintain cost neutrality, the department shall apply a utilization adjustment factor to the amount of service authorized in the member’s service plan before calculating the value of that service to be included in the individual budget amount.

(9) The department shall compute the utilization adjustment factor for each service by dividing the net costs of all claims paid for the service by the total of the authorized costs for that service, using at least 12 consecutive months of aggregate service data. The utilization adjustment factor shall be no lower than 60 percent.

(10) Individual budgets for respite services shall be computed based on the average cost for services identified in subparagraph 78.34(13)“b”(7). Respite services are not subject to the utilization adjustment factor in subparagraph 78.34(13)“b”(8).

(11) Anticipated costs for home and vehicle modification, assistive devices, and specialized medical equipment are not subject to the average cost in subparagraph 78.34(13)“b”(7) or the utilization adjustment factor in subparagraph 78.34(13)“b”(8). The anticipated costs may include the costs of the financial management services and the independent support broker when the home and vehicle modification, assistive device, or specialized medical equipment is the only service included in the CCO monthly budget and the total cost for the home and vehicle modification, assistive device, or specialized medical equipment, including the cost of the financial management services and the independent support broker, is approved by the Iowa Medicaid enterprise or managed care organization as the least costly option to meet the member’s need. Costs for the home and vehicle modification, assistive device, or specialized medical equipment may be paid to the financial management services provider in a one-time payment. Before becoming part of the CCO monthly budget, all home and

vehicle modifications, assistive device, and specialized medical equipment shall be identified in the member's service plan and authorized by the case manager or community-based case manager.

(12) The individual budget amount may be changed only at the first of the month and shall remain fixed for the entire month.

*c. Required service components.* To participate in the consumer choices option, a member must hire an independent support broker and must work with a financial management service that is enrolled as a Medicaid provider. Before hiring the independent support broker, the member shall receive the results of the background check conducted pursuant to 441—Chapter 119.

*d. Optional service components.* A member who elects the consumer choices option may purchase the following goods, services and supports, which shall be provided in the member's home or at an integrated community setting:

(1) Self-directed personal care services. Self-directed personal care services are services that provide a range of assistance in activities of daily living and incidental activities of daily living that help the member remain in the home and community. These services must be identified in the member's service plan developed by the member's case manager or community-based case manager.

(2) Self-directed community supports and employment. Self-directed community supports and employment are services that support the member in developing and maintaining independence and community integration. These services must be identified in the member's service plan developed by the member's case manager or community-based case manager.

(3) Individual-directed goods and services. Individual-directed goods and services are services, equipment, or supplies not otherwise provided through the Medicaid program that address an assessed need or goal identified in the member's service plan. The item or service shall meet the following requirements:

1. Promote opportunities for community living and inclusion.
2. Increase independence or substitute for human assistance, to the extent the expenditures would otherwise be made for that human assistance.
3. Be accommodated within the member's budget without compromising the member's health and safety.
4. Be provided to the member or directed exclusively toward the benefit of the member.
5. Be the least costly to meet the member's needs.
6. Not be available through another source.

*e. Development of the individual budget.* The independent support broker shall assist the member in developing and implementing the member's individual budget. The individual budget shall include:

- (1) The costs of the financial management service.
- (2) The costs of the independent support broker. The independent support broker may be compensated for up to 6 hours of service for assisting with the implementation of the initial individual budget. The independent support broker shall not be paid for more than 30 hours of service for an individual member during a 12-month period without prior approval by the department.

(3) The costs of any optional service component chosen by the member as described in paragraph 78.34(13)“d.” At a minimum, the CCO monthly budget must include the purchase of self-directed personal care, individual-directed goods and services, or self-directed community supports and services needed to meet the amount of service authorized for use in CCO identified in the member's service plan. After funds have been budgeted to meet the identified needs, remaining funds from the monthly budget amount may be used to purchase additional self-directed personal care, individual-directed goods and services, or self-directed community supports and services as allowed by the monthly budget. The additional self-directed personal care, individual-directed goods and services, or self-directed community supports and services may exceed the amount of service or supports authorized in the member's service plan. Costs of the following items and services shall not be covered by the individual budget:

1. Child care services.
2. Clothing not related to an assessed medical need.

3. Conference, meeting or similar venue expenses other than the costs of approved services the member needs while attending the conference, meeting or similar venue.
  4. Costs associated with shipping items to the member.
  5. Experimental and non-FDA-approved medications, therapies, or treatments.
  6. Goods or services covered by other Medicaid programs.
  7. Home furnishings.
  8. Home repairs or home maintenance.
  9. Homeopathic treatments.
  10. Insurance premiums or copayments.
  11. Items purchased on installment payments.
  12. Motorized vehicles.
  13. Nutritional supplements.
  14. Personal entertainment items.
  15. Repairs and maintenance of motor vehicles.
  16. Room and board, including rent or mortgage payments.
  17. School tuition.
  18. Service animals.
  19. Services covered by third parties or services that are the responsibility of a non-Medicaid program.
  20. Sheltered workshop services.
  21. Social or recreational purchases not related to an assessed need or goal identified in the member's service plan.
  22. Vacation expenses, other than the costs of approved services the member needs while on vacation.
  23. Services provided in the family home by a parent, stepparent, legal representative, sibling, or stepsibling during overnight sleeping hours unless the parent, stepparent, legal representative, sibling, or stepsibling is awake and actively providing direct services as authorized in the member's service plan.
  24. Residential services provided to three or more members living in the same residential setting.
    - (4) The costs of any approved home or vehicle modification, assistive device, or specialized medical equipment. When authorized, the budget may include an amount allocated for a home or vehicle modification, an assistive device, or specialized medical equipment. Before becoming part of the individual budget, all home and vehicle modifications, assistive devices, and specialized medical equipment shall be identified in the member's service plan and approved by the case manager or community-based case manager. The authorized amount shall not be used for anything other than the specific modification, assistive device, or specialized medical equipment, as identified in subparagraph 78.34(13)"b"(11).
    - (5) Any amount set aside in a savings plan to reserve funds for the future purchase of self-directed personal care, individual-directed goods and services, or self-directed community supports and services as defined in paragraph 78.34(13)"d." The savings plan shall meet the requirements in paragraph 78.34(13)"f."
- f. Savings plan.* A member savings plan must be in writing and be approved before the start of the savings plan by the department for fee-for-service members or by the member's managed care organization for members in managed care. Budget amounts allocated to the savings plan must result from efficiencies in meeting the member's service needs identified in the member's service plan.
- (1) The savings plan shall identify:
    1. The specific goods, services, supports or supplies to be purchased through the savings plan.
    2. The amount of the individual budget allocated each month to the savings plan.
    3. The amount of the individual budget allocated each month to meet the member's identified service needs.
    4. How the member's assessed needs will continue to be met through the individual budget when funds are placed in savings.

5. Specific time spans for accumulating the savings allocation, not to exceed the member's current service plan year end date.

(2) With the exception of funds allocated for respite care, the savings plan shall not include funds budgeted for direct services or supports that were not received. Funds from unused respite services may be allocated to the savings plan but shall not be used for anything other than future respite care.

(3) Funds allocated to a savings plan may be used to purchase additional self-directed personal care, individual-directed goods and services, or self-directed community supports and services. The additional self-directed personal care, individual-directed goods and services, or self-directed community supports and services included in the monthly budget may exceed the amount of service or supports authorized in the member's service plan. The self-directed personal care, individual-directed goods and services, or self-directed community supports and services purchased with funds from a savings plan must:

1. Be used to meet a member's identified need,
2. Be medically necessary, and
3. Be approved by the member's case manager or community-based case manager.

(4) All funds allocated to a savings plan to purchase additional self-directed personal care, individual-directed goods and services, or self-directed community supports and services must be used during the member's waiver year in which the saving occurred.

(5) The annual reassessment of a member's needs must take into account the purchases of goods and services that substitute for human assistance. Adjustments shall be made to the services used to determine the individual budget based on the reassessment.

*g. Budget authority.* The member shall have authority over the individual budget authorized by the department or managed care organization to perform the following tasks:

(1) Contract with entities to provide services and supports as described in this subrule.

(2) Determine the amount to be paid for services. Reimbursement rates for employees shall be consistent with employee reimbursement rates or the prevailing wages paid by others in the community for the same or substantially similar services. Reimbursement rates for the independent support broker and the financial management service are subject to the limits in 441—subrule 79.1(2).

(3) Schedule the provision of services. A contingency plan must be established in the member's service plan to ensure service delivery in the event the member's employee is unable to provide services due to illness or other unexpected event.

(4) Authorize payment for optional service components identified in the individual budget. When the member's guardian or legal representative is a paid employee, payment authorization for optional service components must be delegated to a representative pursuant to paragraph 78.34(13) "i."

(5) Reallocate funds among services included in the budget. Every purchase of a good or service must be identified and approved in the individual budget before the purchase is made.

*h. Employer authority.* The member shall have the authority to be the common-law employer of employees providing services and support under the CCO. A common-law employer has the right to direct and control the performance of the services. If the member is a child, the parent or the legal representative shall be responsible for completing all employer authority tasks. Adult members who do not have the ability to complete all employer authority tasks shall have a representative delegated to complete the employer authority tasks identified in this paragraph. Documentation of the person responsible for the employer authority tasks, whether the member or another entity, shall be included in the member's service plan. The member or the delegated employer authority may perform the following functions:

- (1) Recruit and hire employees.
- (2) Verify employee qualifications.
- (3) Specify additional employee qualifications.
- (4) Determine employee duties.
- (5) Determine employee wages and benefits.
- (6) Schedule employees.
- (7) Train and supervise employees.

*i. Delegation of budget and employer authority.* The member may delegate responsibilities for the individual budget or employer authority functions to a representative. If the member is a child, the parent or the legal representative shall be delegated all budget and employer authority tasks. Adult members aged 18 and older who do not have the ability to complete all budget or employer authority tasks shall have a representative delegated to complete the applicable budget authority tasks identified in paragraph 78.34(13)“g” and employer authority tasks identified in paragraph 78.34(13)“h.” Documentation of the person responsible for the budget and employer authority tasks, whether the member or a representative, shall be included in the member’s service plan.

(1) The representative must be at least 18 years old.

(2) The representative shall not be a current provider of service to the member.

(3) The member shall sign a consent form that designates who the member has chosen as a representative and the responsibilities of the representative.

(4) The representative shall not be paid for this service.

*j. Employment agreement.* Any person employed by the member to provide services under the consumer choices option shall sign an employment agreement with the member that outlines the employee’s and member’s responsibilities.

*k. Responsibilities of the independent support broker.* The independent support broker shall perform the following services as directed by the member or the member’s representative:

(1) Assist the member with developing the member’s initial and subsequent individual budgets and with making any changes to the individual budget.

(2) Have monthly contact with the member for the first four months of implementation of the initial individual budget and have, at a minimum, quarterly contact thereafter.

(3) Complete the required employment packet with the financial management service.

(4) Assist with interviewing potential employees and entities providing services and supports if requested by the member.

(5) Assist the member with determining whether a potential employee meets the qualifications necessary to perform the job.

(6) Assist the member with obtaining a signed consent from a potential employee to conduct background checks if requested by the member.

(7) Assist the member with negotiating with entities providing services and supports if requested by the member.

(8) Assist the member with contracts and payment methods for services and supports if requested by the member.

(9) Assist the member with developing an emergency backup plan. The emergency backup plan shall address any health and safety concerns.

(10) Review expenditure reports from the financial management service to ensure that services and supports in the individual budget are being provided.

(11) Document in writing on the independent support broker timecard every contact the broker has with the member. Contact documentation shall include information on the extent to which the member’s individual budget has addressed the member’s needs and the satisfaction of the member.

*l. Responsibilities of the financial management service.* The financial management service shall perform all of the following services:

(1) Receive Medicaid funds in an electronic transfer.

(2) Process and pay invoices for approved goods and services included in the individual budget.

(3) Monitor and track the approved individual budget amount authorized each month and document all expenditures as they are paid.

(4) Provide real-time individual budget account balances for the member, the independent support broker, and the department, available at a minimum during normal business hours (9 a.m. to 5 p.m., Monday through Friday).

(5) Conduct criminal background checks on potential employees pursuant to 441—Chapter 119.

(6) Verify for the member an employee’s citizenship or alien status.

(7) Assist the member with fiscal and payroll-related responsibilities including, but not limited to:

1. Verifying that hourly wages comply with federal and state labor rules.
  2. Collecting and processing timecards.
  3. Withholding, filing, and paying federal, state and local income taxes, Medicare and Social Security (FICA) taxes, and federal (FUTA) and state (SUTA) unemployment and disability insurance taxes, as applicable.
  4. Computing and processing other withholdings, as applicable.
  5. Processing all judgments, garnishments, tax levies, or other withholding on an employee's pay as may be required by federal, state, or local laws.
  6. Preparing and issuing employee payroll checks.
  7. Preparing and disbursing IRS Forms W-2 and W-3 annually.
  8. Processing federal advance earned income tax credit for eligible employees.
  9. Refunding over-collected FICA, when appropriate.
  10. Refunding over-collected FUTA, when appropriate.
  - (8) Assist the member in completing required federal, state, and local tax and insurance forms.
  - (9) Establish and manage documents and files for the member and the member's employees.
  - (10) Monitor timecards, receipts, and invoices to ensure that they are consistent with the individual budget. Keep records of all timecards and invoices for each member for a total of five years.
  - (11) Provide to the department, the independent support broker, and the member monthly and quarterly status reports that include a summary of expenditures paid and amount of budget unused.
  - (12) Establish an accessible customer service system and a method of communication for the member and the independent support broker that includes alternative communication formats.
  - (13) Establish a customer services complaint reporting system.
  - (14) Develop a policy and procedures manual that is current with state and federal regulations and update as necessary.
  - (15) Develop a business continuity plan in the case of emergencies and natural disasters.
  - (16) Provide to the department an annual independent audit of the financial management service.
  - (17) Assist in implementing the state's quality management strategy related to the financial management service.
  - (18) The department may request that the financial management service provider withhold payment to any member or member's employee to offset any overpayment or enforce any sanction placed on the service provider pursuant to rule 441—79.3(249A).
- m. Responsibilities of the member and the employee.* A member participating in the CCO and the member's employee(s) are responsible for the following:
- (1) A member participating in the CCO shall be jointly and severally liable with any of the member's employees for any overpayment of medical assistance funds used through a CCO budget.
  - (2) A member may not employ any person who has been sanctioned, or who is affiliated with a person or an entity that has been sanctioned, under 441—Chapter 79. For purposes of this subparagraph, "sanction" also includes anyone who has been temporarily suspended for a credible allegation of fraud under 42 CFR Part 455. Any CCO funds paid to any employee who or which has been sanctioned is an overpayment that the department shall recoup under 441—Chapter 79.
  - (3) A member may not employ any person who has been excluded by the Office of the Inspector General of the Department of Health and Human Services under Sections 1128 or 1156 of the Social Security Act and is not eligible to receive federal funds.
  - (4) Employees shall complete, sign and date Form 470-4429, Consumer Choices Option Semi-Monthly Time Sheet, for each date of service provided to a member. Documentation shall comport with 441—subparagraph 79.3(2) "c"(3), "Service documentation."
  - (5) Members shall sign, and certify under penalty of perjury, each employee timecard identified in subparagraph 78.34(13) "m"(4) prior to the timecard's submission to the financial management service provider for payment in order to verify that all information on the submitted timecard accurately describes the amount, duration, and scope of services provided. When timecard information is submitted to the financial management service provider in an electronic format, the member shall retain the signed employee timecard for five years from the date of service.

**78.34(14) General service standards.** All ill and handicapped waiver services must be provided in accordance with the following standards:

*a.* Reimbursement shall not be available under the waiver for any services that the member can obtain as other nonwaiver Medicaid services or through any other funding source.

*b.* All services provided under the waiver must be delivered in the least restrictive environment possible and in conformity with the member's service plan.

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

(1) Any restrictions on the member's rights, including the rights of privacy, dignity, respect, and freedom from coercion and restraint.

(2) The need for the restriction.

(3) The less intrusive methods of meeting the need that have been tried but did not work.

(4) Either a plan to restore those rights or written documentation that a plan is not necessary or appropriate.

(5) Established time limits for periodic reviews to determine if the restriction is still necessary or can be terminated.

(6) The informed consent of the member.

(7) An assurance that the interventions and supports will cause no harm to the member.

(8) A regular collection and review of data to measure the ongoing effectiveness of the restriction.

*d.* Services must be billed in whole units.

*e.* For all services with a 15-minute unit of service, the following rounding process will apply:

(1) Add together the minutes spent on all billable activities during a calendar day for a daily total.

(2) For each day, divide the total minutes spent on billable activities by 15 to determine the number of full 15-minute units for that day.

(3) Round the remainder using these guidelines: Round 1 to 7 minutes down to zero units; round 8 to 14 minutes up to one unit.

(4) Add together the number of full units and the number of rounded units to determine the total number of units to bill for that day.

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

[ARC 9045B, IAB 9/8/10, effective 11/1/10; ARC 9403B, IAB 3/9/11, effective 5/1/11 (See Delay note at end of chapter); ARC 9704B, IAB 9/7/11, effective 9/1/11; ARC 9884B, IAB 11/30/11, effective 1/4/12; ARC 0707C, IAB 5/1/13, effective 7/1/13; ARC 0709C, IAB 5/1/13, effective 7/1/13; ARC 0757C, IAB 5/29/13, effective 8/1/13; ARC 0842C, IAB 7/24/13, effective 7/1/13; ARC 1056C, IAB 10/2/13, effective 11/6/13; ARC 1610C, IAB 9/3/14, effective 8/13/14; ARC 2848C, IAB 12/7/16, effective 11/15/16; ARC 2936C, IAB 2/1/17, effective 3/8/17; ARC 3552C, IAB 1/3/18, effective 2/7/18; ARC 3874C, IAB 7/4/18, effective 8/8/18; ARC 4430C, IAB 5/8/19, effective 7/1/19; see Delay note at end of chapter]

**441—78.35(249A) Occupational therapist services.** Payment will be approved for the same services provided by an occupational therapist that are payable under Title XVIII of the Social Security Act (Medicare).

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

**441—78.36(249A) Hospice services.**

**78.36(1) General characteristics.** A hospice is a public agency or private organization or a subdivision of either that is primarily engaged in providing care to terminally ill individuals. A hospice provides palliative and supportive services to meet the physical, psychosocial, social and spiritual needs of a terminally ill individual and the individual's family or other persons caring for the individual regardless of where the individual resides. Hospice services are those services to control pain and provide support to individuals to continue life with as little disruption as possible.

*a.* Covered services. Covered services shall include, in accordance with Medicare guidelines, the following:

(1) Nursing care.

(2) Medical social services.

(3) Physician services.

(4) Counseling services provided to the terminally ill individual and the individual's family members or other persons caring for the individual at the individual's place of residence, including bereavement, dietary, and spiritual counseling.

(5) Short-term inpatient care provided in a participating hospice inpatient unit or a participating hospital or nursing facility that additionally meets the special hospice standards regarding staffing and patient areas for pain control, symptom management and respite purposes.

(6) Medical appliances and supplies, including drugs and biologicals, as needed for the palliation and management of the individual's terminal illness and related conditions, except for "covered Part D drugs" as defined by 42 U.S.C. Section 1395w-102(e)(1)-(2) for a "Part D eligible individual" as defined in 42 U.S.C. Section 1395w-101(a)(3)(A), including an individual who is not enrolled in a Part D plan.

(7) Homemaker and home health aide services.

(8) Physical therapy, occupational therapy and speech-language pathology unless this provision has been waived under the Medicare program for a specific provider.

(9) Other items or services specified in the resident's plan that would otherwise be paid under the Medicaid program.

Nursing care, medical social services, and counseling are core hospice services and must routinely be provided directly by hospice employees. The hospice may contract with other providers to provide the remaining services. Bereavement counseling, consisting of counseling services provided after the individual's death to the individual's family or other persons caring for the individual, is a required hospice service but is not reimbursable.

*b.* Noncovered services.

(1) Covered services not related to the terminal illness. In accordance with Medicare guidelines, all medical services related to the terminal illness are the responsibility of the hospice. Services unrelated to the terminal illness are to be billed separately by the respective provider.

(2) Administrative duties performed by the medical director, any hospice-employed physician, or any consulting physician are included in the normal hospice rates. Patient care provided by the medical director, hospice-employed physician, attending physician, or consulting physician is separately reimbursable. Payment to the attending or consulting physician includes other partners in practice.

(3) Hospice care provided by a hospice other than the hospice designated by the individual unless provided under arrangements made by the designated hospice.

(4) AZT (Retrovir) and other curative antiviral drugs targeted at the human immunodeficiency virus for the treatment of AIDS.

**78.36(2) *Categories of care.*** Hospice care entails the following four categories of daily care. Guidelines for core and other services must be adhered to for all categories of care.

*a.* Routine home care is care provided in the place of residence that is not continuous.

*b.* Continuous home care is provided only during a period of crisis when an individual requires continuous care which is primarily nursing care to achieve palliation or management of acute medical symptoms. Nursing care must be provided by either a registered nurse or a licensed practical nurse and a nurse must be providing care for more than half of the period of care. A minimum of eight hours of care per day must be provided during a 24-hour day to qualify as continuous care. Homemaker and aide services may also be provided to supplement the nursing care.

*c.* Inpatient respite care is provided to the individual only when necessary to relieve the family members or other persons caring for the individual at home. Respite care may be provided only on an occasional basis and may not be reimbursed for more than five consecutive days at a time. Respite care may not be provided when the individual is a resident of a nursing facility.

*d.* General inpatient care is provided in periods of acute medical crisis when the individual is hospitalized or in a participating hospice inpatient unit or nursing facility for pain control or acute or chronic symptom management.

**78.36(3) *Residence in a nursing facility.*** For purposes of the Medicaid hospice benefit, a nursing facility can be considered the residence of a beneficiary. When the person does reside in a nursing facility, the requirement that the care of a resident of a nursing facility must be provided under the immediate

direction of either the facility or the resident's personal physician does not apply if all of the following conditions are met:

- a. The resident is terminally ill.
- b. The resident has elected to receive hospice services under the Medicaid program from a Medicaid-enrolled hospice program.
- c. The nursing facility and the Medicaid-enrolled hospice program have entered into a written agreement under which the hospice program takes full responsibility for the professional management of the resident's hospice care and the facility agrees to provide room and board to the resident.

**78.36(4) Approval for hospice benefits.** Payment will be approved for hospice services to individuals who are certified as terminally ill, that is, the individuals have a medical prognosis that their life expectancy is six months or less if the illness runs its normal course, and who elect hospice care rather than active treatment for the illness.

a. *Physician certification process.* The hospice must obtain certification that an individual is terminally ill in accordance with the following procedures:

(1) The hospice may obtain verbal orders to initiate hospice service from the medical director of the hospice or the physician member of the hospice interdisciplinary group and by the individual's attending physician (if the individual has an attending physician). The verbal order shall be noted in the patient's record. The verbal order must be given within two days of the start of care and be followed up in writing no later than eight calendar days after hospice care is initiated. The certification must include the statement that the individual's medical prognosis is that the individual's life expectancy is six months or less if the illness runs its normal course.

(2) When verbal orders are not secured, the hospice must obtain, no later than two calendar days after hospice care is initiated, written certification signed by the medical director of the hospice or the physician member of the hospice interdisciplinary group and by the individual's attending physician (if the individual has an attending physician). The certification must include the statement that the individual's medical prognosis is that the individual's life expectancy is six months or less, if the illness runs its normal course.

(3) Hospice care benefit periods consist of up to two periods of 90 days each and an unlimited number of subsequent 60-day periods as elected by the individual. The medical director or a physician must recertify at the beginning of each benefit period that the individual is terminally ill.

b. *Election procedures.* Individuals who are dually eligible for Medicare and Medicaid must receive hospice coverage under Medicare.

(1) Election statement. An individual, or individual's representative, elects to receive the hospice benefit by filing an election statement, Form 470-2618, Election of Medicaid Hospice Benefit, or a Medicare election of hospice benefit form, with a particular hospice. The hospice may provide the individual with another election form to use provided the form includes the following information:

1. Identification of the hospice that will provide the care.
2. Acknowledgment that the recipient has been given a full understanding of hospice care.
3. Acknowledgment that the recipient waives the right to regular Medicaid benefits, except for payment to the regular physician and treatment for medical conditions unrelated to the terminal illness.
4. Acknowledgment that recipients are not responsible for copayment or other deductibles.
5. The recipient's Medicaid number.
6. The effective date of election.
7. The recipient's signature.

(2) Change of designation. An individual may change the designation of the particular hospice from which the individual elects to receive hospice care one time only.

(3) Effective date. An individual may designate an effective date for the hospice benefit that begins with the first day of the hospice care or any subsequent day of hospice care, but an individual may not designate an effective date that is earlier than the date that the election is made.

(4) Duration of election. The election to receive hospice care will be considered to continue until one of the following occurs:

1. The individual dies.

2. The individual or the individual's representative revokes the election.
3. The individual's situation changes so that the individual no longer qualifies for the hospice benefit.
4. The hospice elects to terminate the recipient's enrollment in accordance with the hospice's established discharge policy.

(5) Revocation. Form 470-2619, Revocation of Medicaid Hospice Benefit, is completed when an individual or the individual's representative revokes the hospice benefit allowed under Medicaid. When an individual revokes the election of Medicaid coverage of hospice care, the individual resumes Medicaid coverage of the benefits waived when hospice care was elected.

This rule is intended to implement Iowa Code section 249A.4.  
[ARC 3553C, IAB 1/3/18, effective 2/7/18]

**441—78.37(249A) HCBS elderly waiver services.** Payment will be approved for the following services to members eligible for the HCBS elderly waiver services as established in 441—Chapter 83 and as identified in the member's service plan. Effective March 17, 2022, payment shall only be made for services provided in integrated, community-based settings that support full access of members receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.

**78.37(1) Adult day care services.** Adult day care services provide an organized program of supportive care in a group environment to persons who need a degree of supervision and assistance on a regular or intermittent basis in a day care center. A unit of service is 15 minutes (up to four units per day), a half day (1.25 to 4 hours per day), a full day (4.25 to 8 hours per day), or an extended day (8.25 to 12 hours per day). Components of the service include health-related care, social services, and other related support services.

**78.37(2) Personal emergency response or portable locator system.**

*a.* A personal emergency response system is an electronic device that transmits a signal to a central monitoring station to summon assistance in the event of an emergency.

- (1) The necessary components of a system are:
  1. An in-home medical communications transceiver.
  2. A remote, portable activator.
  3. A central monitoring station with backup systems staffed by trained attendants at all times.
  4. Current data files at the central monitoring station containing response protocols and personal, medical, and emergency information for each member.

(2) The service shall be identified in the member's service plan.

(3) A unit of service is a one-time installation fee or one month of service.

(4) Maximum units per state fiscal year shall be the initial installation and 12 months of service.

*b.* A portable locator system is an electronic device that transmits a signal to a monitoring device. The system allows a member to access assistance in the event of an emergency and allows law enforcement or the monitoring system provider to locate a member who is unable to request help or to activate a system independently. The member must be unable to access assistance in an emergency situation due to the member's age or disability.

(1) The required components of the portable locator system are:

1. A portable communications transceiver or transmitter to be worn or carried by the member.
2. Monitoring by the provider at a central location with response protocols and personal, medical, and emergency information for each member as applicable.

(2) The service shall be identified in the member's service plan.

(3) Payable units of service are purchase of equipment, an installation or set-up fee, and monthly fees.

(4) Maximum units per state fiscal year shall be one equipment purchase, one installation or set-up fee, and 12 months of service.

**78.37(3) Home health aide services.** Home health aide services are personal or direct care services provided to the client which are not payable under Medicaid as set forth in rule 441—78.9(249A). A unit of service is a visit. Components of the service include:

- a. Observation and reporting of physical or emotional needs.
- b. Helping a client with bath, shampoo, or oral hygiene.
- c. Helping a client with toileting.
- d. Helping a client in and out of bed and with ambulation.
- e. Helping a client reestablish activities of daily living.
- f. Assisting with oral medications ordinarily self-administered and ordered by a physician.
- g. Performing incidental household services which are essential to the client's health care at home and are necessary to prevent or postpone institutionalization in order to complete a full unit of service.

**78.37(4) Homemaker services.** Homemaker services are those services provided when the member lives alone or when the person who usually performs these functions for the member needs assistance with performing the functions. A unit of service is 15 minutes. Components of the service must be directly related to the care of the member and may include only the following:

- a. Essential shopping: shopping for basic need items such as food, clothing or personal care items, or drugs.
- b. Limited housecleaning: maintenance cleaning such as vacuuming, dusting, scrubbing floors, defrosting refrigerators, cleaning stoves, cleaning medical equipment, washing and mending clothes, washing personal items used by the member, and washing dishes.
- c. Meal preparation: planning and preparing balanced meals.

**78.37(5) Nursing care services.** Nursing care services are services provided by licensed agency nurses to clients in the home which are ordered by and included in the plan of treatment established by the physician. The services are reasonable and necessary to the treatment of an illness or injury and include: observation; evaluation; teaching; training; supervision; therapeutic exercise; bowel and bladder care; administration of medications; intravenous, hypodermoclysis, and enteral feedings; skin care; preparation of clinical and progress notes; coordination of services and informing the physician and other personnel of changes in the patient's condition and needs.

A unit of service is one visit. Nursing care service can pay for a maximum of eight nursing visits per month for intermediate level of care persons. There is no limit on the maximum visits for skilled level of care persons.

**78.37(6) Respite care services.** Respite care services are services provided to the member that give temporary relief to the usual caregiver and provide all the necessary care that the usual caregiver would provide during that period. The purpose of respite care is to enable the member to remain in the member's current living situation.

- a. Services provided outside the member's home shall not be reimbursable if the living unit where respite is provided is reserved for another person on a temporary leave of absence.
- b. Member-to-staff ratios shall be appropriate to the individual needs of the member as determined by the member's interdisciplinary team.
- c. A unit of service is 15 minutes.
- d. Respite care is not to be provided to members during the hours in which the usual caregiver is employed except when the member is attending a 24-hour residential camp. Respite cannot be provided to a member whose usual caregiver is a consumer-directed attendant care provider for the member.
- e. The interdisciplinary team shall determine if the member will receive basic individual respite, specialized respite or group respite as defined in 441—Chapter 83.
- f. A maximum of 14 consecutive days of 24-hour respite care may be reimbursed.
- g. Respite services provided for a period exceeding 24 consecutive hours to three or more individuals who require nursing care because of a mental or physical condition must be provided by a health care facility licensed as described in Iowa Code chapter 135C.

*h.* Respite services shall not be provided simultaneously with other residential, nursing, or home health aide services provided through the medical assistance program.

**78.37(7) *Chore services.*** Chore services provide assistance with the household maintenance activities listed in paragraph 78.37(7)“*a*,” as necessary to allow a member to remain in the member’s own home safely and independently. A unit of service is 15 minutes.

*a.* Chore services are limited to the following services:

- (1) Window and door maintenance, such as hanging screen windows and doors, replacing windowpanes, and washing windows;
- (2) Minor repairs to walls, floors, stairs, railings and handles;
- (3) Heavy cleaning which includes cleaning attics or basements to remove fire hazards, moving heavy furniture, extensive wall washing, floor care, painting, and trash removal;
- (4) Lawn mowing and removal of snow and ice from sidewalks and driveways.

*b.* Leaf raking, bush and tree trimming, trash burning, stick removal, and tree removal are not covered services.

**78.37(8) *Home-delivered meals.*** Home-delivered meals are meals prepared elsewhere and delivered to a member at the member’s residence.

*a.* Each meal shall ensure the member receives a minimum of one-third of the daily recommended dietary allowance as established by the Food and Nutrition Board of the National Research Council of the National Academy of Sciences. The meal may also be a liquid supplement which meets the minimum one-third standard.

*b.* When a restaurant provides the home-delivered meal, the member is required to have a nutritional consultation. The nutritional consultation includes contact with the restaurant to explain the dietary needs of the member and what constitutes the minimum one-third daily dietary allowance.

*c.* A unit of service is a meal (morning, noon, evening, or liquid supplement). Any maximum combination of any two meals (morning, noon, evening, or liquid supplement) is allowed per day. Duplication of a meal in any one day is not allowed. The number of approved meals (morning, noon, evening, or liquid supplement) is contained in the member’s service plan.

*d.* The number of meals delivered for any morning, noon, evening, or liquid supplement meal cannot exceed the number of calendar days in a calendar month; nor can the number of delivered meals exceed the number of authorized days in a month. Meals billed in excess of the calendar days in a calendar month and those billed in excess of the number of authorized days in a month are subject to recoupment or denial of payment.

**78.37(9) *Home and vehicle modification.*** Covered home or vehicle modifications are physical modifications to the member’s home or vehicle that directly address the member’s medical or remedial need. Covered modifications must be necessary to provide for the health, welfare, or safety of the member and enable the member to function with greater independence in the home or vehicle.

*a.* Modifications that are necessary or desirable without regard to the member’s medical or remedial need and that would be expected to increase the fair market value of the home or vehicle, such as furnaces, fencing, or adding square footage to the residence, are excluded except as specifically included below. Purchasing or leasing of a motorized vehicle is excluded. Home and vehicle repairs are also excluded.

*b.* Only the following modifications are covered:

- (1) Kitchen counters, sink space, cabinets, special adaptations to refrigerators, stoves, and ovens.
- (2) Bathtubs and toilets to accommodate transfer, special handles and hoses for shower heads, water faucet controls, and accessible showers and sink areas.
- (3) Grab bars and handrails.
- (4) Turnaround space adaptations.
- (5) Ramps, lifts, and door, hall and window widening.
- (6) Fire safety alarm equipment specific for disability.
- (7) Voice-activated, sound-activated, light-activated, motion-activated, and electronic devices directly related to the member’s disability.

(8) Vehicle lifts, driver-specific adaptations, remote-start systems, including such modifications already installed in a vehicle.

(9) Keyless entry systems.

(10) Automatic opening device for home or vehicle door.

(11) Special door and window locks.

(12) Specialized doorknobs and handles.

(13) Plexiglas replacement for glass windows.

(14) Modification of existing stairs to widen, lower, raise or enclose open stairs.

(15) Motion detectors.

(16) Low-pile carpeting or slip-resistant flooring.

(17) Telecommunications device for the deaf.

(18) Exterior hard-surface pathways.

(19) New door opening.

(20) Pocket doors.

(21) Installation or relocation of controls, outlets, switches.

(22) Air conditioning and air filtering if medically necessary.

(23) Heightening of existing garage door opening to accommodate modified van.

(24) Bath chairs.

c. A unit of service is the completion of needed modifications or adaptations.

d. All modifications and adaptations shall be provided in accordance with applicable federal, state, and local building and vehicle codes.

e. Services shall be performed following prior department approval of the modification as specified in 441—subrule 79.1(17) and a binding contract between the provider and the member.

f. All contracts for home or vehicle modification shall be awarded through competitive bidding. The contract shall include the scope of work to be performed, the time involved, supplies needed, the cost, diagrams of the project whenever applicable, and an assurance that the provider has liability and workers' compensation coverage and the applicable permit and license.

g. Service payment shall be made to the enrolled home or vehicle modification provider. If applicable, payment will be forwarded to the subcontracting agency by the enrolled home or vehicle modification provider following completion of the approved modifications.

h. Services shall be included in the member's service plan and shall exceed the Medicaid state plan services.

**78.37(10) Mental health outreach.** Mental health outreach services are services provided in a recipient's home to identify, evaluate, and provide treatment and psychosocial support. The services can only be provided on the basis of a referral from the consumer's interdisciplinary team established pursuant to 441—subrule 83.22(2). A unit of service is 15 minutes.

**78.37(11) Transportation.** Transportation services may be provided for members to conduct business errands and essential shopping and to reduce social isolation. A unit of service is one mile of transportation or one one-way trip.

**78.37(12) Nutritional counseling.** Nutritional counseling services may be provided for a nutritional problem or condition of such a degree of severity that nutritional counseling beyond that normally expected as part of the standard medical management is warranted. A unit of service is 15 minutes.

**78.37(13) Assistive devices.** Assistive devices means practical equipment products to assist persons with activities of daily living and instrumental activities of daily living to allow the person more independence. They include, but are not limited to: long-reach brush, extra long shoehorn, nonslip grippers to pick up and reach items, dressing aids, shampoo rinse tray and inflatable shampoo tray, double-handled cup and sipper lid. A unit is an item.

a. The service shall be included in the member's service plan and shall exceed the services available under the Medicaid state plan.

b. The service shall be provided following prior approval by the Iowa Medicaid enterprise.

c. Payment for most items shall be based on a fee schedule. The amount of the fee shall be determined as directed in 441—subrule 79.1(17).

**78.37(14) Senior companion.** Senior companion services are nonmedical care supervision, oversight, and respite. Companions may assist with such tasks as meal preparation, laundry, shopping and light housekeeping tasks. This service cannot provide hands-on nursing or medical care. A unit of service is 15 minutes.

**78.37(15) Consumer-directed attendant care service.** Consumer-directed attendant care services are service activities performed by a person to help a member with self-care tasks which the member would typically do independently if the member were otherwise able. Covered service activities are limited to the nonskilled activities listed in paragraph 78.37(15)“f” and the skilled activities listed in paragraph 78.37(15)“g.” Covered service activities must be essential to the health, safety, and welfare of the member. Services may be provided in the absence of a parent or guardian if the parent or guardian has given advance direction for the service provision.

*a. Service planning.*

(1) The member, parent, guardian, or attorney in fact under a durable power of attorney for health care shall:

1. Select the individual, agency or assisted living facility that will provide the components of the attendant care services.

2. Determine with the selected provider what components of attendant care services the provider shall perform, subject to confirmation by the service worker or case manager that those components are consistent with the assessment and are authorized covered services.

3. Complete, sign, and date Form 470-3372, HCBS Consumer-Directed Attendant Care Agreement, to indicate the frequency, scope, and duration of services (a description of each service component and the time agreed on for that component). The case manager or service worker and provider shall also sign the agreement.

4. Submit the completed agreement to the service worker or case manager. The agreement shall be part of the member’s service plan and shall be kept in the member’s records, in the provider’s records, and in the service worker’s or case manager’s records. Any service component that is not listed in the agreement shall not be payable.

(2) Assisted living agreements with Iowa Medicaid members must specify the services to be considered covered under the assisted living occupancy agreement and those CDAC services to be covered under the elderly waiver. The funding stream for each service must be identified.

(3) Whenever a legal representative acts as a provider of consumer-directed attendant care as allowed by 441—paragraph 79.9(7)“b,” the following shall apply:

1. The payment rate for the legal representative must be based on the skill level of the legal representative and may not exceed the median statewide reimbursement rate for the service unless the higher rate receives prior approval from the department;

2. The legal representative may not be paid for more than 40 hours of service per week; and

3. A contingency plan must be established in the member’s service plan to ensure service delivery in the event the legal representative is unable to provide services due to illness or other unexpected event.

*b. Supervision of skilled services.* Skilled consumer-directed attendant care services shall be provided under the supervision of a licensed nurse or licensed therapist working under the direction of a physician. The licensed nurse or therapist shall:

(1) Retain accountability for actions that are delegated.

(2) Ensure appropriate assessment, planning, implementation, and evaluation.

(3) Make on-site supervisory visits every two weeks with the service provider present.

*c. Service documentation.* The consumer-directed attendant care individual and agency providers must complete Form 470-4389, Consumer-Directed Attendant Care (CDAC) Service Record, for each day of service. Assisted living facilities may choose to use Form 470-4389 or may devise another system that adheres to the requirements of rule 441—79.3(249A). Any service component that is not documented in accordance with rule 441—79.3(249A) shall not be payable.

*d. Role of guardian or attorney.* If the member has a guardian or attorney in fact under a durable power of attorney for health care:

(1) The service worker's or case manager's service plan shall address how consumer-directed attendant care services will be monitored to ensure that the member's needs are being adequately met. If the guardian or attorney in fact is the service provider, the service plan shall address how the service worker or case manager shall oversee service provision.

(2) The guardian or attorney in fact shall sign the claim form in place of the member, indicating that the service has been provided as presented on the claim.

*e. Service units and billing.* A unit of service is 15 minutes provided by an individual, agency or assisted living facility. Each service shall be billed in whole units.

*f. Nonskilled services.* Covered nonskilled service activities are limited to help with the following activities:

- (1) Dressing.
- (2) Bathing, shampooing, hygiene, and grooming.
- (3) Access to and from bed or a wheelchair, transferring, ambulation, and mobility in general.
- (4) Toileting, including bowel, bladder, and catheter assistance (emptying the catheter bag, collecting a specimen, and cleaning the external area around the catheter).

(5) Meal preparation, cooking, and assistance with feeding, not including the cost of meals themselves. Meal preparation and cooking shall be provided only in the member's home.

(6) Housekeeping, laundry, and shopping essential to the member's health care at home.

(7) Taking medications ordinarily self-administered, including those ordered by a physician or other qualified health care provider.

(8) Minor wound care.

(9) Going to or returning from a place of employment and job-related tasks while the member is on the job site. Transportation for the member and assistance with understanding or performing the essential job functions are not included in consumer-directed attendant care services.

(10) Tasks, such as financial management and scheduling, that require cognitive or physical assistance.

(11) Communication essential to the health and welfare of the member, through interpreting and reading services and use of assistive devices for communication.

(12) Using transportation essential to the health and welfare of the member. The cost of the transportation is not included.

*g. Skilled services.* Covered skilled service activities are limited to help with the following activities:

- (1) Tube feedings of members unable to eat solid foods.
- (2) Intravenous therapy administered by a registered nurse.
- (3) Parenteral injections required more than once a week.
- (4) Catheterizations, continuing care of indwelling catheters with supervision of irrigations, and changing of Foley catheters when required.

(5) Respiratory care including inhalation therapy and tracheotomy care or tracheotomy care and ventilator.

(6) Care of decubiti and other ulcerated areas, noting and reporting to the nurse or therapist.

(7) Rehabilitation services including, but not limited to, bowel and bladder training, range of motion exercises, ambulation training, restorative nursing services, respiratory care and breathing programs, reality orientation, reminiscing therapy, remotivation, behavior modification, and reteaching of the activities of daily living.

(8) Colostomy care.

(9) Care of uncontrolled medical conditions, such as brittle diabetes, and comfort care of terminal conditions.

(10) Postsurgical nursing care.

(11) Monitoring medications requiring close supervision because of fluctuating physical or psychological conditions, e.g., antihypertensives, digitalis preparations, mood-altering or psychotropic drugs, or narcotics.

(12) Preparing and monitoring response to therapeutic diets.

(13) Recording and reporting of changes in vital signs to the nurse or therapist.

*h. Excluded services and costs.* Services, activities, costs and time that are not covered as consumer-directed attendant care include the following (not an exclusive list):

(1) Any activity related to supervising a member. Only direct services are billable.

(2) Any activity that the member is able to perform.

(3) Costs of food.

(4) Costs for the supervision of skilled services by the nurse or therapist. The supervising nurse or therapist may be paid from private insurance, Medicare, or other third-party payment sources, or may be paid as another Medicaid service, including early and periodic screening, diagnosis and treatment services.

(5) Exercise that does not require skilled services.

(6) Parenting or child care for or on behalf of the member.

(7) Reminders and cueing.

(8) Services provided simultaneously with any other similar service regardless of funding source, including other waiver services and state supplementary assistance in-home health-related care services.

(9) Transportation costs.

(10) Wait times for any activity.

**78.37(16) Consumer choices option.** The consumer choices option is service activities provided pursuant to subrule 78.34(13).

**78.37(17) Case management services.** Case management services are services that assist Medicaid members who reside in a community setting or are transitioning to a community setting in gaining access to needed medical, social, educational, housing, transportation, vocational, and other appropriate services in order to ensure the health, safety, and welfare of the member. Case management is provided at the direction of the member and the interdisciplinary team established pursuant to 441—subrule 83.22(2).

*a.* Case management services shall be provided as set forth in rules 441—90.5(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; ARC 4430C, IAB 5/8/19, effective 7/1/19; see Delay note at end of chapter]

**441—78.38(249A) HCBS AIDS/HIV waiver services.** Payment will be approved for the following services to members eligible for the HCBS AIDS/HIV waiver services as established in 441—Chapter 83 and as identified in the member's service plan. Effective March 17, 2022, payment shall only be made for services provided in integrated, community-based settings that support full access of members receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.

**78.38(1) Counseling services.** Counseling services are face-to-face mental health services provided to the member and caregiver by a mental health professional as defined in rule 441—24.1(225C) to facilitate home management of the member and prevent institutionalization. Counseling services are nonpsychiatric services necessary for the management of depression, assistance with the grief process, alleviation of psychosocial isolation and support in coping with a disability or illness, including terminal illness. Counseling services may be provided both for the purpose of training the member's family or other caregiver to provide care, and for the purpose of helping the member and those caring for the member to adjust to the member's disability or terminal condition. Counseling services may be provided to the member's caregiver only when included in the case plan for the member.

Payment will be made for individual and group counseling. A unit of individual counseling for the waiver member or the waiver member and the member's caregiver is 15 minutes. A unit of group counseling is 15 minutes. Payment for group counseling is based on the group rate divided by six, or, if the number of persons who comprise the group exceeds six, the actual number of persons who comprise the group.

**78.38(2) Home health aide services.** Home health aide services are personal or direct care services provided to the client which are not payable under Medicaid as set forth in rule 441—78.9(249A). A unit of service is a visit. Components of the service are:

- a. Observation and reporting of physical or emotional needs.

- b. Helping a client with bath, shampoo, or oral hygiene.
- c. Helping a client with toileting.
- d. Helping a client in and out of bed and with ambulation.
- e. Helping a client reestablish activities of daily living.
- f. Assisting with oral medications ordinarily self-administered and ordered by a physician.
- g. Performing incidental household services which are essential to the client's health care at home and are necessary to prevent or postpone institutionalization in order to complete a full unit of service.

**78.38(3) *Homemaker services.*** Homemaker services are those services provided when the member lives alone or when the person who usually performs these functions for the member needs assistance with performing the functions. A unit of service is 15 minutes. Components of the service must be directly related to the care of the member and may include only the following:

- a. Essential shopping: shopping for basic need items such as food, clothing or personal care items, or drugs.
- b. Limited housecleaning: maintenance cleaning such as vacuuming, dusting, scrubbing floors, defrosting refrigerators, cleaning stoves, cleaning medical equipment, washing and mending clothes, washing personal items used by the member, and washing dishes.
- c. Meal preparation: planning and preparing balanced meals.

**78.38(4) *Nursing care services.*** Nursing care services are services provided by licensed agency nurses to clients in the home which are ordered by and included in the plan of treatment established by the physician. The services shall be reasonable and necessary to the treatment of an illness or injury and include: observation; evaluation; teaching; training; supervision; therapeutic exercise; bowel and bladder care; administration of medications; intravenous and enteral feedings; skin care; preparation of clinical and progress notes; coordination of services; and informing the physician and other personnel of changes in the patient's conditions and needs. A unit of service is a visit.

**78.38(5) *Respite care services.*** Respite care services are services provided to the member that give temporary relief to the usual caregiver and provide all the necessary care that the usual caregiver would provide during that period. The purpose of respite care is to enable the member to remain in the member's current living situation.

- a. Services provided outside the member's home shall not be reimbursable if the living unit where respite is provided is reserved for another person on a temporary leave of absence.
- b. Member-to-staff ratios shall be appropriate to the individual needs of the member as determined by the member's interdisciplinary team.
- c. A unit of service is 15 minutes.
- d. Respite care is not to be provided to members during the hours in which the usual caregiver is employed except when the member is attending a 24-hour residential camp. Respite cannot be provided to a member whose usual caregiver is a consumer-directed attendant care provider for the member.
- e. The interdisciplinary team shall determine if the member will receive basic individual respite, specialized respite or group respite as defined in 441—Chapter 83.
- f. A maximum of 14 consecutive days of 24-hour respite care may be reimbursed.
- g. Respite services provided for a period exceeding 24 consecutive hours to three or more individuals who require nursing care because of a mental or physical condition must be provided by a health care facility licensed as described in Iowa Code chapter 135C.
- h. Respite services shall not be provided simultaneously with other residential, nursing, or home health aide services provided through the medical assistance program.

**78.38(6) *Home-delivered meals.*** Home-delivered meals are meals prepared elsewhere and delivered to a member at the member's residence.

- a. Each meal shall ensure the member receives a minimum of one-third of the daily recommended dietary allowance as established by the Food and Nutrition Board of the National Research Council of the National Academy of Sciences. The meal may also be a liquid supplement which meets the minimum one-third standard.

b. When a restaurant provides the home-delivered meal, the member is required to have a nutritional consultation. The nutritional consultation includes contact with the restaurant to explain the dietary needs of the member and what constitutes the minimum one-third daily dietary allowance.

c. A unit of service is a meal (morning, noon, evening, or liquid supplement). Any maximum combination of any two meals (morning, noon, evening, or liquid supplement) is allowed per day. Duplication of a meal in any one day is not allowed. The number of approved meals (morning, noon, evening, or liquid supplement) is contained in the member's service plan.

d. The number of meals delivered for any morning, noon, evening, or liquid supplement meal cannot exceed the number of calendar days in a calendar month; nor can the number of delivered meals exceed the number of authorized days in a month. Meals billed in excess of the calendar days in a calendar month and those billed in excess of the number of authorized days in a month are subject to recoupment or denial of payment.

**78.38(7) Adult day care services.** Adult day care services provide an organized program of supportive care in a group environment to persons who need a degree of supervision and assistance on a regular or intermittent basis in a day care center. A unit of service is 15 minutes (up to four units per day), a half day (1.25 to 4 hours per day), a full day (4.25 to 8 hours per day), or an extended day (8.25 to 12 hours per day). Components of the service include health-related care, social services, and other related support services.

**78.38(8) Consumer-directed attendant care service.** Consumer-directed attendant care services are service activities performed by a person to help a member with self-care tasks which the member would typically do independently if the member were otherwise able. Covered service activities are limited to the nonskilled activities listed in paragraph 78.38(8) "f" and the skilled activities listed in paragraph 78.38(8) "g." Covered service activities must be essential to the health, safety, and welfare of the member. Services may be provided in the absence of a parent or guardian if the parent or guardian has given advance direction for the service provision.

a. *Service planning.*

(1) The member, parent, guardian, or attorney in fact under a durable power of attorney for health care shall:

1. Select the individual or agency that will provide the components of the attendant care services.
2. Determine with the selected provider what components of attendant care services the provider shall perform, subject to confirmation by the service worker or case manager that those components are consistent with the assessment and are authorized covered services.

3. Complete, sign, and date Form 470-3372, HCBS Consumer-Directed Attendant Care Agreement, to indicate the frequency, scope, and duration of services (a description of each service component and the time agreed on for that component). The case manager or service worker and provider shall also sign the agreement.

4. Submit the completed agreement to the service worker or case manager. The agreement shall be part of the member's service plan and shall be kept in the member's records, in the provider's records, and in the service worker's or case manager's records. Any service component that is not listed in the agreement shall not be payable.

(2) Whenever a legal representative acts as a provider of consumer-directed attendant care as allowed by 441—paragraph 79.9(7) "b," the following shall apply:

1. The payment rate for the legal representative must be based on the skill level of the legal representative and may not exceed the median statewide reimbursement rate for the service unless the higher rate receives prior approval from the department;

2. The legal representative may not be paid for more than 40 hours of service per week; and

3. A contingency plan must be established in the member's service plan to ensure service delivery in the event the legal representative is unable to provide services due to illness or other unexpected event.

b. *Supervision of skilled services.* Skilled consumer-directed attendant care services shall be provided under the supervision of a licensed nurse or licensed therapist working under the direction of a physician. The licensed nurse or therapist shall:

- (1) Retain accountability for actions that are delegated.

- (2) Ensure appropriate assessment, planning, implementation, and evaluation.
- (3) Make on-site supervisory visits every two weeks with the service provider present.

*c. Service documentation.* The consumer-directed attendant care provider must complete Form 470-4389, Consumer-Directed Attendant Care (CDAC) Service Record, for each day of service. Any service component that is not documented in accordance with rule 441—79.3(249A) shall not be payable.

*d. Role of guardian or attorney.* If the member has a guardian or attorney in fact under a durable power of attorney for health care:

(1) The service worker's or case manager's service plan shall address how consumer-directed attendant care services will be monitored to ensure that the member's needs are being adequately met. If the guardian or attorney in fact is the service provider, the service plan shall address how the service worker or case manager shall oversee service provision.

(2) The guardian or attorney in fact shall sign the claim form in place of the member, indicating that the service has been provided as presented on the claim.

*e. Service units and billing.* A unit of service is 15 minutes provided by an individual or agency. Each service shall be billed in whole units.

*f. Nonskilled services.* Covered nonskilled service activities are limited to help with the following activities:

- (1) Dressing.
- (2) Bathing, shampooing, hygiene, and grooming.
- (3) Access to and from bed or a wheelchair, transferring, ambulation, and mobility in general.
- (4) Toileting, including bowel, bladder, and catheter assistance (emptying the catheter bag, collecting a specimen, and cleaning the external area around the catheter).
- (5) Meal preparation, cooking, and assistance with feeding, not including the cost of meals themselves. Meal preparation and cooking shall be provided only in the member's home.
- (6) Housekeeping, laundry, and shopping essential to the member's health care at home.
- (7) Taking medications ordinarily self-administered, including those ordered by a physician or other qualified health care provider.
- (8) Minor wound care.
- (9) Going to or returning from a place of employment and job-related tasks while the member is on the job site. Transportation for the member and assistance with understanding or performing the essential job functions are not included in consumer-directed attendant care services.
- (10) Tasks, such as financial management and scheduling, that require cognitive or physical assistance.
- (11) Communication essential to the health and welfare of the member, through interpreting and reading services and use of assistive devices for communication.
- (12) Using transportation essential to the health and welfare of the member. The cost of the transportation is not included.

*g. Skilled services.* Covered skilled service activities are limited to help with the following activities:

- (1) Tube feedings of members unable to eat solid foods.
- (2) Intravenous therapy administered by a registered nurse.
- (3) Parenteral injections required more than once a week.
- (4) Catheterizations, continuing care of indwelling catheters with supervision of irrigations, and changing of Foley catheters when required.
- (5) Respiratory care including inhalation therapy and tracheotomy care or tracheotomy care and ventilator.
- (6) Care of decubiti and other ulcerated areas, noting and reporting to the nurse or therapist.
- (7) Rehabilitation services including, but not limited to, bowel and bladder training, range of motion exercises, ambulation training, restorative nursing services, respiratory care and breathing programs, reality orientation, reminiscing therapy, remotivation, behavior modification, and reteaching of the activities of daily living.
- (8) Colostomy care.

(9) Care of uncontrolled medical conditions, such as brittle diabetes, and comfort care of terminal conditions.

(10) Postsurgical nursing care.

(11) Monitoring medications requiring close supervision because of fluctuating physical or psychological conditions, e.g., antihypertensive, digitalis preparations, mood-altering or psychotropic drugs, or narcotics.

(12) Preparing and monitoring response to therapeutic diets.

(13) Recording and reporting of changes in vital signs to the nurse or therapist.

*h. Excluded services and costs.* Services, activities, costs and time that are not covered as consumer-directed attendant care include the following (not an exclusive list):

(1) Any activity related to supervising a member. Only direct services are billable.

(2) Any activity that the member is able to perform.

(3) Costs of food.

(4) Costs for the supervision of skilled services by the nurse or therapist. The supervising nurse or therapist may be paid from private insurance, Medicare, or other third-party payment sources, or may be paid as another Medicaid service, including early and periodic screening, diagnosis and treatment services.

(5) Exercise that does not require skilled services.

(6) Parenting or child care for or on behalf of the member.

(7) Reminders and cueing.

(8) Services provided simultaneously with any other similar service regardless of funding source, including other waiver services and state supplementary assistance in-home health-related care services.

(9) Transportation costs.

(10) Wait times for any activity.

**78.38(9) Consumer choices option.** The consumer choices option is service activities provided pursuant to subrule 78.34(13).

**78.38(10) General service standards.** All AIDS/HIV waiver services must be provided in accordance with the following standards:

*a.* Reimbursement shall not be available under the waiver for any services that the member can obtain as other nonwaiver Medicaid services or through any other funding source.

*b.* All services provided under the waiver must be delivered in the least restrictive environment possible and in conformity with the member's service plan.

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

(1) Any restrictions on the member's rights, including the rights of privacy, dignity, respect, and freedom from coercion and restraint.

(2) The need for the restriction.

(3) The less intrusive methods of meeting the need that have been tried but did not work.

(4) Either a plan to restore those rights or written documentation that a plan is not necessary or appropriate.

(5) Established time limits for periodic reviews to determine if the restriction is still necessary or can be terminated.

(6) The informed consent of the member.

(7) An assurance that the interventions and supports will cause no harm to the member.

(8) A regular collection and review of data to measure the ongoing effectiveness of the restriction.

*d.* Services must be billed in whole units.

*e.* For all services with a 15-minute unit of service, the following rounding process will apply:

(1) Add together the minutes spent on all billable activities during a calendar day for a daily total.

(2) For each day, divide the total minutes spent on billable activities by 15 to determine the number of full 15-minute units for that day.

(3) Round the remainder using these guidelines: Round 1 to 7 minutes down to zero units; round 8 to 14 minutes up to one unit.

(4) Add together the number of full units and the number of rounded units to determine the total number of units to bill for that day.

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

[ARC 9045B, IAB 9/8/10, effective 11/1/10; ARC 9403B, IAB 3/9/11, effective 5/1/11 (See Delay note at end of chapter); ARC 0707C, IAB 5/1/13, effective 7/1/13; ARC 0709C, IAB 5/1/13, effective 7/1/13; ARC 1610C, IAB 9/3/14, effective 8/13/14; ARC 3552C, IAB 1/3/18, effective 2/7/18; ARC 3874C, IAB 7/4/18, effective 8/8/18; ARC 4430C, IAB 5/8/19, effective 7/1/19; see Delay note at end of chapter]

**441—78.39(249A) Federally qualified health centers.** Payment shall be made for services as defined in Section 1905(a)(2)(C) of the Social Security Act.

**78.39(1) Utilization review.** Utilization review shall be conducted of Medicaid members who access more than 24 outpatient visits in any 12-month period from physicians, advanced registered nurse practitioners, federally qualified health centers, other clinics, and emergency rooms. Refer to rule 441—76.9(249A) for further information concerning the member lock-in program.

**78.39(2) Risk assessment.** Risk assessment, using Form 470-2942, Medicaid Prenatal Risk Assessment, shall be completed at the initial visit during a Medicaid member's pregnancy.

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

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

**78.39(3) Vaccines.** In order to be paid for the administration of a vaccine covered under the Vaccines for Children (VFC) Program, a federally qualified health center must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

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

[ARC 0065C, IAB 4/4/12, effective 6/1/12]

**441—78.40(249A) Advanced registered nurse practitioners.** Payment shall be approved for services provided by advanced registered nurse practitioners within their scope of practice and the limitations of state law, with the exception of services not payable to physicians under rule 441—78.1(249A) or otherwise not payable under any other applicable rule.

**78.40(1) Direct payment.** Payment shall be made to advanced registered nurse practitioners directly, without regard to whether the advanced registered nurse practitioner is employed by or associated with a physician, hospital, birth center, clinic or other health care provider recognized under state law. An established protocol between a physician and the advanced registered nurse practitioner shall not cause an advanced registered nurse practitioner to be considered auxiliary personnel of a physician, or an employee of a hospital, birth center, or clinic.

**78.40(2) Location of service.** Payment shall be approved for services rendered in any location in which the advanced registered nurse practitioner is legally authorized to provide services under state law. The nurse practitioner shall have promptly available the necessary equipment and personnel to handle emergencies.

**78.40(3) Utilization review.** Utilization review shall be conducted of Medicaid members who access more than 24 outpatient visits in any 12-month period from physicians, advanced registered nurse practitioners, other clinics, and emergency rooms. Refer to rule 441—76.9(249A) for further information concerning the member lock-in program.

**78.40(4) Vaccines.** In order to be paid for the administration of a vaccine covered under the Vaccines for Children (VFC) Program, an advanced registered nurse practitioner must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

**78.40(5) Prenatal risk assessment.** Risk assessment, using Form 470-2942, Medicaid Prenatal Risk Assessment, shall be completed at the initial visit during a Medicaid member's pregnancy.

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

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

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

**441—78.41(249A) HCBS intellectual disability waiver services.** Payment will be approved for the following services to members eligible for the HCBS intellectual disability waiver as established in 441—Chapter 83 and as identified in the member's service plan. Effective March 17, 2022, payment shall only be made for services provided in integrated, community-based settings that support full access of members receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.

**78.41(1) Supported community living services.** Supported community living services are provided by the provider within the member's home and community, according to the individualized member need as identified in the service plan.

a. Available components of the service are personal and home skills training services, individual advocacy services, community skills training services, personal environment support services, transportation, and treatment services.

(1) Personal and home skills training services are activities which assist a member to develop or maintain skills for self-care, self-directedness, and care of the immediate environment.

(2) Individual advocacy is the act or process of representing the member's rights and interests in order to realize the rights to which the member is entitled and to remove barriers to meeting the member's needs.

(3) Community skills training services are activities which assist a member to develop or maintain skills allowing better participation in the community. Services shall focus on the following areas as they apply to the member being served:

1. Personal management skills training services are activities which assist a member to maintain or develop skills necessary to sustain the member in the physical environment and are essential to the management of the member's personal business and property. This includes self-advocacy skills. Examples of personal management skills are the ability to maintain a household budget, plan and prepare nutritional meals, use community resources such as public transportation and libraries, and select foods at the grocery store.

2. Socialization skills training services are activities which assist a member to develop or maintain skills which include self-awareness and self-control, social responsiveness, community participation, social amenities, and interpersonal skills.

3. Communication skills training services are activities which assist a member to develop or maintain skills including expressive and receptive skills in verbal and nonverbal language and the functional application of acquired reading and writing skills.

(4) Personal and environmental support services are activities and expenditures provided to or on behalf of a member in the areas of personal needs in order to allow the member to function in the least restrictive environment.

(5) Transportation services are activities and expenditures designed to assist the member to travel from one place to another to obtain services or carry out life's activities. The services exclude transportation provided as nonemergency medical transportation pursuant to rule 441—78.13(249A).

(6) Treatment services are activities designed to assist the member to maintain or improve physiological, emotional and behavioral functioning and to prevent conditions that would present barriers to the member's functioning. Treatment services include physical or physiological treatment and psychotherapeutic treatment.

1. Physiological treatment includes medication regimens designed to prevent, halt, control, relieve, or reverse symptoms or conditions that interfere with the normal functioning of the human

body. Physiological treatment shall be provided by or under the direct supervision of a certified or licensed health care professional.

2. Psychotherapeutic treatment means activities provided to assist a member in the identification or modification of beliefs, emotions, attitudes, or behaviors in order to maintain or improve the member's functioning in response to the physical, emotional, and social environment.

b. The supported community living services are intended to provide for the daily living needs of the member and shall be available as needed during any 24-hour period. Activities do not include those associated with vocational services, academics, day care, medical services, Medicaid case management or other case management. Services are individualized supportive services provided in a variety of community-based, integrated settings.

(1) Supported community living services shall be available at a daily rate to members living outside the home of their family, legal representative, or foster family and for whom a provider has primary responsibility for supervision or structure during the month. This service will provide supervision or structure in identified periods when another resource is not available.

(2) Supported community living services shall be available at a 15-minute rate to members for whom a daily rate is not established.

c. Services may be provided to a child or an adult. A maximum of four persons may reside in a living unit.

(1) A member may live within the home of the member's family or legal representative or in another typical community living arrangement.

(2) A member living with the member's family or legal representative is not subject to the maximum of four residents in a living unit.

(3) A member may not live in a licensed medical or health care facility or in a setting that is required to be licensed as a medical or health care facility.

d. A member aged 17 or under living in the home of the member's family, legal representative, or foster family shall receive services based on development of adaptive, behavior, or health skills. Duration of services shall be based on age-appropriateness and individual attention span.

e. Maintenance and room and board costs are not reimbursable.

f. Provider budgets shall reflect costs associated with members' specific support needs as determined necessary by the interdisciplinary team for each member. The specific support needs must be identified in the Medicaid case manager's service plan, and the provider must maintain records to support the expenditures. A unit of service is:

(1) One full calendar day when a member residing in the living unit receives on-site staff supervision for eight or more hours per day as an average over a calendar month and the member's service plan identifies and reflects the need for this amount of supervision.

(2) Fifteen minutes when subparagraph 78.41(1) "f"(1) does not apply.

g. The maximum number of units available per member is as follows:

(1) 365 daily units per state fiscal year except a leap year when 366 daily units are available.

(2) 20,440 15-minute units are available per state fiscal year except a leap year when 20,496 15-minute units are available.

h. The service shall be identified in the member's service plan.

i. Supported community living services shall not be simultaneously reimbursed with other residential services or with respite, nursing, or home health aide services provided through Medicaid or the HCBS intellectual disability waiver.

**78.41(2) Respite care services.** Respite care services are services provided to the member that give temporary relief to the usual caregiver and provide all the necessary care that the usual caregiver would provide during that period. The purpose of respite care is to enable the member to remain in the member's current living situation.

a. Services provided outside the member's home shall not be reimbursable if the living unit where respite is provided is reserved for another person on a temporary leave of absence.

b. Member-to-staff ratios shall be appropriate to the individual needs of the member as determined by the member's interdisciplinary team.

- c. A unit of service is 15 minutes.
- d. Respite care is not to be provided to members during the hours in which the usual caregiver is employed except when the member is attending a 24-hour residential camp. Respite care shall not be used as a substitute for a child's day care. Respite cannot be provided to a member whose usual caregiver is a consumer-directed attendant care provider for the member.
- e. The interdisciplinary team shall determine if the member will receive basic individual respite, specialized respite or group respite as defined in 441—Chapter 83.
- f. A maximum of 14 consecutive days of 24-hour respite care may be reimbursed.
- g. Respite services provided for a period exceeding 24 consecutive hours to three or more individuals who require nursing care because of a mental or physical condition must be provided by a health care facility licensed as described in Iowa Code chapter 135C.
- h. Respite services shall not be simultaneously reimbursed with other residential, supported community living, nursing, or home health aide services provided through the medical assistance program.
- i. Payment for respite services shall not exceed \$7,334.62 per the member's waiver year.

**78.41(3) *Personal emergency response or portable locator system.***

a. The personal emergency response system is an electronic device that transmits a signal to a central monitoring station to summon assistance in the event of an emergency.

- (1) The necessary components of the system are:
  - 1. An in-home medical communications transceiver.
  - 2. A remote, portable activator.
  - 3. A central monitoring station with backup systems staffed by trained attendants at all times.
  - 4. Current data files at the central monitoring station containing response protocols and personal, medical and emergency information for each member.
- (2) The service shall be identified in the member's service plan.
- (3) A unit of service is a one-time installation fee or one month of service.
- (4) Maximum units per state fiscal year shall be the initial installation and 12 months of service.

b. A portable locator system is an electronic device that transmits a signal to a monitoring device. The system allows a member to access assistance in the event of an emergency and allows law enforcement or the monitoring system provider to locate a member who is unable to request help or to activate a system independently. The member must be unable to access assistance in an emergency situation due to the member's age or disability.

- (1) The required components of the portable locator system are:
  - 1. A portable communications transceiver or transmitter to be worn or carried by the member.
  - 2. Monitoring by the provider at a central location with response protocols and personal, medical, and emergency information for each member as applicable.
- (2) The service shall be identified in the member's service plan.
- (3) Payable units of service are purchase of equipment, an installation or set-up fee, and monthly fees.
- (4) Maximum units per state fiscal year shall be one equipment purchase, one installation or set-up fee, and 12 months of service.

**78.41(4) *Home and vehicle modification.*** Covered home or vehicle modifications are physical modifications to the member's home or vehicle that directly address the member's medical or remedial need. Covered modifications must be necessary to provide for the health, welfare, or safety of the member and enable the member to function with greater independence in the home or vehicle.

a. Modifications that are necessary or desirable without regard to the member's medical or remedial need and that would be expected to increase the fair market value of the home or vehicle, such as furnaces, fencing, or adding square footage to the residence, are excluded except as specifically included below. Purchasing or leasing of a motorized vehicle is excluded. Home and vehicle repairs are also excluded.

b. Only the following modifications are covered:

- (1) Kitchen counters, sink space, cabinets, special adaptations to refrigerators, stoves, and ovens.

(2) Bathtubs and toilets to accommodate transfer, special handles and hoses for shower heads, water faucet controls, and accessible showers and sink areas.

(3) Grab bars and handrails.

(4) Turnaround space adaptations.

(5) Ramps, lifts, and door, hall and window widening.

(6) Fire safety alarm equipment specific for disability.

(7) Voice-activated, sound-activated, light-activated, motion-activated, and electronic devices directly related to the member's disability.

(8) Vehicle lifts, driver-specific adaptations, remote-start systems, including such modifications already installed in a vehicle.

(9) Keyless entry systems.

(10) Automatic opening device for home or vehicle door.

(11) Special door and window locks.

(12) Specialized doorknobs and handles.

(13) Plexiglas replacement for glass windows.

(14) Modification of existing stairs to widen, lower, raise or enclose open stairs.

(15) Motion detectors.

(16) Low-pile carpeting or slip-resistant flooring.

(17) Telecommunications device for the deaf.

(18) Exterior hard-surface pathways.

(19) New door opening.

(20) Pocket doors.

(21) Installation or relocation of controls, outlets, switches.

(22) Air conditioning and air filtering if medically necessary.

(23) Heightening of existing garage door opening to accommodate modified van.

(24) Bath chairs.

c. A unit of service is the completion of needed modifications or adaptations.

d. All modifications and adaptations shall be provided in accordance with applicable federal, state, and local building and vehicle codes.

e. Services shall be performed following prior department approval of the modification as specified in 441—subrule 79.1(17) and a binding contract between the provider and the member.

f. All contracts for home or vehicle modification shall be awarded through competitive bidding. The contract shall include the scope of work to be performed, the time involved, supplies needed, the cost, diagrams of the project whenever applicable, and an assurance that the provider has liability and workers' compensation coverage and the applicable permit and license.

g. Service payment shall be made to the enrolled home or vehicle modification provider. If applicable, payment will be forwarded to the subcontracting agency by the enrolled home or vehicle modification provider following completion of the approved modifications.

h. Services shall be included in the member's service plan and shall exceed the Medicaid state plan services.

**78.41(5) Nursing services.** Nursing services are individualized in-home medical services provided by licensed nurses. Services shall exceed the Medicaid state plan services and be included in the consumer's individual comprehensive plan.

a. A unit of service is one hour.

b. A maximum of ten units are available per week.

**78.41(6) Home health aide services.** Home health aide services are personal or direct care services provided to the member which are not payable under Medicaid as set forth in rule 441—78.9(249A). Services shall include unskilled medical services and shall exceed those services provided under HCBS intellectual disability waiver supported community living. Instruction, supervision, support or assistance in personal hygiene, bathing, and daily living shall be provided under supported community living.

a. Services shall be included in the member's service plan.

b. A unit is one hour.

c. A maximum of 14 units are available per week.

**78.41(7) Supported employment services.** Supported employment services are service activities provided pursuant to subrule 78.27(10).

**78.41(8) Consumer-directed attendant care service.** Consumer-directed attendant care services are service activities performed by a person to help a member with self-care tasks which the member would typically do independently if the member were otherwise able. Covered service activities are limited to the nonskilled activities listed in paragraph 78.41(8)“f” and the skilled activities listed in paragraph 78.41(8)“g.” Covered service activities must be essential to the health, safety, and welfare of the member. Services may be provided in the absence of a parent or guardian if the parent or guardian has given advance direction for the service provision.

a. *Service planning.*

(1) The member, parent, guardian, or attorney in fact under a durable power of attorney for health care shall:

1. Select the individual or agency that will provide the components of the attendant care services.
2. Determine with the selected provider what components of attendant care services the provider shall perform, subject to confirmation by the service worker or case manager that those components are consistent with the assessment and are authorized covered services.

3. Complete, sign, and date Form 470-3372, HCBS Consumer-Directed Attendant Care Agreement, to indicate the frequency, scope, and duration of services (a description of each service component and the time agreed on for that component). The case manager or service worker and provider shall also sign the agreement.

4. Submit the completed agreement to the service worker or case manager. The agreement shall be part of the member’s service plan and shall be kept in the member’s records, in the provider’s records, and in the service worker’s or case manager’s records. Any service component that is not listed in the agreement shall not be payable.

(2) Whenever a legal representative acts as a provider of consumer-directed attendant care as allowed by 441—paragraph 79.9(7)“b,” the following shall apply:

1. The payment rate for the legal representative must be based on the skill level of the legal representative and may not exceed the median statewide reimbursement rate for the service unless the higher rate receives prior approval from the department;

2. The legal representative may not be paid for more than 40 hours of service per week; and

3. A contingency plan must be established in the member’s service plan to ensure service delivery in the event the legal representative is unable to provide services due to illness or other unexpected event.

b. *Supervision of skilled services.* Skilled consumer-directed attendant care services shall be provided under the supervision of a licensed nurse or licensed therapist working under the direction of a physician. The licensed nurse or therapist shall:

- (1) Retain accountability for actions that are delegated.

- (2) Ensure appropriate assessment, planning, implementation, and evaluation.

- (3) Make on-site supervisory visits every two weeks with the service provider present.

c. *Service documentation.* The consumer-directed attendant care provider must complete Form 470-4389, Consumer-Directed Attendant Care (CDAC) Service Record, for each day of service. Any service component that is not documented in accordance with rule 441—79.3(249A) shall not be payable.

d. *Role of guardian or attorney.* If the member has a guardian or attorney in fact under a durable power of attorney for health care:

- (1) The service worker’s or case manager’s service plan shall address how consumer-directed attendant care services will be monitored to ensure that the member’s needs are being adequately met. If the guardian or attorney in fact is the service provider, the service plan shall address how the service worker or case manager shall oversee service provision.

- (2) The guardian or attorney in fact shall sign the claim form in place of the member, indicating that the service has been provided as presented on the claim.

e. *Service units and billing.* A unit of service is 15 minutes provided by an individual or agency. Each service shall be billed in whole units.

*f. Nonskilled services.* Covered nonskilled service activities are limited to help with the following activities:

- (1) Dressing.
- (2) Bathing, shampooing, hygiene, and grooming.
- (3) Access to and from bed or a wheelchair, transferring, ambulation, and mobility in general.
- (4) Toileting, including bowel, bladder, and catheter assistance (emptying the catheter bag, collecting a specimen, and cleaning the external area around the catheter).
- (5) Meal preparation, cooking, and assistance with feeding, not including the cost of meals themselves. Meal preparation and cooking shall be provided only in the member's home.
- (6) Housekeeping, laundry, and shopping essential to the member's health care at home.
- (7) Taking medications ordinarily self-administered, including those ordered by a physician or other qualified health care provider.
- (8) Minor wound care.
- (9) Going to or returning from a place of employment and job-related tasks while the member is on the job site. Transportation for the member and assistance with understanding or performing the essential job functions are not included in consumer-directed attendant care services.
- (10) Tasks, such as financial management and scheduling, that require cognitive or physical assistance.
- (11) Communication essential to the health and welfare of the member, through interpreting and reading services and use of assistive devices for communication.
- (12) Using transportation essential to the health and welfare of the member. The cost of the transportation is not included.

*g. Skilled services.* Covered skilled service activities are limited to help with the following activities:

- (1) Tube feedings of members unable to eat solid foods.
- (2) Intravenous therapy administered by a registered nurse.
- (3) Parenteral injections required more than once a week.
- (4) Catheterizations, continuing care of indwelling catheters with supervision of irrigations, and changing of Foley catheters when required.
- (5) Respiratory care including inhalation therapy and tracheotomy care or tracheotomy care and ventilator.
- (6) Care of decubiti and other ulcerated areas, noting and reporting to the nurse or therapist.
- (7) Rehabilitation services including, but not limited to, bowel and bladder training, range of motion exercises, ambulation training, restorative nursing services, respiratory care and breathing programs, reality orientation, reminiscing therapy, remotivation, behavior modification, and reteaching of the activities of daily living.
- (8) Colostomy care.
- (9) Care of uncontrolled medical conditions, such as brittle diabetes, and comfort care of terminal conditions.
- (10) Postsurgical nursing care.
- (11) Monitoring medications requiring close supervision because of fluctuating physical or psychological conditions, e.g., antihypertensives, digitalis preparations, mood-altering or psychotropic drugs, or narcotics.
- (12) Preparing and monitoring response to therapeutic diets.
- (13) Recording and reporting of changes in vital signs to the nurse or therapist.

*h. Excluded services and costs.* Services, activities, costs and time that are not covered as consumer-directed attendant care include the following (not an exclusive list):

- (1) Any activity related to supervising a member. Only direct services are billable.
- (2) Any activity that the member is able to perform.
- (3) Costs of food.
- (4) Costs for the supervision of skilled services by the nurse or therapist. The supervising nurse or therapist may be paid from private insurance, Medicare, or other third-party payment sources, or may

be paid as another Medicaid service, including early and periodic screening, diagnosis and treatment services.

- (5) Exercise that does not require skilled services.
- (6) Parenting or child care for or on behalf of the member.
- (7) Reminders and cueing.
- (8) Services provided simultaneously with any other similar service regardless of funding source, including other waiver services and state supplementary assistance in-home health-related care services.
- (9) Transportation costs.
- (10) Wait times for any activity.

**78.41(9)** *Interim medical monitoring and treatment services.* Interim medical monitoring and treatment (IMMT) services are monitoring and treatment of a medical nature for children or adults whose medical needs make alternative care unavailable, inadequate, or insufficient. IMMT services are not intended to provide day care but to supplement available resources. Services must be ordered by a physician.

*a.* Need for service. The member must be currently receiving home health agency services under rule 441—78.9(249A) and require medical assessment, medical monitoring, and regular medical intervention or intervention in a medical emergency during those services. The service worker or case manager must identify the need for IMMT services after evaluating the member's living environment, family and natural supports, ability to perform activities of daily living, and health care needs. The services must be needed:

- (1) To allow the member's usual caregivers to be employed,
- (2) During a search for employment by a usual caregiver,
- (3) To allow for academic or vocational training of a usual caregiver,
- (4) Due to the hospitalization of a usual caregiver for treatment for physical or mental illness, or
- (5) Due to the death of a usual caregiver.

*b.* Service requirements. Interim medical monitoring and treatment services shall:

- (1) Provide experiences for each member's social, emotional, intellectual, and physical development;
- (2) Include comprehensive developmental care and any special services for a member with special needs; and
- (3) Include medical assessment, medical monitoring, and medical intervention as needed on a regular or emergency basis. Medical intervention means the ability to assess the situation and contact the appropriate medical professional, not the direct application of medical care.

*c.* Interim medical monitoring and treatment services may include supervision while the member is being transported to and from school.

*d.* Limitations.

- (1) A maximum of 12 hours of service is available per day.
- (2) Covered services do not include a complete nutritional regimen.
- (3) Interim medical monitoring and treatment services may not duplicate any regular Medicaid or waiver services provided under the state plan. Services under the state plan, including home health agency services under rule 441—78.9(249A), must be exhausted before IMMT services are accessed.

(4) Interim medical monitoring and treatment services shall be provided in the following settings that are approved by the department as integrated, community-based settings: the member's home; a registered child development home; a licensed child care center, residential care facility, or adult day care facility; or during the time when the member is being transported to and from school.

(5) The member-to-staff ratio shall not be more than six members to one staff person.

(6) The parent or guardian of the member shall be responsible for the usual and customary nonmedical cost of day care during the time in which the member is receiving IMMT services. Medical care necessary for monitoring and treatment is an allowable IMMT cost. If the cost of care goes above the usual and customary cost of day care services due to the member's medical condition, the costs above the usual and customary cost shall be covered as IMMT services.

*e.* A unit of service is 15 minutes.

**78.41(10) Residential-based supported community living services.** Residential-based supported community living services are medical or remedial services provided to children under the age of 18 while living outside their home in a residential-based living environment furnished by the residential-based supported community living service provider. The services eliminate barriers to family reunification or develop self-help skills for maximum independence.

*a.* Allowable service components are the following:

(1) Daily living skills development. These are services to develop the child's ability to function independently in the community on a daily basis, including training in food preparation, maintenance of living environment, time and money management, personal hygiene, and self-care.

(2) Social skills development. These are services to develop a child's communication and socialization skills, including interventions to develop a child's ability to solve problems, resolve conflicts, develop appropriate relationships with others, and develop techniques for controlling behavior.

(3) Family support development. These are services necessary to allow a child to return to the child's family or another less restrictive service environment. These services must include counseling and therapy sessions that involve both the child and the child's family at least 50 percent of the time and that focus on techniques for dealing with the special care needs of the child and interventions needed to alleviate behaviors that are disruptive to the family or other group living unit.

(4) Counseling and behavior intervention services. These are services to halt, control, or reverse stress and social, emotional, or behavioral problems that threaten or have negatively affected the child's stability. Activities under this service include counseling and behavior intervention with the child, including interventions to ameliorate problem behaviors.

*b.* Residential-based supported community living services must also address the ordinary daily-living needs of the child, excluding room and board, such as needs for safety and security, social functioning, and other medical care.

*c.* Residential-based supported community living services do not include services associated with vocational needs, academics, day care, Medicaid case management, other case management, or any other services that the child can otherwise obtain through Medicaid.

*d.* Room and board costs are not reimbursable as residential-based supported community living services.

*e.* The scope of service shall be identified in the child's service plan pursuant to 441—paragraph 77.37(23)“*d.*”

*f.* Residential-based supported community living services shall not be simultaneously reimbursed with other residential services provided under an HCBS waiver or otherwise provided under the Medicaid program.

*g.* A unit of service is a day.

*h.* The maximum number of units of residential-based supported community living services available per child is 365 daily units per state fiscal year, except in a leap year when 366 daily units are available.

**78.41(11) Transportation.** Transportation services may be provided for members to conduct business errands and essential shopping, to travel to and from work or day programs, and to reduce social isolation. A unit of service is one mile of transportation or one one-way trip. Transportation may not be reimbursed when HCBS intellectual disability waiver daily supported community living service is authorized in a member's service plan.

**78.41(12) Adult day care services.** Adult day care services provide an organized program of supportive care in a group environment to persons who need a degree of supervision and assistance on a regular or intermittent basis in a day care center. A unit of service is 15 minutes (up to four units per day), a half day (1.25 to 4 hours per day), or a full day (4.25 to 12 hours per day). Components of the service include health-related care, social services, and other related support services.

**78.41(13) Prevocational services.** Prevocational services are service activities provided pursuant to subrule 78.27(9).

**78.41(14) Day habilitation services.**

*a. Scope.* Day habilitation services are services that assist or support the member in developing or maintaining life skills and community integration. Services must enable or enhance the member's intellectual functioning, physical and emotional health and development, language and communication development, cognitive functioning, socialization and community integration, functional skill development, behavior management, responsibility and self-direction, daily living activities, self-advocacy skills, or mobility.

*b. Family training option.* Day habilitation services may include training families in treatment and support methodologies or in the care and use of equipment. Family training may be provided in the member's home. The unit of service is 15 minutes. The units of services payable are limited to a maximum of 40 units per month.

*c. Unit of service.* Except as provided in paragraph 78.41(14) "b," the unit of service is 15 minutes (for up to 16 units per day) or a full day (4.25 to 8 hours per day).

*d. Exclusions.*

(1) Services shall not be provided in the member's home, except as provided in paragraph "b." For this purpose, services provided in a residential care facility where the member lives are not considered to be provided in the member's home.

(2) Services shall not include vocational or prevocational services and shall not involve paid work.

(3) Services shall not duplicate or replace education or related services defined in Public Law 94-142, the Education of the Handicapped Act.

(4) Services shall not be provided simultaneously with other Medicaid-funded services.

**78.41(15) Consumer choices option.** The consumer choices option is service activities provided pursuant to subrule 78.34(13).

**78.41(16) General service standards.** All intellectual disability waiver services must be provided in accordance with the following standards:

*a.* Reimbursement shall not be available under the waiver for any services that the member can obtain as other nonwaiver Medicaid services or through any other funding source.

*b.* All services provided under the waiver must be delivered in the least restrictive environment possible and in conformity with the member's service plan.

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

(1) Any restrictions on the member's rights, including the rights of privacy, dignity, respect, and freedom from coercion and restraint.

(2) The need for the restriction.

(3) The less intrusive methods of meeting the need that have been tried but did not work.

(4) Either a plan to restore those rights or written documentation that a plan is not necessary or appropriate.

(5) Established time limits for periodic reviews to determine if the restriction is still necessary or can be terminated.

(6) The informed consent of the member.

(7) An assurance that the interventions and supports will cause no harm to the member.

(8) A regular collection and review of data to measure the ongoing effectiveness of the restriction.

*d.* Services must be billed in whole units.

*e.* For all services with a 15-minute unit of service, the following rounding process will apply:

(1) Add together the minutes spent on all billable activities during a calendar day for a daily total.

(2) For each day, divide the total minutes spent on billable activities by 15 to determine the number of full 15-minute units for that day.

(3) Round the remainder using these guidelines: Round 1 to 7 minutes down to zero units; round 8 to 14 minutes up to one unit.

(4) Add together the number of full units and the number of rounded units to determine the total number of units to bill for that day.

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

[ARC 9045B, IAB 9/8/10, effective 11/1/10; ARC 9403B, IAB 3/9/11, effective 5/1/11 (See Delay note at end of chapter); ARC 9650B, IAB 8/10/11, effective 10/1/11; ARC 9704B, IAB 9/7/11, effective 9/1/11; ARC 9884B, IAB 11/30/11, effective 1/4/12; ARC 0707C, IAB 5/1/13, effective 7/1/13; ARC 0709C, IAB 5/1/13, effective 7/1/13; ARC 0842C, IAB 7/24/13, effective 7/1/13; ARC 1056C, IAB 10/2/13, effective 11/6/13; ARC 1071C, IAB 10/2/13, effective 10/1/13; ARC 1610C, IAB 9/3/14, effective 8/13/14; ARC 2050C, IAB 7/8/15, effective 7/1/15; ARC 2471C, IAB 3/30/16, effective 5/4/16; ARC 2848C, IAB 12/7/16, effective 11/15/16; ARC 2936C, IAB 2/1/17, effective 3/8/17; ARC 3481C, IAB 12/6/17, effective 12/1/17; ARC 3790C, IAB 5/9/18, effective 6/13/18; ARC 3874C, IAB 7/4/18, effective 8/8/18; ARC 4430C, IAB 5/8/19, effective 7/1/19; see Delay note at end of chapter]

**441—78.42(249A) Pharmacies administering influenza vaccine to children.** Payment will be made to a pharmacy for the administration of influenza vaccine available through the Vaccines for Children (VFC) Program administered by the department of public health if the pharmacy is enrolled in the VFC program. Payment will be made for the vaccine only if the VFC program stock has been depleted.

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

[ARC 9132B, IAB 10/6/10, effective 11/1/10; ARC 9316B, IAB 12/29/10, effective 2/2/11; ARC 0065C, IAB 4/4/12, effective 6/1/12]

**441—78.43(249A) HCBS brain injury waiver services.** Payment shall be approved for the following services to members eligible for the HCBS brain injury waiver services as established in 441—Chapter 83 and as identified in the member's service plan. Effective March 17, 2022, payment shall only be made for services provided in integrated, community-based settings that support full access of members receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.

**78.43(1) Case management services.** Individual case management services means services that assist members who reside in a community setting or are transitioning to a community setting in gaining access to needed medical, social, educational, housing, transportation, vocational, and other appropriate services in order to ensure the health, safety, and welfare of the member.

a. Case management services shall be provided as set forth in rules 441—90.5(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 is service activities provided pursuant to subrule 78.34(13).

**78.43(16) General service standards.** All brain injury waiver services must be provided in accordance with the following standards:

a. Reimbursement shall not be available under the waiver for any services that the member can obtain as other nonwaiver Medicaid services or through any other funding source.

b. All services provided under the waiver must be delivered in the least restrictive environment possible and in conformity with the member's service plan.

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

(1) Any restrictions on the member's rights, including the rights of privacy, dignity, respect, and freedom from coercion and restraint.

(2) The need for the restriction.

(3) The less intrusive methods of meeting the need that have been tried but did not work.

(4) Either a plan to restore those rights or written documentation that a plan is not necessary or appropriate.

(5) Established time limits for periodic reviews to determine if the restriction is still necessary or can be terminated.

(6) The informed consent of the member.

(7) An assurance that the interventions and supports will cause no harm to the member.

(8) A regular collection and review of data to measure the ongoing effectiveness of the restriction.

d. Services must be billed in whole units.

e. For all services with a 15-minute unit of service, the following rounding process will apply:

(1) Add together the minutes spent on all billable activities during a calendar day for a daily total.

(2) For each day, divide the total minutes spent on billable activities by 15 to determine the number of full 15-minute units for that day.

(3) Round the remainder using these guidelines: Round 1 to 7 minutes down to zero units; round 8 to 14 minutes up to one unit.

(4) Add together the number of full units and the number of rounded units to determine the total number of units to bill for that day.

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

[ARC 7957B, IAB 7/15/09, effective 7/1/09; ARC 9045B, IAB 9/8/10, effective 11/1/10; ARC 9403B, IAB 3/9/11, effective 5/1/11 (See Delay note at end of chapter); ARC 9704B, IAB 9/7/11, effective 9/1/11; ARC 9884B, IAB 11/30/11, effective 1/4/12; ARC 0191C, IAB 7/11/12, effective 7/1/12; ARC 0359C, IAB 10/3/12, effective 12/1/12; ARC 0707C, IAB 5/1/13, effective 7/1/13; ARC 0709C, IAB 5/1/13, effective 7/1/13; ARC 0842C, IAB 7/24/13, effective 7/1/13; ARC 1056C, IAB 10/2/13, effective 11/6/13; ARC 1071C, IAB 10/2/13, effective 10/1/13; ARC 1610C, IAB 9/3/14, effective 8/13/14; ARC 2050C, IAB 7/8/15, effective 7/1/15; ARC 2471C, IAB 3/30/16, effective 5/4/16; ARC 2848C, IAB 12/7/16, effective 11/15/16; ARC 2936C, IAB 2/1/17, effective 3/8/17; ARC 3874C, IAB 7/4/18, effective 8/8/18; ARC 4430C, IAB 5/8/19, effective 7/1/19; see Delay note at end of chapter]

**441—78.44(249A) Lead inspection services.** Payment shall be approved for lead inspection services. This service shall be provided for children who have had two venous blood lead levels of 15 to 19 micrograms per deciliter or one venous level greater than or equal to 20 micrograms per deciliter. This service includes, but is not limited to, X-ray fluorescence analyzer (XRF) readings, visual examination of paint, preventive education of the resident and homeowner, health education about lead poisoning, and a written report to the family, homeowner, medical provider, and local childhood lead poisoning prevention program.

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

**441—78.45(249A) Assertive community treatment.** Assertive community treatment (ACT) services are comprehensive, integrated, and intensive outpatient services provided by a multidisciplinary team under the supervision of a psychiatrist. ACT services are directed toward the rehabilitation of behavioral, social, or emotional deficits or the amelioration of symptoms of a mental disorder. Most services are delivered in the member's home or another community setting.

**78.45(1) Applicability.** ACT services may be provided only to a member who meets all of the following criteria:

a. The member is at least 17 years old.

b. The member has a severe and persistent mental illness or complex mental health symptomatology. A severe and persistent mental illness is a psychiatric disorder that causes symptoms and impairments in basic mental and behavioral processes that produce distress and major functional disability in adult role functioning (such as social, personal, family, educational or vocational roles). Specifically, the member has a degree of impairment arising from a psychiatric disorder such that:

(1) The member does not have the resources or skills necessary to maintain an adequate level of functioning in the home or community environment without assistance or support;

(2) The member's judgment, impulse control, or cognitive perceptual abilities are compromised; and

(3) The member exhibits significant impairment in social, interpersonal, or familial functioning.

c. The member has a validated principal mental health diagnosis consistent with a severe and persistent mental illness. For this purpose, a mental health diagnosis means a disorder, dysfunction, or dysphoria diagnosed pursuant to the current version of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association, excluding neurodevelopmental disorders, substance-related disorders, personality disorders, medication-induced movement disorders and other adverse effects of medication, and other conditions that may be a focus of clinical attention. Members with a primary diagnosis of substance-related disorder, developmental disability, or organic disorder are not eligible for ACT services.

d. The member needs a consistent team of professionals and multiple mental health and support services to maintain the member in the community and reduce hospitalizations, as evidenced by:

(1) A pattern of repeated treatment failures with at least two hospitalizations within the previous 24 months, or

(2) A need for multiple or combined mental health and basic living supports to prevent the need for a more intrusive level of care.

e. The member presents a reasonable likelihood that ACT services will lead to specific, observable improvements in the member's functioning and assist the member in achieving or maintaining community tenure. Specifically, the member:

- (1) Is medically stable;
- (2) Does not require a level of care that includes more intensive medical monitoring;
- (3) Presents a low risk to self, others, or property, with treatment and support; and
- (4) Lives independently in the community or demonstrates a capacity to live independently and move from a dependent residential setting to independent living.

f. At the time of admission, the member has a comprehensive assessment that includes psychiatric history, medical history, work and educational history, substance use, problems with activities of daily living, social interests, and family relationships.

g. The member has a written treatment plan containing a work evaluation and the necessary psychiatric rehabilitation treatment and support services. The plan shall identify:

- (1) Treatment objectives and outcomes,
- (2) The expected frequency and duration of each service,
- (3) The location where the services will be provided,
- (4) A crisis plan, and
- (5) The schedule for updates of the treatment plan.

**78.45(2) Services.** The ACT team shall participate in all mental health services provided to the member and shall provide 24-hour service for the psychiatric needs of the member. Available ACT services are:

a. *Evaluation and medication management.*

(1) The evaluation portion of ACT services consists of a comprehensive mental health evaluation and assessment of the member by a psychiatrist, advanced registered nurse practitioner, or physician assistant.

(2) Medication management consists of the prescription and management of medication by a psychiatrist, advanced registered nurse practitioner, or physician assistant to respond to the member's complaints and symptoms. A psychiatric registered nurse assists in this management by contact with the member regarding medications and their effect on the member's complaints and symptoms.

b. *Integrated therapy and counseling for mental health and substance abuse.* This service consists of direct counseling for treatment of mental health and substance abuse symptoms by a psychiatrist, licensed mental health professional, advanced registered nurse practitioner, physician assistant, or substance abuse specialist. Individual counseling is provided by other team members under the supervision of a psychiatrist or licensed mental health practitioner.

c. *Skill teaching.* Skill teaching consists of side-by-side demonstration and observation of daily living activities by a registered nurse, licensed mental health professional, psychologist, substance abuse counselor, peer specialist, community support specialist, advanced registered nurse practitioner, or physician assistant.

d. *Community support.* Community support is provided by a licensed mental health professional, psychologist, substance abuse counselor, peer specialist, community support specialist, advanced registered nurse practitioner, or physician assistant. Community support consists of the following activities focused on recovery and rehabilitation:

(1) Personal and home skills training to assist the member to develop and maintain skills for self-direction and coping with the living situation.

(2) Community skills training to assist the member in maintaining a positive level of participation in the community through development of socialization skills and personal coping skills.

e. *Medication monitoring.* Medication monitoring services are provided by a psychiatric nurse and other team members under the supervision of a psychiatrist or psychiatric nurse and consist of:

- (1) Monitoring the member's day-to-day functioning, medication compliance, and access to medications; and
- (2) Ensuring that the member keeps appointments.

*f. Case management for treatment and service plan coordination.* Case management consists of the development by the ACT team of an individualized treatment and service plan, including personalized goals and outcomes, to address the member's medical symptoms and remedial functional impairments.

(1) Case management includes:

1. Assessments, referrals, follow-up, and monitoring.
2. Assisting the member in gaining access to necessary medical, social, educational, and other services.
3. Assessing the member to determine service needs by collecting relevant historical information through member records and other information from relevant professionals and natural supports.

(2) The team shall:

1. Develop a specific care plan based on the assessment of needs, including goals and actions to address the needed medical, social, educational, and other necessary services.
2. Make referrals to services and related activities to assist the member with the assessed needs.
3. Monitor and perform follow-up activities necessary to ensure that the plan is carried out and that the member has access to necessary services. Activities may include monitoring contacts with providers, family members, natural supports, and others.
4. Hold daily team meetings to facilitate ACT services and coordinate the member's care with other members of the team.

*g. Crisis response.* Crisis response consists of direct assessment and treatment of the member's urgent or crisis symptoms in the community by a registered nurse, licensed mental health professional, psychologist, substance abuse counselor, community support specialist, case manager, advanced registered nurse practitioner, or physician assistant, as appropriate.

*h. Work-related services.* Work-related services may be provided by a registered nurse, licensed mental health professional, psychologist, substance abuse counselor, community support specialist, case manager, advanced registered nurse practitioner, or physician assistant. Services consist of assisting the member in managing mental health symptoms as they relate to job performance. Services may include:

- (1) Collaborating with the member to look for job situations that may cause symptoms to increase and creating strategies to manage these situations.
- (2) Assisting the member to develop or enhance skills to obtain a work placement, such as individual work-related behavioral management.
- (3) Providing supports to maintain employment, such as crisis intervention related to employment.
- (4) Teaching communication, problem solving, and safety skills.
- (5) Teaching personal skills such as time management and appropriate grooming for employment.

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

[ARC 9440B, IAB 4/6/11, effective 4/1/11; ARC 1850C, IAB 2/4/15, effective 4/1/15; ARC 2164C, IAB 9/30/15, effective 10/1/15]

**441—78.46(249A) Physical disability waiver service.** Payment shall be approved for the following services to members eligible for the HCBS physical disability waiver as established in 441—Chapter 83 and as identified in the member's service plan. Effective March 17, 2022, payment shall only be made for services provided in integrated, community-based settings that support full access of members receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.

**78.46(1) Consumer-directed attendant care service.** Consumer-directed attendant care services are service activities performed by a person to help a member with self-care tasks which the member would typically do independently if the member were otherwise able. Covered service activities are limited to the nonskilled activities listed in paragraph 78.46(1) "f" and the skilled activities listed in paragraph 78.46(1) "g." Covered service activities must be essential to the health, safety, and welfare of the member. Services may be provided in the absence of a parent or guardian if the parent or guardian has given advance direction for the service provision.

*a. Service planning.*

(1) The member, parent, guardian, or attorney in fact under a durable power of attorney for health care shall:

1. Select the individual or agency that will provide the components of the attendant care services.

2. Determine with the selected provider what components of attendant care services the provider shall perform, subject to confirmation by the service worker or case manager that those components are consistent with the assessment and are authorized covered services.

3. Complete, sign, and date Form 470-3372, HCBS Consumer-Directed Attendant Care Agreement, to indicate the frequency, scope, and duration of services (a description of each service component and the time agreed on for that component). The case manager or service worker and provider shall also sign the agreement.

4. Submit the completed agreement to the service worker or case manager. The agreement shall be part of the member's service plan and shall be kept in the member's records, in the provider's records, and in the service worker's or case manager's records. Any service component that is not listed in the agreement shall not be payable.

(2) Whenever a legal representative acts as a provider of consumer-directed attendant care as allowed by 441—paragraph 79.9(7) "b," the following shall apply:

1. The payment rate for the legal representative must be based on the skill level of the legal representative and may not exceed the median statewide reimbursement rate for the service unless the higher rate receives prior approval from the department;

2. The legal representative may not be paid for more than 40 hours of service per week; and

3. A contingency plan must be established in the member's service plan to ensure service delivery in the event the legal representative is unable to provide services due to illness or other unexpected event.

*b. Supervision of skilled services.* Skilled consumer-directed attendant care services shall be provided under the supervision of a licensed nurse or licensed therapist working under the direction of a physician. The licensed nurse or therapist shall:

(1) Retain accountability for actions that are delegated.

(2) Ensure appropriate assessment, planning, implementation, and evaluation.

(3) Make on-site supervisory visits every two weeks with the service provider present.

*c. Service documentation.* The consumer-directed attendant care provider must complete Form 470-4389, Consumer-Directed Attendant Care (CDAC) Service Record, for each day of service. Any service component that is not documented in accordance with rule 441—79.3(249A) shall not be payable.

*d. Role of guardian or attorney.* If the member has a guardian or attorney in fact under a durable power of attorney for health care:

(1) The service worker's or case manager's service plan shall address how consumer-directed attendant care services will be monitored to ensure that the member's needs are being adequately met. If the guardian or attorney in fact is the service provider, the service plan shall address how the service worker or case manager shall oversee service provision.

(2) The guardian or attorney in fact shall sign the claim form in place of the member, indicating that the service has been provided as presented on the claim.

*e. Service units and billing.* A unit of service is 15 minutes provided by an individual or agency. Each service shall be billed in whole units.

*f. Nonskilled services.* Covered nonskilled service activities are limited to help with the following activities:

(1) Dressing.

(2) Bathing, shampooing, hygiene, and grooming.

(3) Access to and from bed or a wheelchair, transferring, ambulation, and mobility in general.

(4) Toileting, including bowel, bladder, and catheter assistance (emptying the catheter bag, collecting a specimen, and cleaning the external area around the catheter).

(5) Meal preparation, cooking, and assistance with feeding, not including the cost of meals themselves. Meal preparation and cooking shall be provided only in the member's home.

(6) Housekeeping, laundry, and shopping essential to the member's health care at home.

(7) Taking medications ordinarily self-administered, including those ordered by a physician or other qualified health care provider.

(8) Minor wound care.

(9) Going to or returning from a place of employment and job-related tasks while the member is on the job site. Transportation for the member and assistance with understanding or performing the essential job functions are not included in consumer-directed attendant care services.

(10) Tasks, such as financial management and scheduling, that require cognitive or physical assistance.

(11) Communication essential to the health and welfare of the member, through interpreting and reading services and use of assistive devices for communication.

(12) Using transportation essential to the health and welfare of the member. The cost of the transportation is not included.

*g. Skilled services.* Covered skilled service activities are limited to help with the following activities:

(1) Tube feedings of members unable to eat solid foods.

(2) Intravenous therapy administered by a registered nurse.

(3) Parenteral injections required more than once a week.

(4) Catheterizations, continuing care of indwelling catheters with supervision of irrigations, and changing of Foley catheters when required.

(5) Respiratory care including inhalation therapy and tracheotomy care or tracheotomy care and ventilator.

(6) Care of decubiti and other ulcerated areas, noting and reporting to the nurse or therapist.

(7) Rehabilitation services including, but not limited to, bowel and bladder training, range of motion exercises, ambulation training, restorative nursing services, respiratory care and breathing programs, reality orientation, reminiscing therapy, remotivation, behavior modification, and reteaching of the activities of daily living.

(8) Colostomy care.

(9) Care of uncontrolled medical conditions, such as brittle diabetes, and comfort care of terminal conditions.

(10) Postsurgical nursing care.

(11) Monitoring medications requiring close supervision because of fluctuating physical or psychological conditions, e.g., antihypertensives, digitalis preparations, mood-altering or psychotropic drugs, or narcotics.

(12) Preparing and monitoring response to therapeutic diets.

(13) Recording and reporting of changes in vital signs to the nurse or therapist.

*h. Excluded services and costs.* Services, activities, costs and time that are not covered as consumer-directed attendant care include the following (not an exclusive list):

(1) Any activity related to supervising a member. Only direct services are billable.

(2) Any activity that the member is able to perform.

(3) Costs of food.

(4) Costs for the supervision of skilled services by the nurse or therapist. The supervising nurse or therapist may be paid from private insurance, Medicare, or other third-party payment sources, or may be paid as another Medicaid service, including early and periodic screening, diagnosis and treatment services.

(5) Exercise that does not require skilled services.

(6) Parenting or child care for or on behalf of the member.

(7) Reminders and cueing.

(8) Services provided simultaneously with any other similar service regardless of funding source, including other waiver services and state supplementary assistance in-home health-related care services.

(9) Transportation costs.

(10) Wait times for any activity.

**78.46(2) Home and vehicle modification.** Covered home or vehicle modifications are physical modifications to the member's home or vehicle that directly address the member's medical or remedial need. Covered modifications must be necessary to provide for the health, welfare, or safety of the member and enable the member to function with greater independence in the home or vehicle.

*a.* Modifications that are necessary or desirable without regard to the member's medical or remedial need and that would be expected to increase the fair market value of the home or vehicle, such as furnaces, fencing, or adding square footage to the residence, are excluded except as specifically included below. Purchasing or leasing of a motorized vehicle is excluded. Home and vehicle repairs are also excluded.

*b.* Only the following modifications are covered:

(1) Kitchen counters, sink space, cabinets, special adaptations to refrigerators, stoves, and ovens.  
(2) Bathtubs and toilets to accommodate transfer, special handles and hoses for shower heads, water faucet controls, and accessible showers and sink areas.

(3) Grab bars and handrails.

(4) Turnaround space adaptations.

(5) Ramps, lifts, and door, hall and window widening.

(6) Fire safety alarm equipment specific for disability.

(7) Voice-activated, sound-activated, light-activated, motion-activated, and electronic devices directly related to the member's disability.

(8) Vehicle lifts, driver-specific adaptations, remote-start systems, including such modifications already installed in a vehicle.

(9) Keyless entry systems.

(10) Automatic opening device for home or vehicle door.

(11) Special door and window locks.

(12) Specialized doorknobs and handles.

(13) Plexiglas replacement for glass windows.

(14) Modification of existing stairs to widen, lower, raise or enclose open stairs.

(15) Motion detectors.

(16) Low-pile carpeting or slip-resistant flooring.

(17) Telecommunications device for the deaf.

(18) Exterior hard-surface pathways.

(19) New door opening.

(20) Pocket doors.

(21) Installation or relocation of controls, outlets, switches.

(22) Air conditioning and air filtering if medically necessary.

(23) Heightening of existing garage door opening to accommodate modified van.

(24) Bath chairs.

*c.* A unit of service is the completion of needed modifications or adaptations.

*d.* All modifications and adaptations shall be provided in accordance with applicable federal, state, and local building and vehicle codes.

*e.* Services shall be performed following prior department approval of the modification as specified in 441—subrule 79.1(17) and a binding contract between the provider and the member.

*f.* All contracts for home or vehicle modification shall be awarded through competitive bidding. The contract shall include the scope of work to be performed, the time involved, supplies needed, the cost, diagrams of the project whenever applicable, and an assurance that the provider has liability and workers' compensation coverage and the applicable permit and license.

*g.* Service payment shall be made to the enrolled home or vehicle modification provider. If applicable, payment will be forwarded to the subcontracting agency by the enrolled home or vehicle modification provider following completion of the approved modifications. Payment of up to \$6,366.64 per year may be made to certified providers upon satisfactory completion of the service.

*h.* Services shall be included in the member's service plan and shall exceed the Medicaid state plan services.

**78.46(3) Personal emergency response or portable locator system.**

a. A personal emergency response system is an electronic device that transmits a signal to a central monitoring station to summon assistance in the event of an emergency.

(1) The necessary components of a system are:

1. An in-home medical communications transceiver.
2. A remote, portable activator.
3. A central monitoring station with backup systems staffed by trained attendants at all times.
4. Current data files at the central monitoring station containing response protocols and personal, medical, and emergency information for each member.

(2) The service shall be identified in the member's service plan.

(3) A unit of service is a one-time installation fee or one month of service.

(4) Maximum units per state fiscal year shall be the initial installation and 12 months of service.

b. A portable locator system is an electronic device that transmits a signal to a monitoring device. The system allows a member to access assistance in the event of an emergency and allows law enforcement or the monitoring system provider to locate a member who is unable to request help or to activate a system independently. The member must be unable to access assistance in an emergency situation due to the member's age or disability.

(1) The required components of the portable locator system are:

1. A portable communications transceiver or transmitter to be worn or carried by the member.
2. Monitoring by the provider at a central location with response protocols and personal, medical, and emergency information for each member as applicable.

(2) The service shall be identified in the member's service plan.

(3) Payable units of service are purchase of equipment, an installation or set-up fee, and monthly fees.

(4) Maximum units per state fiscal year shall be one equipment purchase, one installation or set-up fee, and 12 months of service.

**78.46(4) Specialized medical equipment.**

a. Specialized medical equipment shall include medically necessary items which are for personal use by members with a physical disability and which:

- (1) Provide for the health and safety of the member,
- (2) Are not ordinarily covered by Medicaid,
- (3) Are not funded by educational or vocational rehabilitation programs, and
- (4) Are not provided by voluntary means.

b. Coverage includes, but is not limited to:

- (1) Electronic aids and organizers.
- (2) Medicine dispensing devices.
- (3) Communication devices.
- (4) Bath aids.
- (5) Noncovered environmental control units.
- (6) Repair and maintenance of items purchased through the waiver.

c. Payment of up to \$6,366.64 per year may be made to enrolled specialized medical equipment providers upon satisfactory receipt of the service.

d. The need for specialized medical equipment shall be:

- (1) Documented by a health care professional as necessary for the member's health and safety, and
- (2) Identified in the member's service plan.

e. Payment for most items shall be based on a fee schedule. The amount of the fee shall be determined as directed in 441—subrule 79.1(17).

**78.46(5) Transportation.** Transportation services may be provided for members to conduct business errands and essential shopping, to travel to and from work or day programs, and to reduce social isolation. A unit of service is one mile of transportation or one one-way trip.

**78.46(6) Consumer choices option.** The consumer choices option is service activities provided pursuant to subrule 78.34(13).

**78.46(7) General service standards.** All physical disability waiver services must be provided in accordance with the following standards:

- a. Reimbursement shall not be available under the waiver for any services that the member can obtain as other nonwaiver Medicaid services or through any other funding source.
- b. All services provided under the waiver must be delivered in the least restrictive environment possible and in conformity with the member's service plan.
- c. All rights restrictions must be implemented in accordance with 441—subrule 77.25(4). The member service plan or treatment plan shall include documentation of:
  - (1) Any restrictions on the member's rights, including the rights of privacy, dignity, respect, and freedom from coercion and restraint.
  - (2) The need for the restriction.
  - (3) The less intrusive methods of meeting the need that have been tried but did not work.
  - (4) Either a plan to restore those rights or written documentation that a plan is not necessary or appropriate.
  - (5) Established time limits for periodic reviews to determine if the restriction is still necessary or can be terminated.
  - (6) The informed consent of the member.
  - (7) An assurance that the interventions and supports will cause no harm to the member.
  - (8) A regular collection and review of data to measure the ongoing effectiveness of the restriction.
- d. Services must be billed in whole units.
- e. For all services with a 15-minute unit of service, the following rounding process will apply:
  - (1) Add together the minutes spent on all billable activities during a calendar day for a daily total.
  - (2) For each day, divide the total minutes spent on billable activities by 15 to determine the number of full 15-minute units for that day.
  - (3) Round the remainder using these guidelines: Round 1 to 7 minutes down to zero units; round 8 to 14 minutes up to one unit.
  - (4) Add together the number of full units and the number of rounded units to determine the total number of units to bill for that day.

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

[ARC 9045B, IAB 9/8/10, effective 11/1/10; ARC 9403B, IAB 3/9/11, effective 5/1/11; ARC 9704B, IAB 9/7/11, effective 9/1/11; ARC 9884B, IAB 11/30/11, effective 1/4/12; ARC 0707C, IAB 5/1/13, effective 7/1/13; ARC 0842C, IAB 7/24/13, effective 7/1/13; ARC 1056C, IAB 10/2/13, effective 11/6/13; ARC 1071C, IAB 10/2/13, effective 10/1/13; ARC 1610C, IAB 9/3/14, effective 8/13/14; ARC 2050C, IAB 7/8/15, effective 7/1/15; ARC 2848C, IAB 12/7/16, effective 11/15/16; ARC 2936C, IAB 2/1/17, effective 3/8/17; ARC 3874C, IAB 7/4/18, effective 8/8/18; ARC 4430C, IAB 5/8/19, effective 7/1/19; see Delay note at end of chapter]

**441—78.47(249A) Pharmaceutical case management services.** Payment will be approved for pharmaceutical case management services provided by an eligible physician and pharmacist for Medicaid recipients determined to be at high risk for medication-related problems. These services are designed to identify, prevent, and resolve medication-related problems and improve drug therapy outcomes.

**78.47(1) Medicaid recipient eligibility.** Patients are eligible for pharmaceutical case management services if they have active prescriptions for four or more regularly scheduled nontopical medications, are ambulatory, do not reside in a nursing facility, and have at least one of the eligible disease states of congestive heart disease, ischemic heart disease, diabetes mellitus, hypertension, hyperlipidemia, asthma, depression, atrial fibrillation, osteoarthritis, gastroesophageal reflux, or chronic obstructive pulmonary disease.

**78.47(2) Provider eligibility.** Physicians and pharmacists shall meet the following criteria to provide pharmaceutical case management services.

- a. Physicians and pharmacists must be enrolled in the Iowa Medicaid program, have an Iowa Medicaid provider number, and receive training under the direction of the department regarding the provision of pharmaceutical case management services under the Iowa Medicaid program.

A copy of pharmaceutical case management records, including documentation of services provided, shall be maintained on file in each provider's facility and be made available for audit by the department on request.

b. Physicians shall be licensed to practice medicine.

c. Pharmacists shall present to the department evidence of competency including state licensure, submit five acceptable patient care plans, and have successfully completed professional training on patient-oriented, medication-related problem prevention and resolution. Pharmacists shall also maintain problem-oriented patient records, provide a private patient consultation area, and submit a statement indicating that the submitted patient care plans are representative of the pharmacists' usual patient care plans.

Acceptable professional training programs are:

(1) A doctor of pharmacy degree program.

(2) The Iowa Center for Pharmaceutical Care (ICPC) training program, which is a cooperative training initiative of the University of Iowa College of Pharmacy, Drake University College of Pharmacy and Health Sciences, and the Iowa Pharmacy Foundation.

(3) Other programs containing similar coursework and supplemental practice site evaluation and reengineering, approved by the department with input from a peer review advisory committee.

**78.47(3) Services.** Eligible patients may choose whether to receive the services. If patients elect to receive the services, they must receive the services from any eligible physician and pharmacist acting as a pharmaceutical case management (PCM) team. Usually the eligible physician and pharmacist will be the patient's primary physician and pharmacist. Pharmaceutical case management services are to be value-added services complementary to the basic medical services provided by the primary physician and pharmacist.

The PCM team shall provide the following services:

a. *Initial assessment.* The initial assessment shall consist of:

(1) A patient evaluation by the pharmacist, including:

1. Medication history;

2. Assessment of indications, effectiveness, safety, and compliance of medication therapy;

3. Assessment for the presence of untreated illness; and

4. Identification of medication-related problems such as unnecessary medication therapy, suboptimal medication selection, inappropriate compliance, adverse drug reactions, and need for additional medication therapy.

(2) A written report and recommendation from the pharmacist to the physician.

(3) A patient care action plan developed by the PCM team with the patient's agreement and implemented by the PCM team. Specific components of the action plan will vary based on patient needs and conditions but may include changes in medication regimen, focused patient or caregiver education, periodic assessment for changes in the patient's condition, periodic monitoring of the effectiveness of medication therapy, self-management training, provision of patient-specific educational and informational materials, compliance enhancement, and reinforcement of healthy lifestyles. An action plan must be completed for each initial assessment.

b. *New problem assessments.* These assessments are initiated when a new medication-related problem is identified. The action plan is modified and new components are implemented to address the new problem. This assessment may occur in the interim between scheduled follow-up assessments.

c. *Problem follow-up assessments.* These assessments are based on patient need and a problem identified by a prior assessment. The patient's status is evaluated at an appropriate interval. The effectiveness of the implemented action plan is determined and modifications are made as needed.

d. *Preventive follow-up assessments.* These assessments occur approximately every six months when no current medication-related problems have been identified in prior assessments. The patient is reassessed for newly developed medication-related problems and the action plan is reviewed.

This rule is intended to implement Iowa Code section 249A.4 and 2000 Iowa Acts, chapter 1228, section 9.

**441—78.48(249A) Public health agencies.** Payments will be made to local public health agencies on a fee schedule basis for providing vaccine and vaccine administration and testing for communicable disease. In order to be paid for the administration of a vaccine covered under the Vaccines for Children (VFC) Program, a public health agency must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

This rule is intended to implement Iowa Code section 249A.4.  
[ARC 0358C, IAB 10/3/12, effective 11/7/12]

**441—78.49(249A) Infant and toddler program services.** Subject to the following subrules, payment shall be made for medical services provided to Medicaid eligible children by infant and toddler program providers under the infants and toddlers with disabilities program administered by the Iowa Child Health Specialty Clinics and the departments of education, public health, and human services.

**78.49(1) Covered services.** Covered services include, but are not limited to, audiology, psychological evaluation and counseling, health and nursing services, nutrition services, occupational therapy services, physical therapy services, developmental services, speech-language services, vision services, case management, and medical transportation.

**78.49(2) Case management services.** Payment shall also be approved for infant and toddler case management services subject to the following requirements:

*a. Definition.* “Case management” means services that will assist eligible children in gaining access to needed medical, social, educational, and other services. Case management is intended to address the complexities of coordinated service delivery for children with medical needs. The case manager should be the focus for coordinating and overseeing the effectiveness of all providers and programs in responding to the assessed need. Case management does not include the direct delivery of an underlying medical, educational, social, or other service to which an eligible child has been referred or any activities that are an integral part or an extension of the direct services.

*b. Choice of provider.* Children who also are eligible to receive targeted case management services under 441—Chapter 90 must choose whether to receive case management through the infant and toddler program or through 441—Chapter 90. The chosen provider must meet the requirements of this subrule.

(1) When a child resides in a medical institution, the institution is responsible for case management. The child is not eligible for any other case management services. However, noninstitutional case management services may be provided during the last 14 days before the child’s planned discharge if the child’s stay in the institution has been less than 180 consecutive days. If the child has been in the institution 180 consecutive days or longer, the child may receive noninstitutional case management services during the last 60 days before the child’s planned discharge.

(2) If the case management agency also provides direct services, the case management unit must be designed so that conflict of interest is addressed and does not result in self-referrals.

(3) If the costs of any part of case management services are reimbursable under another program, the costs must be allocated between those programs and Medicaid in accordance with OMB Circular No. A-87 or any related or successor guidance or regulations regarding allocation of costs.

(4) The case manager must complete a competency-based training program with content related to knowledge and understanding of eligible children, Early ACCESS rules, the nature and scope of services in Early ACCESS, and the system of payments for services, as well as case management responsibilities and strategies. The department of education or its designee shall determine whether a person has successfully completed the training.

*c. Assessment.* The case manager shall conduct a comprehensive assessment and periodic reassessment of an eligible child to identify all of the child’s service needs, including the need for any medical, educational, social, or other services. Assessment activities are defined to include the following:

- (1) Taking the child’s history;
- (2) Identifying the needs of the child;
- (3) Gathering information from other sources, such as family members, medical providers, social workers, and educators, if necessary, to form a complete assessment of the child;

- (4) Completing documentation of the information gathered and the assessment results; and
- (5) Repeating the assessment every six months to determine whether the child's needs or preferences have changed.

*d. Plan of care.* The case manager shall develop a plan of care based on the information collected through the assessment or reassessment. The plan of care shall:

- (1) Include the child's strengths and preferences;
- (2) Consider the child's physical and social environment;
- (3) Specify goals of providing services to the child; and
- (4) Specify actions to address the child's medical, social, educational, and other service needs.

These actions may include activities such as ensuring the active participation of the child and working with the child or the child's authorized health care decision maker and others to develop goals and identify a course of action to respond to the assessed needs of the child.

*e. Other service components.* Case management must include the following components:

(1) Contacts with the child and family. The case manager shall have face-to-face contact with the child and family within the first 30 days of service and every three months thereafter. In months in which there is no face-to-face contact, a telephone contact between the service coordinator and the family is required.

(2) Referral and related activities to help a child obtain needed services. The case manager shall help to link the child with medical, social, or educational providers or other programs and services that are capable of providing needed services. Referral activities do not include provision of the direct services, program, or activity to which the child has been linked. Referral activities include:

1. Assisting the family in gaining access to the infant and toddler program services and other services identified in the child's plan of care.

2. Assisting the family in identifying available service providers and funding resources and documenting unmet needs and gaps in services.

3. Making referrals to providers for needed services.

4. Scheduling appointments for the child.

5. Facilitating the timely delivery of services.

6. Arranging payment for medical transportation.

(3) Monitoring and follow-up activities. Monitoring activities shall take place at least once annually for the duration of the child's eligibility, but may be conducted as frequently as necessary to ensure that the plan of care is effectively implemented and adequately addresses the needs of the child. Monitoring and follow-up activities may be with the child, family members, providers, or other entities. The purpose of these activities is to help determine:

1. Whether services are being furnished in accordance with the child's plan of care.

2. Whether the services in the plan of care are adequate to meet the needs of the child.

3. Whether there are changes in the needs or status of the child. If there are changes in the child's needs or status, follow-up activities shall include making necessary adjustments to the plan of care and to service arrangements with providers.

(4) Keeping records, including preparing reports, updating the plan of care, making notes about plan activities in the child's record, and preparing and responding to correspondence with the family and others.

*f. Documentation of case management.* For each child receiving case management, case records must document:

(1) The name of the child;

(2) The dates of case management services;

(3) The agency chosen by the family to provide the case management services;

(4) The nature, content, and units of case management services received;

(5) Whether the goals specified in the care plan have been achieved;

(6) Whether the family has declined services in the care plan;

(7) Time lines for providing services and reassessment; and

(8) The need for and occurrences of coordination with case managers of other programs.

**78.49(3) *Child's eligibility.*** Payable services must be provided to a child under the age of 36 months who is experiencing developmental delay or who has a condition that is known to have a high probability of resulting in developmental delay at a later date.

**78.49(4) *Delivery of services.*** Services must be delivered directly by the infant and toddler program provider or by a practitioner under contract with the infant and toddler program provider.

**78.49(5) *Remission of nonfederal share of costs.*** Payment for services shall be made only when the following conditions are met:

- a. Rescinded IAB 5/10/06, effective 7/1/06.
- b. The infant and toddler program provider has executed an agreement to remit the nonfederal share of the cost to the department.
- c. The infant and toddler program provider shall sign and return Form 470-3816, Medicaid Billing Remittance, along with the funds remitted for the nonfederal share of the costs of the services specified on the form.

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

**441—78.50(249A) Local education agency services.** Subject to the following subrules, payment shall be made for medical services provided by local education agency services providers to Medicaid members under the age of 21.

**78.50(1) *Covered services.*** Covered services include, but are not limited to, audiology services, behavior services, consultation services, medical transportation, nursing services, nutrition services, occupational therapy services, personal assistance, physical therapy services, psychologist services, speech-language services, social work services, vision services, and school-based clinic visit services.

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

b. Payment for supplies shall be approved when the supplies are incidental to the patient's care, e.g., syringes for injections, and do not exceed \$25 per month. Durable medical equipment and other supplies are not covered as local education agency services.

c. To the extent that federal funding is not available under Title XIX of the Social Security Act, payment for transportation between home and school is not a covered service.

**78.50(2) *Coordination services.*** Rescinded IAB 12/3/08, effective 2/1/09.

**78.50(3) *Delivery of services.*** Services must be delivered directly by the local education agency services providers or by a practitioner under contract with the local education agency services provider.

**78.50(4) *Remission of nonfederal share of costs.*** Payment for services shall be made only when the following conditions are met:

- a. Rescinded IAB 5/10/06, effective 7/1/06.
- b. The local education agency services provider has executed an agreement to remit the nonfederal share of the cost to the department.
- c. The local education agency provider shall sign and return Form 470-3816, Medicaid Billing Remittance, along with the funds remitted for the nonfederal share of the costs of the services as specified on the form.

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

[ARC 0065C, IAB 4/4/12, effective 6/1/12]

**441—78.51(249A) Indian health service 638 facility services.** Payment shall be made for all medically necessary services and supplies provided by a licensed practitioner at an Indian health service 638 facility, as defined at rule 441—77.45(249A), within the practitioner's scope of practice and subject to the limitations and exclusions set forth in subrule 78.1(1).

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

**441—78.52(249A) HCBS children's mental health waiver services.** Payment will be approved for the following services to members eligible for the HCBS children's mental health waiver as established

in 441—Chapter 83 and as identified in the member's service plan. Effective March 17, 2022, payment shall only be made for services provided in integrated, community-based settings that support full access of members receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.

**78.52(1) General service standards.** All children's mental health waiver services must be provided in accordance with the following standards:

*a.* Reimbursement shall not be available under the waiver for any services that the member can obtain as other nonwaiver Medicaid services or through any other funding source.

*b.* All services provided under the waiver must be delivered in the least restrictive environment possible and in conformity with the member's service plan.

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

(1) Any restrictions on the member's rights, including the rights of privacy, dignity, respect, and freedom from coercion and restraint.

(2) The need for the restriction.

(3) The less intrusive methods of meeting the need that have been tried but did not work.

(4) Either a plan to restore those rights or written documentation that a plan is not necessary or appropriate.

(5) Established time limits for periodic reviews to determine if the restriction is still necessary or can be terminated.

(6) The informed consent of the member.

(7) An assurance that the interventions and supports will cause no harm to the member.

(8) A regular collection and review of data to measure the ongoing effectiveness of the restriction.

*d.* Services must be billed in whole units.

*e.* For all services with a 15-minute unit of service, the following rounding process will apply:

(1) Add together the minutes spent on all billable activities during a calendar day for a daily total.

(2) For each day, divide the total minutes spent on billable activities by 15 to determine the number of full 15-minute units for that day.

(3) Round the remainder using these guidelines: Round 1 to 7 minutes down to zero units; round 8 to 14 minutes up to one unit.

(4) Add together the number of full units and the number of rounded units to determine the total number of units to bill for that day.

**78.52(2) Environmental modifications and adaptive devices.**

*a.* Environmental modifications and adaptive devices include medically necessary items installed or used within the member's home that are used by the member to address specific, documented health, mental health, or safety concerns. The following items are excluded under this service:

(1) Items ordinarily covered by Medicaid.

(2) Items funded by educational or vocational rehabilitation programs.

(3) Items provided by voluntary means.

(4) Repair and maintenance of items purchased through the waiver.

(5) Fencing.

*b.* A unit of service is one modification or device.

*c.* For each unit of service provided, the case manager shall maintain in the member's case file a signed statement from a mental health professional on the member's interdisciplinary team that the service has a direct relationship to the member's diagnosis of serious emotional disturbance.

*d.* Payment for most items shall be based on a fee schedule. The amount of the fee shall be determined as directed in 441—subrule 79.1(17).

**78.52(3) Family and community support services.** Family and community support services shall support the member and the member's family by the development and implementation of strategies and

interventions that will result in the reduction of stress and depression and will increase the member's and the family's social and emotional strength.

a. Dependent on the needs of the member and the member's family members individually or collectively, family and community support services may be provided to the member, to the member's family members, or to the member and the family members as a family unit.

b. Family and community support services shall be provided under the recommendation and direction of a mental health professional who is a member of the member's interdisciplinary team pursuant to 441—Chapter 83.

c. Family and community support services shall incorporate recommended support interventions and activities, which may include the following:

(1) Developing and maintaining a crisis support network for the member and for the member's family.

(2) Modeling and coaching effective coping strategies for the member's family members.

(3) Building resilience to the stigma of serious emotional disturbance for the member and the family.

(4) Reducing the stigma of serious emotional disturbance by the development of relationships with peers and community members.

(5) Modeling and coaching the strategies and interventions identified in the member's crisis intervention plan as defined in 441—24.1(225C) for life situations with the member's family and in the community.

(6) Developing medication management skills.

(7) Developing personal hygiene and grooming skills that contribute to the member's positive self-image.

(8) Developing positive socialization and citizenship skills.

d. Family and community support services may include an amount not to exceed \$1500 per member per year for transportation within the community and purchase of therapeutic resources. Therapeutic resources may include books, training materials, and visual or audio media.

(1) The interdisciplinary team must have identified the transportation or therapeutic resource as a support need and included that need in the case manager's plan.

(2) The annual amount available for transportation and therapeutic resources must be listed in the member's service plan.

(3) The member's parent or legal guardian shall submit a signed statement that the transportation or therapeutic resource cannot be provided by the member or the member's family or legal guardian.

(4) The member's Medicaid case manager shall maintain a signed statement that potential community resources are unavailable and shall list the community resources contacted to fund the transportation or therapeutic resource.

(5) The transportation or therapeutic resource must not be otherwise eligible for Medicaid reimbursement.

e. The following components are specifically excluded from family and community support services:

(1) Vocational services.

(2) Prevocational services.

(3) Supported employment services.

(4) Room and board.

(5) Academic services.

(6) General supervision and care.

f. A unit of family and community support services is 15 minutes.

**78.52(4) *In-home family therapy.*** In-home family therapy provides skilled therapeutic services to the member and family that will increase their ability to cope with the effects of serious emotional disturbance on the family unit and the familial relationships. The service must support the family by the development of coping strategies that will enable the member to continue living within the family environment.

a. The goal of in-home family therapy is to maintain a cohesive family unit.

b. In-home family therapy is exclusive of and cannot serve as a substitute for individual therapy, family therapy, or other mental health therapy that may be obtained through the Iowa Plan or other funding sources.

c. A unit of in-home family therapy service is 15 minutes.

**78.52(5) Respite care services.** Respite care services are services provided to the member that give temporary relief to the usual caregiver and provide all the necessary care that the usual caregiver would provide during that period. The purpose of respite care is to enable the member to remain in the member's current living situation.

a. Respite services provided outside the member's home shall not be reimbursable if the living unit where respite care is provided is reserved for another person on a temporary leave of absence.

b. Member-to-staff ratios shall be appropriate to the individual needs of the member as determined by the member's interdisciplinary team.

c. A unit of service is 15 minutes.

d. Respite care is not to be provided to members during the hours in which the usual caregiver is employed except when the member is attending a 24-hour residential camp. Respite care shall not be used as a substitute for a child's day care.

e. The interdisciplinary team shall determine if the member will receive basic individual respite, specialized respite or group respite as defined in 441—Chapter 83.

f. A maximum of 14 consecutive days of 24-hour respite care may be reimbursed.

g. Respite services provided for a period exceeding 24 consecutive hours to three or more members who require nursing care because of a mental or physical condition must be provided by a health care facility licensed under Iowa Code chapter 135C.

h. Respite services shall not be provided simultaneously with other residential, nursing, or home health aide services provided through the medical assistance program.

This rule is intended to implement Iowa Code section 249A.4 and 2005 Iowa Acts, chapter 167, section 13, and chapter 117, section 3.

[**ARC 9403B**, IAB 3/9/11, effective 5/1/11 (See Delay note at end of chapter); **ARC 9704B**, IAB 9/7/11, effective 9/1/11; **ARC 9884B**, IAB 11/30/11, effective 1/4/12; **ARC 0707C**, IAB 5/1/13, effective 7/1/13; **ARC 0709C**, IAB 5/1/13, effective 7/1/13; **ARC 3874C**, IAB 7/4/18, effective 8/8/18]

**441—78.53(249A) Health home services.** Subject to federal approval in the Medicaid state plan, payment shall be made for health home services as described in subrule 78.53(1) provided to an eligible Medicaid member as described in subrule 78.53(2) who has selected a health home services provider as provided in subrule 78.53(3).

**78.53(1) Covered services.** Health home services consist of the following services provided in a comprehensive, timely, and high-quality manner using health information technology to link services, as feasible and appropriate:

a. Comprehensive care management, which means:

(1) Providing for all the member's health care needs or taking responsibility for arranging care with other qualified professionals;

(2) Developing and maintaining for each member a continuity of care document that details all important aspects of the member's medical needs, treatment plan, and medication list; and

(3) Implementing a formal screening tool to assess behavioral health treatment needs and physical health care needs.

b. Care coordination, which means assisting members with:

(1) Medication adherence;

(2) Chronic disease management;

(3) Appointments, referral scheduling, and reminders; and

(4) Understanding health insurance coverage.

c. Health promotion, which means coordinating or providing behavior modification interventions aimed at:

(1) Supporting health management;

- (2) Improving disease control; and
- (3) Enhancing safety, disease prevention, and an overall healthy lifestyle.
- d. Comprehensive transitional care following a member's move from an inpatient setting to another setting. Comprehensive transitional care includes:
  - (1) Updates of the member's continuity of care document and case plan to reflect the member's short-term and long-term care coordination needs; and
  - (2) Personal follow-up with the member regarding all needed follow-up after the transition.
- e. Member and family support (including authorized representatives). This support may include:
  - (1) Communicating with and advocating for the member or family for the assessment of care decisions;
  - (2) Assisting with obtaining and adhering to medications and other prescribed treatments;
  - (3) Increasing health literacy and self-management skills; and
  - (4) Assessing the member's physical and social environment so that the plan of care incorporates needs, strengths, preferences, and risk factors.
- f. Referral to community and social support services available in the community.

**78.53(2) Members eligible for health home services.**

a. Subject to the authority of the Secretary of the United States Department of Health and Human Services pursuant to 42 U.S.C. §1396w-4(h)(1)(B) to establish higher levels for the number or severity of chronic or mental health conditions for purposes of determining eligibility for receipt of health home services, payment shall be made only for health home services provided to a Medicaid member who:

- (1) Has at least two chronic conditions;
- (2) Has one chronic condition and is at risk of having a second chronic condition;
- (3) Has a serious mental illness; or
- (4) Has a serious emotional disturbance.

b. For purposes of this rule, the term "chronic condition" means:

- (1) A mental health disorder.
- (2) A substance use disorder.
- (3) Asthma.
- (4) Diabetes.
- (5) Heart disease.
- (6) Being overweight, as evidenced by:
  - 1. Having a body mass index (BMI) over 25 for an adult, or
  - 2. Weighing over the 85th percentile for the pediatric population.
- (7) Hypertension.

c. For purposes of this rule, the term "serious mental illness" means:

- (1) A psychotic disorder;
- (2) Schizophrenia;
- (3) Schizoaffective disorder;
- (4) Major depression;
- (5) Bipolar disorder;
- (6) Delusional disorder; or
- (7) Obsessive-compulsive disorder.

d. For purposes of this rule, the term "serious emotional disturbance" means a diagnosable mental, behavioral, or emotional disorder (not including substance use disorders, learning disorders, or intellectual disorders) that is of sufficient duration to meet diagnostic criteria specified in the most current Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association and that results in a functional impairment. For this purpose, the term "functional impairment" means episodic, recurrent, or continuous difficulties that substantially interfere with or limit a person from achieving or maintaining one or more developmentally appropriate social, behavioral, cognitive, communicative, or adaptive skills and that substantially interfere with or limit the person's role or functioning in family, school, or community activities, not including difficulties resulting from temporary and expected responses to stressful events in a person's environment.

**78.53(3) Selection of health home services provider.** As a condition of payment for health home services, the eligible member receiving the services must have selected the billing provider as the member's health home, as reported by the provider. A member must select a provider located in the member's county of residence or in a contiguous county.

This rule is intended to implement Iowa Code section 249A.4 and 2011 Iowa Acts, chapter 129, section 10.

[ARC 0198C, IAB 7/11/12, effective 7/1/12; ARC 0838C, IAB 7/24/13, effective 7/1/13]

**441—78.54(249A) Speech-language pathology services.** Payment will be approved for the same services provided by a speech-language pathologist that are payable under Title XVIII of the Social Security Act (Medicare).

This rule is intended to implement Iowa Code section 249A.4 and 2012 Iowa Acts, Senate File 2158. [ARC 0360C, IAB 10/3/12, effective 12/1/12]

**441—78.55(249A) Services rendered via telehealth.** An in-person contact between a health care professional and a patient is not required as a prerequisite for payment for otherwise-covered services appropriately provided through telehealth in accordance with generally accepted health care practices and standards prevailing in the applicable professional community at the time the services are provided, as well as being in accordance with provisions under rule 653—13.11(147,148,272C). Health care services provided through in-person consultations or through telehealth shall be treated as equivalent services for the purposes of reimbursement.

This rule is intended to implement Iowa Code section 249A.4 and 2015 Iowa Acts, Senate File 505, division V, section 12(23).

[ARC 2166C, IAB 9/30/15, effective 11/4/15]

**441—78.56(249A) Community-based neurobehavioral rehabilitation services.** Payment will be made for community-based neurobehavioral rehabilitation services that do not duplicate other services covered in this chapter.

**78.56(1) Definitions.**

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

*“Brain injury”* means a diagnosis in accordance with rule 441—83.81(249A).

*“Health care”* means the services provided by trained and licensed health care professionals to restore or maintain the member's health.

*“Intermittent community-based neurobehavioral rehabilitation services”* are provided to a Medicaid member on an as-needed basis to support the member and the member's family or caregivers to assist the member to increase adaptive behaviors, decrease maladaptive behaviors, and adapt and accommodate to challenging behaviors to support the member to remain in the member's own home and community.

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

*“Neurobehavioral rehabilitation”* refers to a specialized category of neurorehabilitation provided by a multidisciplinary team that has been trained in, and delivers, services individually designed to address cognitive, medical, behavioral and psychosocial challenges, as well as the physical manifestations of acquired brain injury. Services concurrently work to optimize functioning at personal, family and community levels, by supporting the increase of adaptive behaviors, decrease of maladaptive behaviors and adaptation and accommodation to challenging behaviors to support a member to maximize the member's independence in activities of daily living and ability to live in the member's home and community.

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

“*Standardized assessment*” means a valid, reliable, and comprehensive functional assessment tool(s) or process, or both, approved by the department for use in the assessment of a member’s individual needs.

**78.56(2) Member eligibility.** To be eligible to receive community-based neurobehavioral rehabilitation services, a member shall meet the following criteria:

*a. Brain injury diagnosis.* To be eligible for community-based neurobehavioral rehabilitation services, the member must have a brain injury diagnosis as set forth in rule 441—83.81(249A).

*b. Risk factors.* The member has the following post-brain injury risk factors:

(1) The member is exhibiting neurobehavioral symptoms in such frequency or severity that the member has undergone or is currently undergoing treatment more intensive than outpatient care and is currently hospitalized, institutionalized, incarcerated or homeless or is at risk of hospitalization, institutionalization, incarceration or homelessness; or

(2) The member has a history of presenting with neurobehavioral or psychiatric symptoms resulting in at least one episode that required professional supportive care more intensive than outpatient care more than once in a lifetime (e.g., emergency services, alternative home care, partial hospitalization, or inpatient hospitalization).

*c. Need for assistance.* The member exhibits neurobehavioral symptoms in such frequency, severity or intensity that community-based neurobehavioral rehabilitation is required.

*d. Needs assessment.* The member shall have 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]

[Filed 3/11/70; amended 3/20/74]

[Filed 11/25/75, Notice 10/6/75—published 12/15/75, effective 1/19/76]

[Filed emergency 12/23/75—published 1/12/76, effective 2/1/76]

[Filed emergency 1/16/76—published 2/9/76, effective 2/1/76]

[Filed emergency 1/29/76—published 2/9/76, effective 1/29/76]

[Filed 4/30/76, Notice 3/22/76—published 5/17/76, effective 6/21/76]

[Filed emergency 6/9/76—published 6/28/76, effective 6/9/76]

[Filed 6/25/76, Notice 5/17/76—published 7/12/76, effective 8/16/76]

[Filed emergency 12/17/76—published 1/12/77, effective 1/1/77]

[Filed 2/25/77, Notice 1/12/77—published 3/23/77, effective 4/27/77]

[Filed emergency 4/13/77—published 5/4/77, effective 4/13/77]

[Filed emergency 7/20/77—published 8/10/77, effective 7/20/77]

[Filed emergency 8/24/77—published 9/21/77, effective 8/26/77]

[Filed emergency 9/1/77—published 9/21/77, effective 9/1/77]

[Filed 11/22/77, Notice 9/7/77—published 12/14/77, effective 2/1/78]

[Filed 12/6/77, Notice 10/19/77—published 12/28/77, effective 2/1/78]

- [Filed 1/16/78, Notice 11/30/77—published 2/8/78, effective 4/1/78]
- [Filed 3/27/78, Notice 2/8/78—published 4/19/78, effective 5/24/78]
- [Filed without Notice 3/31/78—published 4/19/78, effective 7/1/78]
- [Filed emergency 6/9/78—published 6/28/78, effective 7/5/78]
- [Filed emergency 6/28/78—published 7/26/78, effective 7/1/78]
- [Filed 8/9/78, Notice 6/28/78—published 9/6/78, effective 10/11/78]
- [Filed 8/18/78, Notice 5/31/78—published 9/6/78, effective 10/11/78]
- [Filed 9/12/78, Notice 4/19/78—published 10/4/78, effective 11/8/78]
- [Filed 9/12/78, Notice 7/26/78—published 10/4/78, effective 12/1/78]
- [Filed 11/20/78, Notice 10/4/78—published 12/13/78, effective 1/17/79]
- [Filed 12/6/78, Notice 10/4/78—published 12/27/78, effective 2/1/79]
- [Filed 12/6/78, Notice 5/31/78—published 12/27/78, effective 2/1/79]
- [Filed 1/4/79, Notice 11/29/78—published 1/24/79, effective 3/1/79]
- [Filed emergency 1/31/79—published 2/21/79, effective 3/8/79]
- [Filed 3/30/79, Notice 2/21/79—published 4/18/79, effective 6/1/79]
- [Filed 7/3/79, Notice 4/18/79—published 7/25/79, effective 8/29/79]
- [Filed emergency 6/26/79—published 7/25/79, effective 7/1/79]
- [Filed 9/6/79, Notice 6/27/79—published 10/3/79, effective 11/7/79]
- [Filed emergency 9/6/79 after Notice 7/11/79—published 10/3/79, effective 10/1/79]
- [Filed 10/24/79, Notice 5/30/79—published 11/14/79, effective 12/19/79]
- [Filed 10/24/79, Notice 8/22/79—published 11/14/79, effective 12/19/79]
- [Filed emergency 1/23/80—published 2/20/80, effective 1/23/80]
- [Filed 4/4/80, Notice 1/23/80—published 4/30/80, effective 6/4/80]
- [Filed emergency 6/30/80—published 7/23/80, effective 7/1/80]
- [Filed emergency 7/3/80—published 7/23/80, effective 7/8/80 to 1/1/81]
- [Filed 7/3/80, Notice 4/14/80—published 7/23/80, effective 8/27/80]
- [Filed 9/25/80, Notice 8/6/80—published 10/15/80, effective 11/19/80]
- [Filed without Notice 9/26/80—published 10/15/80, effective 12/1/80]
- [Filed 10/23/80, Notice 7/23/80—published 11/12/80, effective 12/17/80]
- [Filed 11/21/80, Notice 9/3/80—published 12/10/80, effective 1/14/81]
- [Filed 12/19/80, Notices 10/15/80, 10/29/80—published 1/7/81, effective 2/11/81]
- [Filed emergency 1/20/81—published 2/18/81, effective 1/20/81]
- [Filed 2/12/81, Notice 11/12/80—published 3/4/81, effective 7/1/81]
- [Filed 3/24/81, Notice 2/4/81—published 4/15/81, effective 6/1/81]
- [Filed emergency 6/30/81—published 7/22/81, effective 7/1/81]
- [Filed emergency 8/24/81 after Notice 7/8/81—published 9/16/81, effective 9/1/81]
- [Filed 10/23/81, Notice 9/2/81—published 11/11/81, effective 1/1/82]
- [Filed emergency 12/3/81—published 12/23/81, effective 1/1/82]
- [Filed 1/28/82, Notice 10/28/81—published 2/17/82, effective 4/1/82]
- [Filed 1/28/82, Notice 11/25/81—published 2/17/82, effective 4/1/82]
- [Filed 2/26/82, Notice 10/14/81—published 3/17/82, effective 5/1/82]
- [Filed emergency 3/26/82—published 4/14/82, effective 4/1/82]
- [Filed 4/5/82, Notice 1/20/82—published 4/28/82, effective 6/2/82]
- [Filed 4/29/82, Notice 12/9/81—published 5/26/82, effective 7/1/82]
- [Filed 7/30/82, Notices 3/3/82, 4/28/82—published 8/18/82, effective 10/1/82]
- [Filed emergency 9/23/82 after Notice 6/23/82—published 10/13/82, effective 10/1/82]
- [Filed 11/5/82, Notice 9/15/82—published 11/24/82, effective 1/1/83]
- [Filed 2/25/83, Notice 1/5/83—published 3/16/83, effective 5/1/83]
- [Filed 5/20/83, Notices 3/30/83, 4/13/83—published 6/8/83, effective 8/1/83]<sup>1710</sup>
- [Filed emergency 6/17/83—published 7/6/83, effective 7/1/83]
- [Filed emergency 7/29/83—published 8/17/83, effective 8/1/83]<sup>1710</sup>
- [Filed 7/29/83, Notice 5/25/83—published 8/17/83, effective 10/1/83]

- [Filed emergency 10/7/83—published 10/26/83, effective 11/1/83]
- [Filed without Notice 10/7/83—published 10/26/83, effective 12/1/83]
- [Filed 10/28/83, Notices 8/31/83, 9/14/83—published 11/23/83, effective 1/1/84]<sup>17 10</sup>
- [Filed emergency 11/18/83—published 12/7/83, effective 12/1/83]
- [Filed 11/18/83, Notice 10/12/83—published 12/7/83, effective 2/1/84]
- [Filed 5/4/84, Notice 3/14/84—published 5/23/84, effective 7/1/84]
- [Filed emergency 6/15/84—published 7/4/84, effective 7/1/84]
- [Filed 6/15/84, Notice 5/9/84—published 7/4/84, effective 9/1/84]
- [Filed emergency 8/31/84—published 9/26/84, effective 10/1/84]
- [Filed 11/1/84, Notice 9/12/84—published 11/21/84, effective 1/1/85]
- [Filed 12/11/84, Notice 10/10/84—published 1/2/85, effective 3/1/85]
- [Filed 1/21/85, Notice 10/24/84—published 2/13/85, effective 4/1/85]
- [Filed 4/29/85, Notice 12/19/84—published 5/22/85, effective 7/1/85]
- [Filed 4/29/85, Notice 2/27/85—published 5/22/85, effective 7/1/85]
- [Filed 5/29/85, Notice 3/27/85—published 6/19/85, effective 8/1/85]
- [Filed emergency 8/23/85—published 9/11/85, effective 9/1/85]
- [Filed emergency 10/1/85—published 10/23/85, effective 11/1/85]
- [Filed without Notice 10/1/85—published 10/23/85, effective 12/1/85]
- [Filed emergency 10/18/85 after Notice 9/11/85—published 11/6/85, effective 11/1/85]
- [Filed 11/15/85, Notice 9/25/85—published 12/4/85, effective 2/1/86]
- [Filed emergency 12/2/85—published 12/18/85, effective 1/1/86]
- [Filed 12/2/85, Notice 10/23/85—published 12/18/85, effective 2/1/86]
- [Filed 1/22/86, Notice 12/4/85—published 2/12/86, effective 4/1/86]
- [Filed 2/21/86, Notices 12/18/85, 1/1/86, 1/15/86—published 3/12/86, effective 5/1/86]
- [Filed emergency 6/26/86—published 7/16/86, effective 7/1/86]
- [Filed 9/26/86, Notice 8/13/86—published 10/22/86, effective 12/1/86]
- [Filed emergency 12/22/86—published 1/14/87, effective 2/1/87]
- [Filed 12/22/86, Notice 11/5/86—published 1/14/87, effective 3/1/87]
- [Filed emergency 1/15/87—published 2/11/87, effective 1/15/87]
- [Filed 3/3/87, Notices 12/17/86, 12/31/86, 1/14/87—published 3/25/87, effective 5/1/87]
- [Filed 4/29/87, Notice 3/11/87—published 5/20/87, effective 7/1/87]
- [Filed 5/29/87, Notices 4/8/87, 4/22/87—published 6/17/87, effective 8/1/87]
- [Filed emergency 6/19/87—published 7/15/87, effective 7/1/87]
- [Filed 6/19/87, Notice 5/6/87—published 7/15/87, effective 9/1/87]
- [Filed 7/24/87, Notice 5/20/87—published 8/12/87, effective 10/1/87]
- [Filed emergency 8/28/87—published 9/23/87, effective 9/1/87]
- [Filed 8/28/87, Notices 6/17/87, 7/15/87—published 9/23/87, effective 11/1/87]
- [Filed 9/24/87, Notice 8/12/87—published 10/21/87, effective 12/1/87]
- [Filed 12/10/87, Notice 10/21/87—published 12/30/87, effective 3/1/88]<sup>2</sup>
- [Filed emergency 4/28/88 after Notice 3/23/88—published 5/18/88, effective 6/1/88]
- [Filed emergency 6/9/88—published 6/29/88, effective 7/1/88]
- [Filed 9/2/88, Notice 6/29/88—published 9/21/88, effective 11/1/88]
- [Filed emergency 11/16/88 after Notice 10/5/88—published 12/14/88, effective 1/1/89]
- [Filed emergency 11/23/88 after Notices 7/13/88, 9/21/88—published 12/14/88, effective 12/1/88, 1/1/89]
- [Filed 12/8/88, Notice 10/19/88—published 12/28/88, effective 2/1/89]
- [Filed 3/15/89, Notice 2/8/89—published 4/5/89, effective 6/1/89]
- [Filed emergency 6/8/89 after Notice 2/22/89—published 6/28/89, effective 7/1/89]
- [Filed emergency 6/9/89—published 6/28/89, effective 7/1/89]
- [Filed 7/14/89, Notices 4/19/89, 5/31/89—published 8/9/89, effective 10/1/89]
- [Filed 8/17/89, Notice 6/28/89—published 9/6/89, effective 11/1/89]
- [Filed 9/15/89, Notice 8/9/89—published 10/4/89, effective 12/1/89]

- [Filed 10/11/89, Notice 8/23/89—published 11/1/89, effective 1/1/90]  
[Filed 11/16/89, Notice 8/23/89—published 12/13/89, effective 2/1/90]  
[Filed emergency 12/15/89 after Notice 10/4/89—published 1/10/90, effective 1/1/90]  
[Filed 1/17/90, Notice 8/23/89—published 2/7/90, effective 4/1/90]<sup>3</sup>  
[Filed emergency 2/14/90—published 3/7/90, effective 2/14/90]  
[Filed 3/16/90, Notices 11/15/89, 1/24/90, 2/7/90—published 4/4/90, effective 6/1/90]  
[Filed 4/13/90, Notice 3/7/90—published 5/2/90, effective 7/1/90]  
[Filed 4/13/90, Notice 11/29/89—published 5/2/90, effective 8/1/90]  
[Filed emergency 6/20/90—published 7/11/90, effective 7/1/90]  
[Filed 7/13/90, Notices 5/16/90, 5/30/90—published 8/8/90, effective 10/1/90]  
[Filed 8/16/90, Notice 7/11/90—published 9/5/90, effective 11/1/90]  
[Filed 9/28/90, Notices 7/11/90, 7/25/90, 8/8/90—published 10/17/90, effective 12/1/90]  
[Filed 10/12/90, Notice 7/11/90—published 10/31/90, effective 1/1/91]  
[Filed 10/12/90, Notice 8/8/90—published 10/31/90, effective 2/1/91]  
[Filed 11/16/90, Notices 9/19/90, 10/3/90—published 12/12/90, effective 2/1/91]  
[Filed 12/13/90, Notice 10/31/90—published 1/9/91, effective 3/1/91]  
[Filed emergency 1/17/91—published 2/6/91, effective 2/1/91]  
[Filed 1/17/91, Notices 11/14/90, 11/28/90—published 2/6/91, effective 4/1/91]<sup>4</sup>  
[Filed emergency 2/22/91—published 3/20/91, effective 3/1/91]  
[Filed 3/14/91, Notice 2/6/91—published 4/3/91, effective 6/1/91]  
[Filed 4/11/91, Notice 3/6/91—published 5/1/91, effective 7/1/91]  
[Filed emergency 6/14/91—published 7/10/91, effective 7/1/91]  
[Filed 6/14/91, Notice 3/20/91—published 7/10/91, effective 9/1/91]  
[Filed 7/10/91, Notice 5/29/91—published 8/7/91, effective 10/1/91]  
[Filed 9/18/91, Notices 7/10/91, 7/24/91—published 10/16/91, effective 12/1/91]  
[Filed 12/11/91, Notice 10/16/91—published 1/8/92, effective 3/1/92]  
[Filed 12/11/91, Notice 10/30/91—published 1/8/92, effective 3/1/92]  
[Filed emergency 1/16/92 after Notice 11/27/91—published 2/5/92, effective 3/1/92]<sup>5</sup>  
[Filed 2/13/92, Notice 1/8/92—published 3/4/92, effective 5/1/92]  
[Filed emergency 4/15/92—published 5/13/92, effective 4/16/92]  
[Filed emergency 6/12/92—published 7/8/92, effective 7/1/92]  
[Filed 6/11/92, Notices 3/18/92, 4/29/92—published 7/8/92, effective 9/1/92]  
[Filed emergency 7/17/92—published 8/5/92, effective 8/1/92]  
[Filed 7/17/92, Notices 5/27/92—published 8/5/92, effective 10/1/92]<sup>7 10</sup>  
[Filed emergency 8/14/92—published 9/2/92, effective 9/1/92]  
[Filed 8/14/92, Notices 6/24/92, 7/8/92, 8/5/92—published 9/2/92, effective 11/1/92]  
[Filed emergency 9/11/92—published 9/30/92, effective 10/1/92]  
[Filed 9/11/92, Notices 7/8/92, 8/5/92—published 9/30/92, effective 12/1/92]  
[Filed 9/11/92, Notice 8/5/92—published 9/30/92, effective 1/1/93]  
[Filed 10/15/92, Notices 8/19/92, 9/2/92—published 11/11/92, effective 1/1/93]  
[Filed emergency 11/10/92—published 12/9/92, effective 11/10/92]  
[Filed 11/10/92, Notice 9/30/92—published 12/9/92, effective 2/1/93]  
[Filed 1/14/93, Notices 10/28/92, 11/25/92—published 2/3/93, effective 4/1/93]  
[Filed emergency 4/15/93 after Notice 3/3/93—published 5/12/93, effective 5/1/93]  
[Filed 4/15/93, Notice 3/3/93—published 5/12/93, effective 7/1/93]  
[Filed emergency 5/14/93 after Notice 3/31/93—published 6/9/93, effective 6/1/93]  
[Filed 5/14/93, Notice 3/31/93—published 6/9/93, effective 8/1/93]  
[Filed emergency 6/11/93—published 7/7/93, effective 7/1/93]  
[Filed emergency 7/13/93 after Notice 5/12/93—published 8/4/93, effective 8/1/93]  
[Filed emergency 7/14/93—published 8/4/93, effective 8/1/93]  
[Filed without Notice 8/12/93—published 9/1/93, effective 11/1/93]  
[Filed 8/12/93, Notice 7/7/93—published 9/1/93, effective 11/1/93]

- [Filed 9/17/93, Notice 8/4/93—published 10/13/93, effective 12/1/93]
- [Filed 10/14/93, Notice 8/18/93—published 11/10/93, effective 1/1/94]
- [Filed 11/12/93, Notice 9/15/93—published 12/8/93, effective 2/1/94]
- [Filed emergency 12/16/93 after Notice 10/13/93—published 1/5/94, effective 1/1/94]
- [Filed 12/16/93, Notice 9/1/93—published 1/5/94, effective 3/1/94]
- [Filed 1/12/94, Notice 11/10/93—published 2/2/94, effective 4/1/94]
- [Filed emergency 2/10/94 after Notice 12/22/93—published 3/2/94, effective 3/1/94]
- [Filed 3/10/94, Notice 2/2/94—published 3/30/94, effective 6/1/94]
- [Filed emergency 6/16/94—published 7/6/94, effective 7/1/94]
- [Filed 8/12/94, Notice 6/22/94—published 8/31/94, effective 11/1/94]
- [Filed 9/15/94, Notices 7/6/94, 8/3/94—published 10/12/94, effective 12/1/94]
- [Filed 11/9/94, Notice 9/14/94—published 12/7/94, effective 2/1/95]
- [Filed 12/15/94, Notices 10/12/94, 11/9/94—published 1/4/95, effective 3/5/95]
- [Filed 5/11/95, Notices 3/29/95—published 6/7/95, effective 8/1/95]
- [Filed 6/7/95, Notice 4/26/95—published 7/5/95, effective 9/1/95]
- [Filed 6/14/95, Notice 5/10/95—published 7/5/95, effective 9/1/95]
- [Filed 10/12/95, Notice 8/30/95—published 11/8/95, effective 1/1/96]
- [Filed 11/16/95, Notices 8/2/95, 9/27/95<sup>6</sup>—published 12/6/95, effective 2/1/96]
- [Filed 12/12/95, Notice 10/25/95—published 1/3/96, effective 3/1/96]
- [Filed 5/15/96, Notice 2/14/96—published 6/5/96, effective 8/1/96]
- [Filed 6/13/96, Notice 4/24/96—published 7/3/96, effective 9/1/96]
- [Filed 7/10/96, Notice 4/24/96—published 7/31/96, effective 10/1/96]
- [Filed 8/15/96, Notice 7/3/96—published 9/11/96, effective 11/1/96]
- [Filed 9/17/96, Notice 7/31/96—published 10/9/96, effective 12/1/96]
- [Filed 1/15/97, Notice 12/4/96—published 2/12/97, effective 4/1/97]
- [Filed 3/12/97, Notices 1/1/97, 1/29/97—published 4/9/97, effective 6/1/97]
- [Filed 4/11/97, Notice 2/12/97—published 5/7/97, effective 7/1/97]
- [Filed emergency 5/14/97 after Notice 3/12/97—published 6/4/97, effective 7/1/97]
- [Filed emergency 6/12/97—published 7/2/97, effective 7/1/97]
- [Filed 6/12/97, Notice 4/23/97—published 7/2/97, effective 9/1/97]
- [Filed 7/9/97, Notice 5/21/97—published 7/30/97, effective 10/1/97]
- [Filed 9/16/97, Notice 7/2/97—published 10/8/97, effective 12/1/97]
- [Filed 11/12/97, Notice 9/10/97—published 12/3/97, effective 2/1/98]
- [Filed 1/14/98, Notice 11/19/97—published 2/11/98, effective 4/1/98]
- [Filed 4/8/98, Notices 2/11/98, 2/25/98—published 5/6/98, effective 7/1/98]
- [Filed 5/13/98, Notice 3/25/98—published 6/3/98, effective 8/1/98]
- [Filed emergency 6/10/98—published 7/1/98, effective 6/10/98]
- [Filed without Notice 6/10/98—published 7/1/98, effective 8/15/98]
- [Filed 8/12/98, Notice 7/1/98—published 9/9/98, effective 11/1/98]
- [Filed 9/15/98, Notice 7/15/98—published 10/7/98, effective 12/1/98]
- [Filed 10/14/98, Notice 7/1/98—published 11/4/98, effective 12/9/98]
- [Filed 12/9/98, Notice 10/7/98—published 12/30/98, effective 3/1/99]
- [Filed 1/13/99, Notice 11/4/98—published 2/10/99, effective 4/1/99]
- [Filed 2/10/99, Notice 12/16/98—published 3/10/99, effective 5/1/99]
- [Filed 3/10/99, Notice 1/27/99—published 4/7/99, effective 6/1/99]
- [Filed emergency 6/10/99—published 6/30/99, effective 7/1/99]
- [Filed 7/15/99, Notice 6/2/99—published 8/11/99, effective 10/1/99]
- [Filed 8/12/99, Notice 6/30/99—published 9/8/99, effective 11/1/99]
- [Filed 10/13/99, Notice 6/30/99—published 11/3/99, effective 1/1/00]
- [Filed 4/12/00, Notice 2/23/00—published 5/3/00, effective 7/1/00]
- [Filed emergency 6/8/00—published 6/28/00, effective 7/1/00]
- [Filed 6/8/00, Notice 4/19/00—published 6/28/00, effective 8/2/00]

- [Filed 6/8/00, Notices 1/26/00, 4/19/00—published 6/28/00, effective 9/1/00]
- [Filed 8/9/00, Notices 6/14/00, 6/28/00—published 9/6/00, effective 11/1/00]
- [Filed emergency 9/12/00 after Notice 7/26/00—published 10/4/00, effective 10/1/00]
  - [Filed 9/12/00, Notice 6/14/00—published 10/4/00, effective 12/1/00]
  - [Filed 10/11/00, Notice 4/19/00—published 11/1/00, effective 1/1/01]
- [Filed emergency 12/14/00 after Notice 9/20/00—published 1/10/01, effective 1/1/01]
  - [Filed 12/14/00, Notice 11/1/00—published 1/10/01, effective 3/1/01]
  - [Filed 2/14/01, Notice 12/13/00—published 3/7/01, effective 5/1/01]
  - [Filed 5/9/01, Notice 3/21/01—published 5/30/01, effective 7/4/01]
  - [Filed 5/9/01, Notices 1/24/01, 3/7/01—published 5/30/01, effective 8/1/01]
- [Filed emergency 6/13/01 after Notice 4/18/01—published 7/11/01, effective 7/1/01]<sup>17 10</sup>
  - [Filed emergency 6/13/01—published 7/11/01, effective 7/1/01]<sup>17 10</sup>
  - [Filed 6/13/01, Notice 4/18/01—published 7/11/01, effective 9/1/01]
  - [Filed 7/11/01, Notice 5/16/01—published 8/8/01, effective 10/1/01]
- [Filed 11/14/01, Notices 9/19/01, 10/3/01—published 12/12/01, effective 2/1/02]
- [Filed emergency 12/12/01 after Notice 10/17/01—published 1/9/02, effective 12/12/01]
  - [Filed 12/12/01, Notice 7/11/01—published 1/9/02, effective 3/1/02]
  - [Filed 12/12/01, Notice 10/17/01—published 1/9/02, effective 3/1/02]<sup>17 10</sup>
- [Filed emergency 1/9/02 after Notice 11/14/01—published 2/6/02, effective 2/1/02]<sup>17 10</sup>
  - [Filed emergency 1/16/02—published 2/6/02, effective 2/1/02]<sup>8</sup>
  - [Filed emergency 2/14/02—published 3/6/02, effective 3/1/02]
  - [Filed 3/13/02, Notice 1/9/02—published 4/3/02, effective 6/1/02]
  - [Filed 3/13/02, Notice 1/23/02—published 4/3/02, effective 6/1/02]
  - [Filed emergency 4/12/02—published 5/1/02, effective 4/12/02]
  - [Filed 4/10/02, Notice 1/9/02—published 5/1/02, effective 7/1/02]
  - [Filed 4/10/02, Notice 3/6/02—published 5/1/02, effective 7/1/02]
  - [Filed emergency 7/11/02—published 8/7/02, effective 7/11/02]
  - [Filed 7/15/02, Notice 5/1/02—published 8/7/02, effective 10/1/02]
  - [Filed emergency 8/15/02—published 9/4/02, effective 9/1/02]
  - [Filed 9/12/02, Notice 8/7/02—published 10/2/02, effective 12/1/02]
  - [Filed emergency 11/18/02—published 12/11/02, effective 12/1/02]
  - [Filed emergency 11/18/02—published 12/11/02, effective 12/15/02]<sup>9</sup>
  - [Filed 11/18/02, Notice 9/4/02—published 12/11/02, effective 2/1/03]
- [Filed emergency 12/12/02 after Notice 10/16/02—published 1/8/03, effective 1/1/03]
  - [Filed 12/12/02, Notice 10/30/02—published 1/8/03, effective 3/1/03]
  - [Filed emergency 1/9/03—published 2/5/03, effective 2/1/03]<sup>17 10</sup>
  - [Filed 2/13/03, Notice 11/27/02—published 3/5/03, effective 5/1/03]
  - [Filed 2/13/03, Notice 12/11/02—published 3/5/03, effective 5/1/03]
  - [Filed emergency 6/12/03—published 7/9/03, effective 7/1/03]<sup>17 10</sup>
  - [Filed 9/22/03, Notice 7/9/03—published 10/15/03, effective 12/1/03]<sup>17 10</sup>
  - [Filed emergency 11/19/03—published 12/10/03, effective 1/1/04]
- [Filed 1/16/04, Notices 9/17/03, 10/29/03—published 2/4/04, effective 3/10/04]
  - [Filed 3/11/04, Notice 1/21/04—published 3/31/04, effective 6/1/04]
- [Filed emergency 6/14/04 after Notice 4/28/04—published 7/7/04, effective 7/1/04]
  - [Filed 8/12/04, Notice 6/23/04—published 9/1/04, effective 11/1/04]<sup>17 10</sup>
  - [Filed emergency 4/15/05—published 5/11/05, effective 5/1/05]
  - [Filed without Notice 5/4/05—published 5/25/05, effective 7/1/05]
  - [Filed 7/15/05, Notice 5/25/05—published 8/3/05, effective 10/1/05]
  - [Filed emergency 9/21/05—published 10/12/05, effective 10/1/05]
  - [Filed emergency 10/21/05—published 11/9/05, effective 11/1/05]
- [Filed 10/21/05, Notices 5/11/05 and 7/6/05—published 11/9/05, effective 12/14/05]<sup>17 10</sup>
  - [Filed 10/21/05, Notice 8/31/05—published 11/9/05, effective 1/1/06]

- [Filed 1/12/06, Notice 11/9/05—published 2/1/06, effective 3/8/06]
- [Filed 3/10/06, Notice 10/12/05—published 3/29/06, effective 5/3/06]
- [Filed 4/17/06, Notice 2/15/06—published 5/10/06, effective 7/1/06]
- [Filed 5/12/06, Notice 3/15/06—published 6/7/06, effective 8/1/06]
- [Filed emergency 6/16/06—published 7/5/06, effective 7/1/06]
- [Filed emergency 8/10/06 after Notice 3/15/06—published 8/30/06, effective 10/1/06]
- [Filed emergency 9/14/06—published 10/11/06, effective 10/1/06]
- [Filed 9/19/06, Notice 7/5/06—published 10/11/06, effective 11/16/06]
- [Filed emergency 10/12/06 after Notice 8/30/06—published 11/8/06, effective 11/1/06]
- [Filed 10/20/06, Notice 8/2/06—published 11/8/06, effective 1/1/07]
- [Filed emergency 12/13/06—published 1/3/07, effective 1/1/07]
- [Filed emergency 3/14/07 after Notice 1/3/07—published 4/11/07, effective 4/1/07]
- [Filed emergency 3/14/07 after Notice 1/17/07—published 4/11/07, effective 4/1/07]
- [Filed 3/14/07, Notice 10/11/06—published 4/11/07, effective 5/16/07]
- [Filed emergency 7/12/07—published 8/1/07, effective 7/12/07]
- [Filed emergency 7/12/07 after Notice 5/23/07—published 8/1/07, effective 8/1/07]
- [Filed 7/12/07, Notice 5/23/07—published 8/1/07, effective 9/5/07]
- [Filed without Notice 7/20/07—published 8/15/07, effective 10/1/07]
- [Filed 8/9/07, Notice 6/20/07—published 8/29/07, effective 11/1/07]
- [Filed emergency 9/12/07 after Notice 7/18/07—published 10/10/07, effective 10/1/07]
- [Filed emergency 1/9/08 after Notice 10/10/07—published 1/30/08, effective 2/1/08]
- [Filed 1/9/08, Notice 11/7/07—published 1/30/08, effective 4/1/08]
- [Filed emergency 5/14/08 after Notice 3/26/08—published 6/4/08, effective 5/15/08]
- [Filed emergency 5/14/08 after Notice 3/26/08—published 6/4/08, effective 6/1/08]
- [Filed emergency 6/11/08 after Notice 3/12/08—published 7/2/08, effective 7/1/08]
- [Filed emergency 6/12/08—published 7/2/08, effective 7/1/08]
- [Filed 6/11/08, Notice 4/23/08—published 7/2/08, effective 9/1/08]
- [Filed emergency 8/18/08—published 9/10/08, effective 9/1/08]
- [Filed emergency 8/18/08 after Notice 7/2/08—published 9/10/08, effective 10/1/08]
- [Filed 9/17/08, Notice 7/2/08—published 10/8/08, effective 11/12/08]
- [Filed emergency 10/14/08 after Notice 7/16/08—published 11/5/08, effective 12/1/08]
- [Filed 10/14/08, Notice 8/13/08—published 11/5/08, effective 1/1/09]
- [Filed emergency 11/12/08 after Notice 9/10/08—published 12/3/08, effective 12/1/08]
- [Filed 11/12/08, Notice 9/24/08—published 12/3/08, effective 2/1/09]
- [Filed 12/11/08, Notice 9/10/08—published 1/14/09, effective 2/18/09]
- [Filed 12/11/08, Notice 10/22/08—published 1/14/09, effective 3/1/09]
- [Filed ARC 7548B (Notice ARC 7369B, IAB 11/19/08), IAB 2/11/09, effective 4/1/09]
- [Filed Emergency After Notice ARC 7957B (Notice ARC 7631B, IAB 3/11/09; Amended Notice ARC 7732B, IAB 4/22/09), IAB 7/15/09, effective 7/1/09]<sup>11</sup>
- [Filed Emergency After Notice ARC 8008B (Notice ARC 7771B, IAB 5/20/09), IAB 7/29/09, effective 8/1/09]
- [Filed ARC 8097B (Notice ARC 7816B, IAB 6/3/09), IAB 9/9/09, effective 11/1/09]
- [Filed ARC 8205B (Notice ARC 7827B, IAB 6/3/09), IAB 10/7/09, effective 11/11/09]
- [Filed Emergency ARC 8344B, IAB 12/2/09, effective 12/1/09]
- [Filed ARC 8504B (Notice ARC 8247B, IAB 10/21/09), IAB 2/10/10, effective 3/22/10]
- [Filed Emergency After Notice ARC 8643B (Notice ARC 8345B, IAB 12/2/09), IAB 4/7/10, effective 3/11/10]
- [Filed Emergency After Notice ARC 8714B (Notice ARC 8538B, IAB 2/24/10), IAB 5/5/10, effective 5/1/10]
- [Filed ARC 8993B (Notice ARC 8722B, IAB 5/5/10), IAB 8/11/10, effective 10/1/10]
- [Filed ARC 8994B (Notice ARC 8756B, IAB 5/19/10), IAB 8/11/10, effective 10/1/10]
- [Filed ARC 9045B (Notice ARC 8832B, IAB 6/2/10), IAB 9/8/10, effective 11/1/10]

- [Filed Emergency ARC 9132B, IAB 10/6/10, effective 11/1/10]
- [Filed ARC 9175B (Notice ARC 8975B, IAB 7/28/10), IAB 11/3/10, effective 1/1/11]
- [Filed Emergency ARC 9256B, IAB 12/1/10, effective 1/1/11]
- [Filed Emergency ARC 9311B, IAB 12/29/10, effective 1/1/11]
- [Filed ARC 9315B (Notice ARC 9111B, IAB 10/6/10), IAB 12/29/10, effective 2/2/11]
- [Filed ARC 9316B (Notice ARC 9133B, IAB 10/6/10), IAB 12/29/10, effective 2/2/11]
- [Filed ARC 9403B (Notice ARC 9170B, IAB 10/20/10), IAB 3/9/11, effective 5/1/11]<sup>12</sup>
- [Filed Emergency After Notice ARC 9440B (Notice ARC 9276B, IAB 12/15/10), IAB 4/6/11, effective 4/1/11]
- [Editorial change: IAC Supplement 4/20/11]
- [Filed ARC 9487B (Notice ARC 9399B, IAB 2/23/11), IAB 5/4/11, effective 7/1/11]
- [Filed ARC 9588B (Notice ARC 9367B, IAB 2/9/11; Amended Notice ARC 9448B, IAB 4/6/11), IAB 6/29/11, effective 9/1/11]
- [Filed Emergency After Notice ARC 9649B (Notice ARC 9538B, IAB 6/1/11), IAB 8/10/11, effective 8/1/11]
- [Filed ARC 9650B (Notice ARC 9497B, IAB 5/4/11), IAB 8/10/11, effective 10/1/11]
- [Filed Emergency ARC 9699B, IAB 9/7/11, effective 9/1/11]
- [Filed Emergency ARC 9702B, IAB 9/7/11, effective 9/1/11]
- [Filed Emergency ARC 9704B, IAB 9/7/11, effective 9/1/11]
- [Filed Emergency ARC 9834B, IAB 11/2/11, effective 11/1/11]
- [Filed ARC 9882B (Notice ARC 9700B, IAB 9/7/11), IAB 11/30/11, effective 1/4/12]
- [Filed ARC 9883B (Notice ARC 9703B, IAB 9/7/11), IAB 11/30/11, effective 1/4/12]
- [Filed ARC 9884B (Notice ARC 9705B, IAB 9/7/11), IAB 11/30/11, effective 1/4/12]
- [Filed ARC 9981B (Notice ARC 9835B, IAB 11/2/11), IAB 2/8/12, effective 3/14/12]
- [Filed ARC 0065C (Notice ARC 9940B, IAB 12/28/11), IAB 4/4/12, effective 6/1/12]
- [Filed Emergency ARC 0191C, IAB 7/11/12, effective 7/1/12]
- [Filed Emergency ARC 0194C, IAB 7/11/12, effective 7/1/12]
- [Filed Emergency After Notice ARC 0198C (Notice ARC 0117C, IAB 5/2/12), IAB 7/11/12, effective 7/1/12]
- [Filed ARC 0305C (Notice ARC 0144C, IAB 5/30/12), IAB 9/5/12, effective 11/1/12]
- [Filed ARC 0358C (Notice ARC 0231C, IAB 7/25/12), IAB 10/3/12, effective 11/7/12]
- [Filed ARC 0359C (Notice ARC 0193C, IAB 7/11/12), IAB 10/3/12, effective 12/1/12]
- [Filed ARC 0354C (Notice ARC 0195C, IAB 7/11/12), IAB 10/3/12, effective 12/1/12]
- [Filed ARC 0360C (Notice ARC 0203C, IAB 7/11/12), IAB 10/3/12, effective 12/1/12]
- [Filed ARC 0545C (Notice ARC 0366C, IAB 10/3/12), IAB 1/9/13, effective 3/1/13]
- [Filed ARC 0580C (Notice ARC 0434C, IAB 10/31/12), IAB 2/6/13, effective 4/1/13]
- [Filed ARC 0631C (Notice ARC 0497C, IAB 12/12/12), IAB 3/6/13, effective 5/1/13]
- [Filed ARC 0632C (Notice ARC 0496C, IAB 12/12/12), IAB 3/6/13, effective 5/1/13]
- [Filed ARC 0707C (Notice ARC 0567C, IAB 1/23/13), IAB 5/1/13, effective 7/1/13]
- [Filed ARC 0709C (Notice ARC 0589C, IAB 2/6/13), IAB 5/1/13, effective 7/1/13]
- [Filed ARC 0757C (Notice ARC 0615C, IAB 2/20/13), IAB 5/29/13, effective 8/1/13]
- [Filed ARC 0823C (Notice ARC 0649C, IAB 3/20/13), IAB 7/10/13, effective 9/1/13]
- [Filed Emergency After Notice ARC 0838C (Notice ARC 0667C, IAB 4/3/13; Amended Notice ARC 0748C, IAB 5/15/13), IAB 7/24/13, effective 7/1/13]
- [Filed Emergency ARC 0842C, IAB 7/24/13, effective 7/1/13]
- [Filed Emergency ARC 0844C, IAB 7/24/13, effective 7/1/13]
- [Filed Emergency ARC 0846C, IAB 7/24/13, effective 7/1/13]
- [Filed Emergency ARC 0848C, IAB 7/24/13, effective 7/1/13]
- [Filed ARC 0994C (Notice ARC 0789C, IAB 6/12/13), IAB 9/4/13, effective 11/1/13]
- [Filed Emergency After Notice ARC 1071C (Notice ARC 0887C, IAB 7/24/13), IAB 10/2/13, effective 10/1/13]
- [Filed ARC 1052C (Notice ARC 0845C, IAB 7/24/13), IAB 10/2/13, effective 11/6/13]

- [Filed ARC 1056C (Notice ARC 0841C, IAB 7/24/13), IAB 10/2/13, effective 11/6/13]  
 [Filed ARC 1054C (Notice ARC 0843C, IAB 7/24/13), IAB 10/2/13, effective 11/6/13]  
 [Filed ARC 1051C (Notice ARC 0847C, IAB 7/24/13), IAB 10/2/13, effective 11/6/13]  
 [Filed ARC 1151C (Notice ARC 0920C, IAB 8/7/13), IAB 10/30/13, effective 1/1/14]  
 [Filed ARC 1264C (Notice ARC 1161C, IAB 10/30/13), IAB 1/8/14, effective 3/1/14]  
 [Filed ARC 1297C (Notice ARC 1185C, IAB 11/13/13), IAB 2/5/14, effective 4/1/14]  
 [Filed Emergency After Notice ARC 1610C (Notice ARC 1510C, IAB 6/25/14), IAB 9/3/14, effective 8/13/14]  
 [Filed ARC 1696C (Notice ARC 1620C, IAB 9/3/14), IAB 10/29/14, effective 1/1/15]  
 [Filed ARC 1850C (Notice ARC 1729C, IAB 11/12/14), IAB 2/4/15, effective 4/1/15]  
 [Filed ARC 1976C (Notice ARC 1901C, IAB 3/4/15), IAB 4/29/15, effective 7/1/15]  
 [Filed Emergency After Notice ARC 2050C (Notice ARC 1982C, IAB 4/29/15), IAB 7/8/15, effective 7/1/15]  
 [Filed Emergency After Notice ARC 2164C (Notice ARC 2062C, IAB 7/22/15), IAB 9/30/15, effective 10/1/15]  
 [Filed ARC 2166C (Notice ARC 2096C, IAB 8/5/15), IAB 9/30/15, effective 11/4/15]  
 [Filed Emergency After Notice ARC 2361C (Notice ARC 2242C, IAB 11/11/15), IAB 1/6/16, effective 1/1/16]  
 [Filed ARC 2340C (Notice ARC 2115C, IAB 8/19/15), IAB 1/6/16, effective 2/10/16]  
 [Filed ARC 2341C (Notice ARC 2113C, IAB 8/19/15), IAB 1/6/16, effective 2/10/16]  
 [Filed ARC 2471C (Notice ARC 2114C, IAB 8/19/15; Amended Notice ARC 2380C, IAB 2/3/16), IAB 3/30/16, effective 5/4/16]  
 [Filed Emergency ARC 2848C, IAB 12/7/16, effective 11/15/16]  
 [Filed ARC 2930C (Notice ARC 2824C, IAB 11/23/16), IAB 2/1/17, effective 4/1/17]  
 [Filed ARC 2936C (Notice ARC 2849C, IAB 12/7/16), IAB 2/1/17, effective 3/8/17]  
 [Filed ARC 3005C (Notice ARC 2897C, IAB 1/18/17), IAB 3/29/17, effective 5/3/17]  
 [Filed ARC 3184C (Notice ARC 2920C, IAB 2/1/17), IAB 7/5/17, effective 8/9/17]  
 [Filed Emergency ARC 3481C, IAB 12/6/17, effective 12/1/17]  
 [Filed ARC 3494C (Notice ARC 3321C, IAB 9/27/17), IAB 12/6/17, effective 1/10/18]  
 [Filed ARC 3551C (Notice ARC 3439C, IAB 11/8/17), IAB 1/3/18, effective 2/7/18]  
 [Filed ARC 3552C (Notice ARC 3374C, IAB 10/11/17), IAB 1/3/18, effective 2/7/18]  
 [Filed ARC 3553C (Notice ARC 3419C, IAB 10/25/17), IAB 1/3/18, effective 2/7/18]  
 [Filed ARC 3790C (Notice ARC 3476C, IAB 12/6/17; Amended Notice ARC 3602C, IAB 1/31/18), IAB 5/9/18, effective 6/13/18]  
 [Filed ARC 3874C (Notice ARC 3784C, IAB 5/9/18), IAB 7/4/18, effective 8/8/18]  
 [Filed ARC 4430C (Notice ARC 4288C, IAB 2/13/19), IAB 5/8/19, effective 7/1/19]<sup>13</sup>  
 [Filed ARC 4575C (Notice ARC 4444C, IAB 5/22/19), IAB 7/31/19, effective 9/4/19]

<sup>1</sup> Two ARCs

<sup>2</sup> Effective date of 78.3 and 78.31 delayed 70 days by the Administrative Rules Review Committee at its January 1, 1988 meeting.

<sup>3</sup> Effective date of 4/1/90 delayed 70 days by the Administrative Rules Review Committee at its March 12, 1990, meeting.

<sup>4</sup> 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.

<sup>5</sup> 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.

<sup>6</sup> Two ARCs

<sup>7</sup> Two ARCs

<sup>8</sup> 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**.

<sup>9</sup> Effective date of 12/15/02 delayed 70 days by the Administrative Rules Review Committee at its December 10, 2002, meeting.

<sup>10</sup> Two or more ARCs

<sup>11</sup> 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.

- <sup>12</sup> 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.
- <sup>13</sup> July 1, 2019, effective date of **ARC 4430C** [amendments to chs 78, 79] delayed until the adjournment of the 2020 session of the General Assembly by the Administrative Rules Review Committee at its meeting held June 11, 2019; delay lifted at the meeting held September 10, 2019.

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

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

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

**79.1(1) Types of reimbursement.**

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

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

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

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

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

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

Fee schedules in effect for the providers covered by fee schedules can be obtained from the department's website at: [dhs.iowa.gov/ime/providers/csrp/fee-schedule](https://dhs.iowa.gov/ime/providers/csrp/fee-schedule).

*d. Fee for service with cost settlement.* Rescinded IAB 10/10/18, effective 12/1/18.

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

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

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

(3) The prospective rates paid to both new and established providers are subject to the maximums listed in subrule 79.1(2) and to retrospective adjustment based on the provider's actual, current costs of operation as shown by financial and statistical reports submitted by the provider, so as not to exceed reasonable and proper costs actually incurred by more than 4.5 percent.

*f. Contractual rate.* Providers are reimbursed on a basis of costs incurred pursuant to a contract between the provider and subcontractor.

*g. Retrospectively adjusted prospective rates.* Critical access hospitals are reimbursed prospectively, with retrospective adjustments based on annual cost reports submitted by the hospital at the end of the hospital's fiscal year. The retroactive adjustment equals the difference between the reasonable costs of providing covered services to eligible fee-for-service Medicaid members (excluding members in managed care), determined in accordance with Medicare cost principles, and the Medicaid reimbursement received. Amounts paid that exceed reasonable costs shall be recovered by the department. See paragraphs 79.1(5) "aa" and 79.1(16) "h."

*h. Indian health facilities.*

(1) Indian health facilities enrolled pursuant to rule 441—77.45(249A) are paid for all Medicaid-covered services rendered to American Indian or Alaskan native persons who are Medicaid-eligible at the current daily visit rates approved by the U.S. Indian Health Service (IHS) for services provided by IHS facilities to Medicaid beneficiaries, as published in the Federal Register. For services provided to American Indians or Alaskan natives, Indian health facilities may bill for one visit per patient per calendar day for medical services (at the "outpatient per visit rate (excluding Medicare)"), which shall constitute payment in full for all medical services provided on that day, except as follows:

1. For services provided to American Indians and Alaskan natives, Indian health facilities may bill for multiple visits per patient per calendar day for medical services (at the "outpatient per visit rate (excluding Medicare)") only if medical services are provided for different diagnoses or if distinctly different medical services from different categories of services are provided for the same diagnoses in different units of the facility. For this purpose, the categories of medical services are vision services; dental services; mental health and addiction services; early and periodic screening, diagnosis, and treatment services for children; other outpatient services; and other inpatient services. A visit is a face-to-face contact between a patient and a health professional at or through the facility.

2. For services provided to American Indians or Alaskan natives, Indian health facilities may also bill for one visit per patient per calendar day for outpatient prescribed drugs provided by the facility (at the "outpatient per visit rate (excluding Medicare)"), which shall constitute payment in full for all outpatient prescribed drugs provided on that day.

(2) Services provided to Medicaid recipients who are not American Indians or Alaskan natives will be paid at the reimbursement rate otherwise allowed by Iowa Medicaid for the services provided and will be billed separately by CPT code on the CMS-1500 Health Insurance Claim Form or through pharmacy point of sale. Claims for nonpharmacy services provided to Medicaid recipients who are not American Indians or Alaskan natives must be submitted by the individual practitioner enrolled in the Iowa Medicaid program, but may be paid to the facility if the provider agreement so stipulates.

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

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
Advanced registered nurse practitioners	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.
Ambulance	Fee schedule	Ground ambulance: Fee schedule in effect 6/30/14 plus 10%. Air ambulance: Fee schedule in effect 6/30/14 plus 10%.
Ambulatory surgical centers	Base rate fee schedule as determined by Medicare. See 79.1(3)	Fee schedule in effect 6/30/13 plus 1%.
Area education agencies	Fee schedule	Fee schedule in effect 6/30/00 plus 0.7%.
Assertive community treatment	Fee schedule	\$51.08 per day for each day on which a team meeting is held. Maximum of 5 days per week.
Audiologists	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.
Behavioral health intervention	Fee schedule	Fee schedule in effect 7/1/13.
Behavioral health services	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.
Birth centers	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.
Child care medical services	Fee schedule	Fee schedule in effect 1/1/16.
Chiropractors	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.
Clinics	Fee schedule	Maximum physician reimbursement rate.
Community-based neurobehavioral rehabilitation services	Fee schedule, see 79.1(28)	Residential: Limit in effect as of June 30 each year plus CPI-U for the preceding 12-month period ending June 30. Intermittent: \$21.11 per 15-minute unit.
Community mental health centers and providers of mental health services to county residents pursuant to a waiver approved under Iowa Code section 225C.7(3)	Retrospective cost-related. See 79.1(25)	100% of reasonable Medicaid cost as determined by Medicare cost reimbursement principles.
Crisis response services	Fee schedule	Fee schedule in effect 2/1/18, not to exceed the daily per diem for crisis stabilization services.
Crisis stabilization community-based services	Fee schedule	Fee schedule in effect 2/1/18, not to exceed the daily per diem for crisis stabilization services.
Crisis stabilization residential services	Fee schedule	Fee schedule in effect 2/1/18.
Dentists	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.
Drug and alcohol services	Fee schedule	Fee schedule in effect 1/1/16.
Durable medical equipment, prosthetic devices and medical supply dealers	Fee schedule. See 79.1(4)	Fee schedule in effect 6/30/13 plus 1%.
Emergency psychiatric services	Fee schedule	Fee schedule in effect 1/1/16.
Family planning clinics	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
Federally qualified health centers	Retrospective cost-related. See 441—Chapter 73	<ol style="list-style-type: none"> <li>1. Prospective payment rate as required by the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA 2000) or an alternative methodology allowed thereunder, as specified in “2” below.</li> <li>2. 100% of reasonable cost as determined by Medicare cost reimbursement principles.</li> <li>3. In the case of services provided pursuant to a contract between an FQHC and a managed care organization (MCO), reimbursement from the MCO shall be supplemented to achieve “1” or “2” above.</li> </ol>
HCBS waiver service providers, including:		Except as noted, limits apply to all waivers that cover the named provider.
1. Adult day care	For AIDS/HIV, brain injury, elderly, and ill and handicapped waivers: Fee schedule	Effective 7/1/16, for AIDS/HIV, brain injury, elderly, and ill and handicapped waivers: Provider’s rate in effect 6/30/16 plus 1%, converted to a 15-minute, half-day, full-day, or extended-day rate. If no 6/30/16 rate: Veterans Administration contract rate or \$1.47 per 15-minute unit, \$23.47 per half day, \$46.72 per full day, or \$70.06 per extended day if no Veterans Administration contract.
	For intellectual disability waiver: Fee schedule for the member’s acuity tier, determined pursuant to 79.1(30)	Effective 7/1/17, for intellectual disability waiver: The provider’s rate in effect 6/30/16 plus 1%, converted to a 15-minute or half-day rate. If no 6/30/16 rate, \$1.96 per 15-minute unit or \$31.27 per half day.  For daily services, the fee schedule rate published on the department’s website, pursuant to 79.1(1)“c,” for the member’s acuity tier, determined pursuant to 79.1(30).
2. Emergency response system: Personal response system	Fee schedule	Effective 7/1/13, provider’s rate in effect 6/30/13 plus 3%. If no 6/30/13 rate: Initial one-time fee: \$52.04. Ongoing monthly fee: \$40.47.

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
Portable locator system	Fee schedule	Effective 7/1/13, provider's rate in effect 6/30/13 plus 3%. If no 6/30/13 rate: One equipment purchase: \$323.26. Initial one-time fee: \$52.04. Ongoing monthly fee: \$40.47.
3. Home health aides	Retrospective cost-related	For AIDS/HIV, elderly, and health and disability waivers effective 7/1/16: Lesser of maximum Medicare rate in effect 6/30/16 plus 1% or maximum Medicaid rate in effect 6/30/16 plus 1%.  For intellectual disability waiver effective 7/1/16: Lesser of maximum Medicare rate in effect 6/30/16 plus 1% or maximum Medicaid rate in effect 6/30/16 plus 1%, converted to an hourly rate.
4. Homemakers	Fee schedule	Effective 7/1/13, provider's rate in effect 6/30/13 plus 3%, converted to a 15-minute rate. If no 6/30/13 rate: \$5.20 per 15-minute unit.
5. Nursing care	Fee schedule	For AIDS/HIV, health and disability, elderly and intellectual disability waiver effective 7/1/16, provider's rate in effect 6/30/16 plus 1%. If no 6/30/16 rate: \$87.99 per visit.

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
6. Respite care when provided by:		
Home health agency:		
Specialized respite	Cost-based rate for nursing services provided by a home health agency	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: Lesser of maximum Medicare rate in effect 6/30/16 plus 1%, converted to a 15-minute rate, or maximum Medicaid rate in effect 6/30/16 plus 1%, converted to a 15-minute rate, not to exceed \$315.09 per day.
Basic individual respite	Cost-based rate for home health aide services provided by a home health agency	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: Lesser of maximum Medicare rate in effect 6/30/16 plus 1%, converted to a 15-minute rate, or maximum Medicaid rate in effect 6/30/16 plus 1%, converted to a 15-minute rate, not to exceed \$315.09 per day.
Group respite	Fee schedule	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: \$3.49 per 15-minute unit, not to exceed \$315.09 per day.
Home care agency:		
Specialized respite	Fee schedule	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: \$8.96 per 15-minute unit, not to exceed \$315.09 per day.
Basic individual respite	Fee schedule	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: \$4.78 per 15-minute unit, not to exceed \$315.09 per day.
Group respite	Fee schedule	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: \$3.49 per 15-minute unit, not to exceed \$315.09 per day.
Nonfacility care:		
Specialized respite	Fee schedule	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: \$8.96 per 15-minute unit, not to exceed \$315.09 per day.

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
Basic individual respite	Fee schedule	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: \$4.78 per 15-minute unit, not to exceed \$315.09 per day.
Group respite	Fee schedule	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: \$3.49 per 15-minute unit, not to exceed \$315.09 per day.
Facility care:		
Hospital or nursing facility providing skilled care	Fee schedule	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: \$3.49 per 15-minute unit, not to exceed the facility's daily Medicaid rate for skilled nursing level of care.
Nursing facility	Fee schedule	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: \$3.49 per 15-minute unit, not to exceed the facility's daily Medicaid rate.
Camps	Fee schedule	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: \$3.49 per 15-minute unit, not to exceed \$315.09 per day.
Adult day care	Fee schedule	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: \$3.49 per 15-minute unit, not to exceed rate for regular adult day care services.
Intermediate care facility for persons with an intellectual disability	Fee schedule	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: \$3.49 per 15-minute unit, not to exceed the facility's daily Medicaid rate.
Residential care facilities for persons with an intellectual disability	Fee schedule	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: \$3.49 per 15-minute unit, not to exceed contractual daily rate.

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
Foster group care	Fee schedule	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: \$3.49 per 15-minute unit, not to exceed daily rate for child welfare services.
Child care facilities	Fee schedule	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: \$3.49 per 15-minute unit, not to exceed contractual daily rate.
7. Chore service	Fee schedule	Effective 7/1/13, provider's rate in effect 6/30/13 plus 3%, converted to a 15-minute rate. If no 6/30/13 rate: \$4.05 per 15-minute unit.
8. Home-delivered meals	Fee schedule	Effective 7/1/13, provider's rate in effect 6/30/13 plus 3%. If no 6/30/13 rate: \$8.10 per meal. Maximum of 14 meals per week.
9. Home and vehicle modification	Fee schedule. See 79.1(17)	For elderly waiver effective 7/1/13: \$1,061.11 lifetime maximum.  For intellectual disability waiver effective 7/1/13: \$5,305.53 lifetime maximum.  For brain injury, health and disability, and physical disability waivers effective 7/1/13: \$6,366.64 per year.
10. Mental health outreach providers	Fee schedule	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%. If no 6/30/16 rate: On-site Medicaid reimbursement rate for center or provider. Maximum of 1,440 units per year.
11. Transportation	Fee schedule	Effective 10/1/13: The provider's nonemergency medical transportation contract rate or, in the absence of a nonemergency medical transportation contract rate, the median nonemergency medical transportation contract rate paid per mile or per trip within the member's DHS region.
12. Nutritional counseling	Fee schedule	Effective 7/1/16 for non-county contract: Provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: \$8.76 per 15-minute unit.
13. Assistive devices	Fee schedule. See 79.1(17)	Effective 7/1/13: \$115.62 per unit.

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
14. Senior companion	Fee schedule	Effective 7/1/16 for non-county contract: Provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: \$1.89 per 15-minute unit.
15. Consumer-directed attendant care provided by:		
Agency (other than an elderly waiver assisted living program)	Fee agreed upon by member and provider	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: \$5.35 per 15-minute unit, not to exceed \$123.85 per day.
Assisted living program (for elderly waiver only)	Fee agreed upon by member and provider	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: \$5.35 per 15-minute unit, not to exceed \$123.85 per day.
Individual	Fee agreed upon by member and provider	Effective 7/1/16, \$3.58 per 15-minute unit, not to exceed \$83.36 per day. When an individual who serves as a member's legal representative provides services to the member as allowed by 79.9(7) "b," the payment rate must be based on the skill level of the legal representative and may not exceed the median statewide reimbursement rate for the service unless the higher rate receives prior approval from the department.
16. Counseling:		
Individual	Fee schedule	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: \$11.45 per 15-minute unit.
Group	Fee schedule	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: \$11.44 per 15-minute unit. Rate is divided by six, or, if the number of persons who comprise the group exceeds six, the actual number of persons who comprise the group.
17. Case management	Fee schedule	For brain injury and elderly waivers: Fee schedule in effect 7/1/18.

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
18. Supported community living	For brain injury waiver: Retrospectively limited prospective rates. See 79.1(15)	For brain injury waiver effective 7/1/16: \$9.28 per 15-minute unit, not to exceed the maximum daily ICF/ID rate per day plus 3.927%.
	For intellectual disability waiver: Fee schedule for the member's acuity tier, determined pursuant to 79.1(30). Retrospectively limited prospective rate for SCL 15-minute unit. See 79.1(15)	For intellectual disability waiver effective 7/1/17: \$9.28 per 15-minute unit. For daily service, the fee schedule rate published on the department's website, pursuant to 79.1(1) "c," for the member's acuity tier, determined pursuant to 79.1(30).
19. Supported employment:		
Individual supported employment	Fee schedule	Fee schedule in effect 7/1/16. Total monthly cost for all supported employment services not to exceed \$3,059.29 per month.
Long-term job coaching	Fee schedule	Fee schedule in effect 7/1/16. Total monthly cost for all supported employment services not to exceed \$3,059.29 per month.
Small-group supported employment (2 to 8 individuals)	Fee schedule	Fee schedule in effect 7/1/16. Maximum 160 units per week. Total monthly cost for all supported employment services not to exceed \$3,059.29 per month.
20. Specialized medical equipment	Fee schedule. See 79.1(17)	Effective 7/1/13, \$6,366.64 per year.
21. Behavioral programming	Fee schedule	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%. If no 6/30/16 rate: \$11.45 per 15 minutes.
22. Family counseling and training	Fee schedule	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: \$11.44 per 15-minute unit.
23. Prevocational services, including career exploration	Fee schedule	Fee schedule in effect 7/1/16.
24. Interim medical monitoring and treatment:		
Home health agency (provided by home health aide)	Cost-based rate for home health aide services provided by a home health agency	Effective 7/1/16: Lesser of maximum Medicare rate in effect 6/30/16 plus 1%, converted to a 15-minute rate, or maximum Medicaid rate in effect 6/30/16 plus 1%, converted to a 15-minute rate.

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
Home health agency (provided by nurse)	Cost-based rate for nursing services provided by a home health agency	Effective 7/1/16: Lesser of maximum Medicare rate in effect 6/30/16 plus 1%, converted to a 15-minute rate, or maximum Medicaid rate in effect 6/30/16 plus 1%, converted to a 15-minute rate.
Child development home or center	Fee schedule	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: \$3.49 per 15-minute unit.
Supported community living provider	Retrospectively limited prospective rate. See 79.1(15)	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: \$9.28 per 15-minute unit, not to exceed the maximum ICF/ID rate per day plus 3.927%.
25. Residential-based supported community living	Fee schedule for the member's acuity tier, determined pursuant to 79.1(30)	Effective 7/1/17: The fee schedule rate published on the department's website, pursuant to 79.1(1) "c," for the member's acuity tier, determined pursuant to 79.1(30).
26. Day habilitation	Fee schedule for the member's acuity tier, determined pursuant to 79.1(30)	Effective 7/1/17: Provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: \$3.51 per 15-minute unit. For daily service, the fee schedule rate published on the department's website, pursuant to 79.1(1) "c," for the member's acuity tier, determined pursuant to 79.1(30).
27. Environmental modifications and adaptive devices	Fee schedule. See 79.1(17)	Effective 7/1/13, \$6,366.64 per year.
28. Family and community support services	Retrospectively limited prospective rates. See 79.1(15)	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: \$9.28 per 15-minute unit.
29. In-home family therapy	Fee schedule	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: \$24.85 per 15-minute unit.
30. Financial management services	Fee schedule	Effective 7/1/13, provider's rate in effect 6/30/13 plus 3%. If no 6/30/13 rate: \$68.97 per enrolled member per month.
31. Independent support broker	Rate negotiated by member	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%. If no 6/30/16 rate: \$16.07 per hour.

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
32. Self-directed personal care	Rate negotiated by member	Determined by member's individual budget. When an individual who serves as a member's legal representative provides services to the member as allowed by 79.9(7) "b," the payment rate must be based on 441—subparagraph 78.34(13) "g"(2).
33. Self-directed community supports and employment	Rate negotiated by member	Determined by member's individual budget. When an individual who serves as a member's legal representative provides services to the member as allowed by 79.9(7) "b," the payment rate must be based on 441—subparagraph 78.34(13) "g"(2).
34. Individual-directed goods and services	Rate negotiated by member	Determined by member's individual budget. When an individual who serves as a member's legal representative provides services to the member as allowed by 79.9(7) "b," the payment rate must be based on 441—subparagraph 78.34(13) "g"(2).
35. Assisted living on-call service providers (elderly waiver only)	Fee agreed upon by member and provider	\$26.08 per day.
Health home services provider	Fee schedule based on the member's qualifying health condition(s).	Monthly fee schedule amount.
Hearing aid dispensers	Fee schedule plus product acquisition cost	Fee schedule in effect 6/30/13 plus 1%.
Home- and community-based habilitation services:		
1. Case management	Fee schedule. See 79.1(24) "d"	Fee schedule in effect 7/1/18.
2. Home-based habilitation	See 79.1(24) "d"	Effective 7/1/13: \$11.68 per 15-minute unit, not to exceed \$6,083 per month, or \$200 per day.
3. Day habilitation	See 79.1(24) "d"	Effective 7/1/13: \$3.30 per 15-minute unit or \$64.29 per day.
4. Prevocational habilitation Career exploration	Fee schedule	Fee schedule in effect May 4, 2016.
5. Supported employment: Individual supported employment	Fee schedule	Fee schedule in effect May 4, 2016. Total monthly cost for all supported employment services not to exceed \$3,029.00 per month.

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
Long-term job coaching	Fee schedule	Fee schedule in effect May 4, 2016. Total monthly cost for all supported employment services not to exceed \$3,029.00 per month.
Small-group supported employment (2 to 8 individuals)	Fee schedule	Fee schedule in effect May 4, 2016. Maximum 160 units per week. Total monthly cost for all supported employment services not to exceed \$3,029.00 per month.
Home health agencies		
1. Skilled nursing, physical therapy, occupational therapy, speech therapy, home health aide, and medical social services; home health care for maternity patients and children	Fee schedule. See 79.1(26). For members living in a nursing facility, see 441—paragraph 81.6(11)“r.”	Effective 7/1/18: Medicare LUPA rates in effect on 6/30/18 plus a 3% increase.
2. Private-duty nursing and personal cares for members aged 20 or under	Retrospective cost-related. See 79.1(27)	Effective 7/1/13: Actual and allowable cost not to exceed a maximum of 133% of statewide average.
3. Administration of vaccines	Physician fee schedule	Physician fee schedule rate.
Hospices	Fee schedule as determined by Medicare	Medicare cap. (See 79.1(14)“d”)
Hospitals (Critical access)	Retrospectively adjusted prospective rates. See 79.1(1)“g” and 79.1(5)	The reasonable cost of covered services provided to medical assistance recipients or the upper limits for other hospitals, whichever is greater.
Hospitals (Inpatient)	Prospective reimbursement. See 79.1(5)	Reimbursement rate in effect 6/30/13 plus 1%.
Hospitals (Outpatient)	Prospective reimbursement or hospital outpatient fee schedule. See 79.1(16)“c”	Ambulatory payment classification rate or hospital outpatient fee schedule rate in effect 6/30/13 plus 1%.
Independent laboratories	Fee schedule. See 79.1(6)	Medicare fee schedule less 5%. See 79.1(6)
Indian health facilities	1. Daily visit rate approved by the U.S. Indian Health Service (IHS) for services provided to American Indian and Alaskan native members. See 79.1(1)“h” 2. Fee schedule for service provided for all other Medicaid members.	1. IHS-approved rate published in the Federal Register as outpatient per visit rate (excluding Medicare). 2. Fee schedule.
Infant and toddler program providers	Fee schedule	Fee schedule.
Intermediate care facilities for persons with an intellectual disability	Prospective reimbursement. See 441—82.5(249A)	Eightieth percentile of facility costs as calculated from annual cost reports.
Lead inspection agency	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.
Local education agency services providers	Fee schedule	Fee schedule.

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
Maternal health centers	Reasonable cost per procedure on a prospective basis as determined by the department based on financial and statistical data submitted annually by the provider group	Fee schedule in effect 6/30/13 plus 1%.
Nursing facilities:		
1. Nursing facility care	Prospective reimbursement. See 441—subrule 81.10(1) and 441—81.6(249A). The percentage of the median used to calculate the direct care excess payment allowance ceiling under 441—81.6(16) “d”(1)“1” and (2)“1” is 95% of the patient-day-weighted median. The percentage of the difference used to calculate the direct care excess payment allowance is 0%. The percentage of the median used to calculate the direct care excess payment allowance limit is 10% of the patient-day-weighted median. The percentage of the median used to calculate the non-direct care excess payment allowance ceiling under 441—81.6(16) “d”(1)“2” and (2)“2” is 96% of the patient-day-weighted median. The percentage of the difference used to calculate the non-direct care excess payment allowance limit is 0%. The percentage of the median used to calculate the non-direct care excess payment allowance limit is 8% of the patient-day-weighted median.	See 441—subrules 81.6(4) and 81.6(14) and paragraph 81.6(16)“f.” The direct care rate component limit under 441—81.6(16)“f”(1) and (2) is 120% of the patient-day-weighted median. The non-direct care rate component limit under 441—81.6(16)“f”(1) and (2) is 110% of the patient-day-weighted median.
2. Hospital-based, Medicare-certified nursing care	Prospective reimbursement. See 441—subrule 81.10(1) and 441—81.6(249A). The percentage of the median used to calculate the direct care excess payment allowance ceiling under 441—81.6(16) “d”(3)“1” is 95% of the patient-day-weighted median. The percentage of the difference used to calculate the direct care excess payment allowance is 0%. The percentage of the median used to calculate the direct care excess payment allowance limit is 10% of the patient-day-weighted median. The percentage of the median used to calculate the non-direct care excess payment allowance ceiling under 441—81.6(16) “d”(3)“2” is 96% of the patient-day-weighted median. The percentage of the difference used to calculate the	See subrules 441—81.6(4) and 81.6(14) and paragraph 81.6(16)“f.” The direct care rate component limit under 441—81.6(16)“f”(3) is 120% of the patient-day-weighted median. The non-direct care rate component limit under 441—81.6(16)“f”(3) is 110% of the patient-day-weighted median.

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
	non-direct care excess payment allowance limit is 0%. The percentage of the median used to calculate the non-direct care excess payment allowance limit is 8% of the patient-day-weighted median.	
Occupational therapists	Fee schedule. For members residing in a nursing facility, see 441—paragraph 81.6(11)“r.”	Fee schedule in effect 6/30/13 plus 1%.
Opticians	Fee schedule. Fixed fee for lenses and frames; other optical materials at product acquisition cost	Fee schedule in effect 6/30/13 plus 1%.
Optometrists	Fee schedule. Fixed fee for lenses and frames; other optical materials at product acquisition cost	Fee schedule in effect 6/30/13 plus 1%.
Orthopedic shoe dealers	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.
Pharmaceutical case management	Fee schedule. See 79.1(18)	Refer to 79.1(18).
Pharmacy administration of influenza vaccine to children	Physician fee schedule for immunization administration	Fee schedule in effect 6/30/13 plus 1%.
Physical therapists	Fee schedule. For members residing in a nursing facility, see 441—paragraph 81.6(11)“r.”	Fee schedule in effect 6/30/13 plus 1%.
Physicians (doctors of medicine or osteopathy)	Fee schedule. See 79.1(7)“a”	Fee schedule in effect 6/30/13 plus 1%.
Anesthesia services	Fee schedule. See 79.1(7)“d”	Fee schedule in effect 7/1/17. See 79.1(7)“d.”
Physician-administered drugs	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.
Qualified primary care services	See 79.1(7)“c”	Rate provided by 79.1(7)“c”
Podiatrists	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.
Prescribed drugs	See 79.1(8)	Amount pursuant to 79.1(8).
Psychiatric medical institutions for children:		
1. Inpatient in non-state-owned facilities	Fee schedule	Effective 7/1/14: non-state-owned facilities provider-specific fee schedule in effect.
2. Inpatient in state-owned facilities	Retrospective cost-related	Effective 8/1/11: 100% of actual and allowable cost.
3. Outpatient day treatment	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.
Psychiatric services	Fee schedule	Fee schedule in effect 1/1/16.
Psychologists	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.
Public health agencies	Fee schedule	Fee schedule rate in effect 6/30/13 plus 1%.

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
Rehabilitation agencies	Fee schedule. For members residing in a nursing facility, see 441—paragraph 81.6(11)“r.”	Medicaid fee schedule in effect 6/30/13 plus 1%; refer to 79.1(21).
Remedial services	Retrospective cost-related. See 79.1(23)	110% of average cost less 5%.
Rural health clinics	Retrospective cost-related. See 441—Chapter 73	1. Prospective payment rate as required by the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA 2000) or an alternative methodology allowed thereunder, as specified in “2” below. 2. 100% of reasonable cost as determined by Medicare cost reimbursement principles. 3. In the case of services provided pursuant to a contract between an RHC and a managed care organization (MCO), reimbursement from the MCO shall be supplemented to achieve “1” or “2” above.
Screening centers	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.
Speech-language pathologists	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.
State-operated institutions	Retrospective cost-related	
Subacute mental health facility	Fee schedule	Fee schedule in effect 2/1/18.
Targeted case management providers	Fee schedule	Fee schedule in effect 7/1/18.

**79.1(3) Ambulatory surgical centers.**

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

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

**79.1(4) Durable medical equipment, prosthetic devices, medical supply dealers.** Fees for durable medical appliances, prosthetic devices and medical supplies are developed from several pricing sources and are based on pricing appropriate to the date of service; prices are developed using prior calendar year price information. The average wholesale price from all available sources is averaged to determine the fee for each item. Payment for used equipment will be no more than 80 percent of the purchase allowance. For supplies, equipment, and servicing of standard wheelchairs, standard hospital beds, enteral nutrients, and enteral and parenteral supplies and equipment, the fee for payment shall be the lowest price for which the devices are widely and consistently available in a locality. Reimbursement over an established Medicaid fee schedule amount may be allowed pursuant to the criteria at 441—paragraph 78.10(5)“n.”

**79.1(5) Reimbursement for hospitals.**

*a. Definitions.*

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

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

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

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

“*Blended base amount*” shall mean the case-mix-adjusted, hospital-specific operating cost per discharge associated with treating Medicaid patients, plus the statewide average case-mix-adjusted operating cost per Medicaid discharge, divided by two. This base amount is the value to which payments for inflation and capital costs are added to form a final payment rate. The costs of hospitals receiving reimbursement as critical access hospitals during any of the period included in the base-year cost report shall not be used in determining the statewide average case-mix-adjusted operating cost per Medicaid discharge.

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

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

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

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

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

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

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

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

1. Either provides services predominantly to children under 18 years of age or includes a distinct area or areas that provide services predominantly to children under 18 years of age, and

2. Is a voting member of the National Association of Children's Hospitals and Related Institutions for dates of service prior to October 1, 2014, or a member of the National Association of Children's Hospitals and Related Institutions for dates of service on or after October 1, 2014.

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

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

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

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

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

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

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

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

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

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

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

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

*"Final payment rate"* shall mean the aggregate sum of the two components (the blended base amount and capital costs) that, when added together, form the final dollar value used to calculate each provider's

reimbursement amount when multiplied by the DRG weight. These dollar values are displayed on the rate table listing.

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

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

*“GME/DSH fund implementation year”* means 2009.

*“Graduate medical education and disproportionate share fund”* or *“GME/DSH fund”* means a reimbursement fund developed as an adjunct reimbursement methodology to directly reimburse qualifying hospitals for the direct and indirect costs associated with the operation of graduate medical education programs and the costs associated with the treatment of a disproportionate share of poor, indigent, nonreimbursed or nominally reimbursed patients for inpatient services.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1. Determine the statewide geometric mean charge for all cases classified in each DRG.

2. Compute the statewide aggregate geometric mean charge for each DRG by multiplying the statewide geometric mean charge for each DRG by the total number of cases classified in that DRG.

3. Sum the statewide aggregate geometric mean charges for all DRGs and divide by the total number of cases for all DRGs to determine the weighted average charge for all DRGs.

4. Divide the statewide geometric mean charge for each DRG by the weighted average charge for all DRGs to derive the Iowa-specific weight for each DRG.

5. Normalize the weights so that the average case has a weight of one.

(2) The hospital-specific case-mix index is computed by taking each hospital's trimmed claims that match the hospital's base year cost reporting period, summing the assigned DRG weights associated with those claims and dividing by the total number of Medicaid claims associated with that specific hospital for that period. Case-mix indices are not computed for hospitals receiving reimbursement as critical access hospitals.

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

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

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

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

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

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

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

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

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

*e. Add-ons to the base amount.*

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

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

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

The 50/50 blend is calculated by adding the case-mix-adjusted hospital-specific per discharge capital cost to the statewide average case-mix-adjusted per discharge capital costs and dividing by two. Hospitals whose blended capital add-on exceeds one standard deviation off the mean Medicaid blended capital rate will be subject to a reduction in their capital add-on to equal the first standard deviation.

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

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

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

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

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

(3) Cost outliers. Cases qualify as cost outliers when costs of service in a given case, not including any add-on amounts for direct or indirect medical education or disproportionate share costs exceed the cost threshold. This cost threshold is determined to be the greater of two times the statewide average DRG payment for that case or the hospital's individual DRG payment for that case plus \$75,000. Costs are calculated using hospital-specific cost-to-charge ratios determined in the base-year cost reports. Additional payment for cost outliers is 80 percent of the excess between the hospital's cost for the discharge and the cost threshold established to define cost outliers. Payment of cost outlier amounts shall be paid at 100 percent of the calculated amount and made at the time the claim is paid.

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

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

*g. Billing for patient transfers and readmissions.*

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

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

(3) Physical rehabilitation hospitals or units. When a patient requiring physical rehabilitation is discharged from an acute care hospital and admitted to a rehabilitation hospital or unit certified pursuant to 79.1(5) "r," and the admission is medically appropriate, then payment for time spent in the unit is through a per diem. The discharging hospital will receive 100 percent of the DRG payment. When a patient is discharged from a certified physical rehabilitation hospital or unit and admitted to an acute care hospital, the acute care hospital will receive 100 percent of the DRG payment.

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

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

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

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

(5) Inpatient readmissions within 30 days for same condition. Effective for dates of service on or after July 1, 2015, when an inpatient is discharged or transferred from an acute care hospital and is readmitted as an inpatient to the same hospital within 30 days for the same condition, any claim for the subsequent inpatient stay shall be combined with the claim for the original inpatient stay and payment shall be under a single DRG for both stays. The readmission policy does not apply to the following:

1. Scheduled readmissions that are part of repetitive or periodic treatments; and
2. Critical access hospitals.

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

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

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

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

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

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

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

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

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

*k. Inflation factors, rebasing, and recalibration.*

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

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

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

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

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

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

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

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

(2) Hospitals that qualify for disproportionate share payment based on the definition established by their state's Medicaid agency for the calculation of the Medicaid inpatient utilization rate will be eligible to receive disproportionate share payments according to paragraph 79.1(5) "y," for dates of service prior to October 1, 2014. Out-of-state hospitals do not qualify for disproportionate share payments for dates of service on or after October 1, 2014.

(3) Out-of-state hospitals do not qualify for direct medical education or indirect medical education payments pursuant to paragraph 79.1(5) "y."

*n. Preadmission, preauthorization, or inappropriate services.* Medicaid adopts most Medicare QIO regulations to control increased admissions or reduced services. Exceptions to the Medicare review practice are that the QIO reviews Medicaid short stay outliers and all Medicaid patients readmitted within 31 days. Payment can be denied if either admissions or discharges are performed without medical justification as determined by the QIO. Inpatient or outpatient services which require preadmission or preprocedure approval by the QIO are updated yearly by the department and are listed in the provider manual. Preauthorization for any of these services is transmitted directly from the QIO to the Iowa Medicaid enterprise and no additional information needs to be submitted as part of the claim filing for inpatient or outpatient services. To safeguard against these and other inappropriate practices, the department through the QIO will monitor admission practices and quality of care. If an abuse of the prospective payment system is identified, payments for abusive practices may be reduced or denied. In reducing or denying payment, Medicaid adopts the Medicare QIO regulations.

*o. Hospital billing.* Hospitals shall normally submit claims for DRG reimbursement to the Iowa Medicaid enterprise after a patient's discharge.

(1) Payment for outlier days or costs is determined when the claim is paid by the Iowa Medicaid enterprise, as described in paragraph "f."

(2) When a Medicaid patient requires acute care in the same facility for a period of no less than 120 days, a request for partial payment may be made. Written requests for this interim DRG payment shall be addressed to the Iowa Medicaid Enterprise, Attention: Provider Services Unit, P.O. Box 36450, Des Moines, Iowa 50315. A request for interim payment shall include:

1. The patient's name, state identification number, and date of admission;
2. A brief summary of the case;
3. A current listing of charges; and
4. A physician's attestation that the recipient has been an inpatient for 120 days and is expected to remain in the hospital for a period of no less than 60 additional days.

A departmental representative will then contact the facility to assist the facility in filing the interim claim.

*p. Determination of inpatient admission.* A person is considered to be an inpatient when a formal inpatient admission occurs, when a physician intends to admit a person as an inpatient, or when a physician determines that a person being observed as an outpatient in an observation or holding bed should be admitted to the hospital as an inpatient.

(1) In cases involving outpatient observation status, the determinant of patient status is not the length of time the patient was being observed, but rather that the observation period was medically necessary for the physician to determine whether a patient should be released from the hospital or admitted to the hospital as an inpatient.

(2) Outpatient observation lasting greater than a 24-hour period will be subject to review by the Iowa Medicaid Enterprise (IME) Medical Services Unit to determine the medical necessity of each case. For those outpatient observation cases where medical necessity is not established by the IME, reimbursement shall be denied for the services found to be unnecessary for the provision of that care, such as the use of the observation room.

*q. Inpatient admission after outpatient services.* A patient may be admitted to the hospital as an inpatient after receiving outpatient services. If the patient is admitted as an inpatient within three days of the day outpatient services were rendered, all outpatient services related to the principal diagnosis are considered inpatient services for billing purposes. The day of formal admission as an inpatient is considered as the first day of hospital inpatient services.

*r. Certification for reimbursement as a special unit or physical rehabilitation hospital.* Certification for Medicaid reimbursement as a substance abuse unit under subparagraph 79.1(5)“b”(1), a neonatal intensive care unit under subparagraph 79.1(5)“b”(2), a psychiatric unit under paragraph 79.1(5)“i,” or a physical rehabilitation hospital or unit under paragraph 79.1(5)“i” shall be awarded as provided in this paragraph.

(1) Certification procedure. All hospital special units and physical rehabilitation hospitals must be certified by the Iowa Medicaid enterprise to qualify for Medicaid reimbursement as a special unit or physical rehabilitation hospital. Hospitals shall submit requests for certification to Iowa Medicaid Enterprise, Attention: Provider Services Unit, P.O. Box 36450, Des Moines, Iowa 50315, with documentation that the certification requirements are met. The provider services unit will notify the facility of any additional documentation needed after review of the submitted documentation.

Upon certification, reimbursement as a special unit or physical rehabilitation hospital shall be retroactive to the first day of the month during which the Iowa Medicaid enterprise received the request for certification. No additional retroactive payment adjustment shall be made when a hospital fails to make a timely request for certification.

(2) Certification criteria for substance abuse units. An in-state substance abuse unit may be certified for Medicaid reimbursement under 79.1(5)“b”(1) if the unit’s program is licensed by the Iowa department of public health as a substance abuse treatment program in accordance with Iowa Code chapter 125 and 643—Chapter 3. In addition to documentation of the license, an in-state hospital must submit documentation of the specific substance abuse programs available at the facility with a description of their staffing, treatment standards, and population served.

An out-of-state substance abuse unit may be certified for Medicaid reimbursement under 79.1(5)“b”(1) if it is excluded from the Medicare prospective payment system as a psychiatric unit pursuant to 42 Code of Federal Regulations, Sections 412.25 and 412.27, as amended to September 1, 1994. An out-of-state hospital requesting reimbursement as a substance abuse unit must initially submit a copy of its current Medicare prospective payment system exemption notice, unless the facility had certification for reimbursement as a substance abuse unit before July 1, 1993. All out-of-state hospitals certified for reimbursement for substance abuse units must submit copies of new Medicare prospective payment system exemption notices as they are issued, at least annually.

(3) Certification criteria for neonatal intensive care units. A neonatal intensive care unit may be certified for Medicaid reimbursement under 79.1(5)“b”(2) if it is certified as a level II or level III neonatal unit and the hospital where it is located is accredited by the Joint Commission on Accreditation of Healthcare Organizations or the American Osteopathic Association. The Iowa Medicaid enterprise shall verify the unit’s certification as a level II or level III neonatal unit in accordance with recommendations

set forth by the American Academy of Pediatrics for newborn care. Neonatal units in Iowa shall be certified by the Iowa department of public health pursuant to 641—Chapter 150. Out-of-state units shall submit proof of level II or level III certification.

(4) Certification criteria for psychiatric units. A psychiatric unit may be certified for Medicaid reimbursement under paragraph 79.1(5) “i” if it is excluded from the Medicare prospective payment system as a psychiatric unit pursuant to 42 Code of Federal Regulations, Sections 412.25 and 412.27 as amended to August 1, 2002.

(5) Certification criteria for physical rehabilitation hospitals and units. A physical rehabilitation hospital or unit may be certified for Medicaid reimbursement under 79.1(5) “i” if it receives or qualifies to receive Medicare reimbursement as a rehabilitative hospital or unit pursuant to 42 Code of Federal Regulations, Sections 412.600 through 412.632 (Subpart P), as amended to January 1, 2002, and the hospital is accredited by the Joint Commission on Accreditation of Healthcare Organizations or the American Osteopathic Association.

*s. Health care access assessment inflation factor.* Effective with the implementation of the health care access assessment paid pursuant to 441—Chapter 36, Division III, a health care access assessment inflation factor shall be applied to the Medicaid DRG blended base amount as otherwise calculated pursuant to this subrule for all “participating hospitals” as defined in 441—subrule 36.10(1).

(1) Calculation of inflation factor. The health care access assessment inflation factor for participating hospitals shall be calculated by dividing the amount allowed under the Medicare inpatient upper payment limit for the fiscal year beginning July 1, 2010, by the sum of the projected expenditures for participating hospitals for the fiscal year beginning July 1, 2010, as determined by the fiscal management division of the department, and the amount allowed under the Medicare inpatient upper payment limit.

(2) Implementation date. The health care access assessment inflation factor shall not be applied until federal financial participation to match money collected from the health care access assessment pursuant to 441—Chapter 36, Division III, has been approved by the federal Centers for Medicare and Medicaid Services.

(3) End date. Application of the health care access assessment inflation factor shall terminate if the health care access assessment is terminated pursuant to rule 441—36.12(83GA,SF2388). If federal match money is unavailable for a retroactive period or the authority to collect the assessment is rescinded for a retroactive period, the department shall:

1. Recalculate Medicaid rates in effect during that period without the application of the health care access assessment inflation factor;
2. Recompute Medicaid payments due based on the recalculated Medicaid rates;
3. Recoup any previous overpayments; and
4. Determine for each hospital the amount of health care access assessment collected during that period and refund that amount to the facility.

*t. Limitations and application of limitations on payment.* Diagnosis-related group payments are subject to the upper payment limits as stated in 42 CFR 447.271 and 42 CFR 447.272 as amended to September 5, 2001.

(1) The department may not pay a provider more for inpatient hospital services under Medicaid than the provider’s customary charges to the general public for the services. This limit is applied in the aggregate during the cost settlement process at the end of the hospital’s fiscal year.

(2) Aggregate payments to hospitals and state-operated hospitals may not exceed the amount that can reasonably be estimated would have been paid for those services under Medicare payment principles. This limit is applied to aggregate Medicaid payments at the end of the state’s fiscal year.

*u. State-owned teaching hospital disproportionate share payment.* In addition to payments from the graduate medical education and disproportionate share fund made pursuant to paragraph 79.1(5) “y,” payment shall be made to Iowa hospitals qualifying for the Iowa state-owned teaching hospital disproportionate share fund. Interim monthly payments based on estimated allowable costs will be paid to qualifying hospitals under this paragraph.

(1) Qualifying criteria. A hospital qualifies for Iowa state-owned teaching hospital disproportionate share payments if it qualifies for disproportionate share payments pursuant to paragraph 79.1(5) "y" and is an Iowa state-owned hospital with more than 500 beds and eight or more distinct residency specialty or subspecialty programs recognized by the American College of Graduate Medical Education.

(2) Allocation to fund. The total amount of funding that is allocated on July 1 of each year to the Iowa state-owned teaching hospital disproportionate share fund is \$26,633,430.

(3) Amount of payment. The total amount of disproportionate share payments from the graduate medical education and disproportionate share fund and from the Iowa state-owned teaching hospital disproportionate share fund shall not exceed the amount of the state's allotment under Public Law 102-234. In addition, the total amount of all disproportionate share payments shall not exceed the hospital-specific disproportionate share limits under Public Law 103-666.

(4) Final disproportionate share adjustment. The department's total year-end disproportionate share obligations to a qualifying hospital will be calculated following completion of the desk review or audit of CMS 2552-96, Hospital and Healthcare Complex Cost Report.

v. *Non-state-owned teaching hospital disproportionate share payment.* In addition to payments from the graduate medical education and disproportionate share fund made pursuant to paragraph 79.1(5) "y," payment shall be made to Iowa hospitals qualifying for Iowa non-state-government-owned acute care teaching hospital disproportionate share payments. Interim monthly payments based on estimated allowable costs will be paid to qualifying hospitals under this paragraph.

(1) Qualifying criteria. A hospital qualifies for the Iowa non-state-government-owned acute care teaching hospital disproportionate share payments if it qualifies for disproportionate share payments pursuant to paragraph 79.1(5) "y" and is an Iowa non-state-government-owned acute care teaching hospital located in a county with a population over 350,000.

(2) Amount of payment. The total amount of disproportionate share payments pursuant to paragraph 79.1(5) "y" and the Iowa non-state-government-owned acute care teaching hospital disproportionate share payments shall not exceed the amount of the state's allotment under Public Law 102-234. In addition, the total amount of all disproportionate share payments shall not exceed the hospital-specific disproportionate share limits under Public Law 103-666.

(3) Final disproportionate share adjustment. The department's total year-end disproportionate share obligations to a qualifying hospital will be calculated following completion of the desk review or audit of CMS 2552-96, Hospital and Healthcare Complex Cost Report. The department's total year-end disproportionate share obligation shall not exceed the difference between the following:

1. The annual amount appropriated to the IowaCare account for distribution to publicly owned acute care teaching hospitals located in a county with a population over 350,000; and

2. The actual IowaCare expansion population claims submitted and paid by the Iowa Medicaid enterprise to qualifying hospitals.

w. *Rate adjustments for hospital mergers.* When one or more hospitals merge to form a distinctly different legal entity, the base rate plus applicable add-ons will be revised to reflect this new entity. Financial information from the original cost reports and original rate calculations will be added together and averaged to form the new rate for that entity.

x. For cost reporting periods beginning on or after July 1, 1993, reportable Medicaid administrative and general expenses are allowable only to the extent that they are defined as allowable using Medicare Reimbursement Principles or Health Insurance Reimbursement Manual 15 (HIM-15). Appropriate, reportable costs are those that meet the Medicare (or HIM-15) principles, are reasonable, and are directly related to patient care. In instances where costs are not directly related to patient care or are not in accord with Medicare Principles of Reimbursement, inclusion of those costs in the cost report would not be appropriate. Examples of administrative and general costs that must be related to patient care to be included as a reportable cost in the report are:

- (1) Advertising.
- (2) Promotional items.
- (3) Feasibility studies.
- (4) Administrative travel and entertainment.

- (5) Dues, subscriptions, or membership costs.
- (6) Contributions made to other organizations.
- (7) Home office costs.
- (8) Public relations items.
- (9) Any patient convenience items.
- (10) Management fees for administrative services.
- (11) Luxury employee benefits (i.e., country club dues).
- (12) Motor vehicles for other than patient care.
- (13) Reorganization costs.

y. *Graduate medical education and disproportionate share fund.* Payment shall be made to hospitals in Iowa qualifying for direct medical education, indirect medical education, or disproportionate share payments directly from the graduate medical education and disproportionate share fund. The requirements to receive payments from the fund, the amounts allocated to the fund, and the methodology used to determine the distribution amounts from the fund are as follows:

(1) Qualifying for direct medical education. Iowa hospitals qualify for direct medical education payments if direct medical education costs that qualify for payment as medical education costs under the Medicare program are contained in the hospital's base year cost report and in the most recent cost report submitted before the start of the state fiscal year for which payments are being made. Out-of-state hospitals do not qualify for direct medical education payments.

(2) Allocation to fund for direct medical education. The total state fiscal year annual amount of funding that is allocated to the graduate medical education and disproportionate share fund for direct medical education related to inpatient services is \$7,594,294.03. If a hospital fails to qualify for direct medical education payments from the fund because the hospital does not report direct medical education costs that qualify for payment as medical education costs under the Medicare program in the most recent cost report submitted before the start of the state fiscal year for which payments are being made, the amount of money that would have been paid to that hospital shall be removed from the fund.

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

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

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

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

(4) Qualifying for indirect medical education. Iowa hospitals qualify for indirect medical education payments from the fund when they receive a direct medical education payment from Iowa Medicaid and qualify for indirect medical education payments from Medicare. Qualification for indirect medical education payments is determined without regard to the individual components of the specific hospital's teaching program, state ownership, or bed size. Out-of-state hospitals do not qualify for indirect medical education payments.

(5) Allocation to fund for indirect medical education. The total state fiscal year annual amount of funding that is allocated to the graduate medical education and disproportionate share fund for indirect medical education related to inpatient services is \$13,450,285.14. If a hospital fails to qualify for indirect medical education payments from the fund because the hospital does not report direct medical education costs that qualify for payment as medical education costs under the Medicare program in the most recent cost report submitted before the start of the state fiscal year for which payments are being made, the amount of money that would have been paid to that hospital shall be removed from the fund.

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

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

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

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

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

1. For those hospitals that qualify for disproportionate share under both the low-income utilization rate definition and the Medicaid inpatient utilization rate definition, the disproportionate share percentage shall be the greater of (1) the product of 2½ percent multiplied by the number of standard deviations by which the hospital's own Medicaid inpatient utilization rate exceeds the statewide mean Medicaid inpatient utilization rate for all hospitals, or (2) 2½ percent.

2. For those hospitals that qualify for disproportionate share under the low-income utilization rate definition, but do not qualify under the Medicaid inpatient utilization rate definition, the disproportionate share percentage shall be 2½ percent.

3. For those hospitals that qualify for disproportionate share under the Medicaid inpatient utilization rate definition, but do not qualify under the low-income utilization rate definition, the disproportionate share percentage shall be the product of 2½ percent multiplied by the number of standard deviations by which the hospital's own Medicaid inpatient utilization rate exceeds the statewide mean Medicaid inpatient utilization rate for all hospitals.

4. For those hospitals that qualify for disproportionate share as a children's hospital, the disproportionate share percentage shall be the greater of (1) the product of 2½ percent multiplied by the number of standard deviations by which the Medicaid inpatient utilization rate for children under 18 years of age at the time of admission in all areas of the hospital where services are provided predominantly to children under 18 years of age exceeds the statewide mean Medicaid inpatient utilization rate for all hospitals, or (2) 2½ percent.

5. Additionally, a qualifying hospital other than a children's hospital must also have at least two obstetricians who have staff privileges at the hospital and who have agreed to provide obstetric services to Medicaid-eligible persons who are in need of obstetric services. In the case of a hospital located in a rural area as defined in Section 1886 of the Social Security Act, the term "obstetrician" includes any physician with staff privileges at the hospital to perform nonemergency obstetric procedures.

6. Out-of-state hospitals serving Iowa Medicaid patients qualify for disproportionate share payments from the fund based on their state Medicaid agency's calculation of the Medicaid inpatient utilization rate. The disproportionate share percentage is calculated using the number of standard deviations by which the hospital's own state Medicaid inpatient utilization rate exceeds the hospital's own statewide mean Medicaid inpatient utilization rate.

7. Hospitals qualify for disproportionate share payments from the fund without regard to the facility's status as a teaching facility or bed size.

8. Hospitals receiving reimbursement as critical access hospitals shall not qualify for disproportionate share payments from the fund.

(8) Allocation to fund for disproportionate share. The total state fiscal year annual amount of funding that is allocated to the graduate medical education and disproportionate share fund for disproportionate share payments is \$6,959,868.59. If a hospital fails to qualify for disproportionate share payments from the fund due to closure or for any other reason, the amount of money that would have been paid to that hospital shall be removed from the fund.

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

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

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

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

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

(10) Qualifying for disproportionate share as a children's hospital. A licensed hospital qualifies for disproportionate share payments as a children's hospital if the hospital provides services predominantly to children under 18 years of age or includes a distinct area or areas providing services predominantly to children under 18 years of age and has Medicaid utilization and low-income utilization rates of 1 percent or greater for children under 18 years of age at the time of admission in all distinct areas of the hospital where services are provided predominantly to children under 18 years of age. In addition, the hospital must be a voting member of the National Association of Children's Hospitals and Related Institutions for dates of service prior to October 1, 2014, or a member of the National Association of Children's Hospitals and Related Institutions for dates of service on or after October 1, 2014.

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

1. Base year cost reports.

2. Medicaid claims data for children under the age of 18 at the time of admission to the hospital in all distinct areas of the hospital where services are provided predominantly to children under 18 years of age.

3. Other information needed to determine a disproportionate share rate encompassing the periods used to determine the disproportionate share rate and distribution amounts.

*z. Final settlement for state-owned teaching hospital.*

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

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

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

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

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

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

(1) The base rate upon which the DRG payment is built shall be changed after any retrospective adjustment to reflect, as accurately as is possible, the reasonable costs of providing the covered service to eligible fee-for-service Medicaid members for the coming year using the most recent utilization as submitted to the Iowa Medicaid enterprise provider cost audit and rate setting unit and Medicare cost principles.

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

*ab. Nonpayment for preventable conditions.* Preventable conditions identified pursuant to this rule that develop during inpatient hospital treatment shall not be considered in determining reimbursement for such treatment.

(1) Coding. All diagnoses included on an inpatient hospital claim must include one of the following codes indicating whether the condition was present or developing at the time of the order for inpatient admission:

Present on Admission (POA) Indicator Codes

Code Explanation

- |   |  |
|---|--|
| Y | The condition was present or developing at the time of the order for inpatient admission.  |
| N | The condition was not present or developing at the time of the order for inpatient admission.  |
| U | Documentation is insufficient to determine whether the condition was present or developing at the time of the order for inpatient admission.                                     |
| W | Clinically undetermined. The provider is clinically unable to determine whether or not the condition was present or developing at the time of the order for inpatient admission. |

(2) Payment processing. Claims will be processed according to the DRG methodology without consideration of any diagnosis identified by the Secretary of the United States Department of Health and Human Services pursuant to Section 1886(d)(4)(D)(iv) of the Social Security Act (42 U.S.C. 1395ww(d)(4)(D)(iv)) if the condition was not present or developing at the time of the order for inpatient admission.

*ac. Rural hospital disproportionate share payment.* In addition to payments from the graduate medical education and disproportionate share fund made pursuant to paragraph 79.1(5)"j," payment shall be made to qualifying Iowa hospitals that elect to participate in rural hospital disproportionate share payments. Interim monthly payments will be made based on the amount of state share that is transferred to the department.

(1) Qualifying criteria. A hospital that qualifies for disproportionate share payments pursuant to paragraph 79.1(5)“y” and that is a rural prospective payment hospital not designated as a critical access hospital qualifies for rural hospital disproportionate share payments.

(2) Source of nonfederal share. The required nonfederal share shall be funds generated from tax levy collections of the county or city in which the hospital is located, and is subject to the conditions specified in this subparagraph and applicable federal law and regulations.

1. The nonfederal share funds shall be distributed to the department prior to the issuance of any disproportionate share payment to a qualifying hospital.

2. The city or county providing the nonfederal share funds shall annually document and certify that the funds provided as the nonfederal share were generated from tax proceeds, and not from any other source including federal grants or another federal funding source.

3. The applicable federal matching rate for the fiscal year shall apply.

(3) Amount of payment. The total amount of disproportionate share payments made pursuant to paragraph 79.1(5)“y” and the rural hospital disproportionate share payments shall not exceed the amount of the state’s allotment under Public Law 102-234. In addition, the total amount of all disproportionate share payments shall not exceed the hospital-specific disproportionate share limits under Public Law 103-666.

(4) Final disproportionate share adjustment. Qualifying hospitals shall annually provide a disproportionate share hospital survey within the time frames specified by the department, for the purpose of calculating the hospital-specific disproportionate share limits under Public Law 103-666.

**79.1(6) Independent laboratories.** The maximum payment for clinical diagnostic laboratory tests performed by an independent laboratory will be the areawide fee schedule established by the Centers for Medicare and Medicaid Services (CMS). The fee schedule is based on the definition of laboratory procedures from the Physician’s Current Procedural Terminology (CPT) published by the American Medical Association. The fee schedules are adjusted annually by CMS to reflect changes in the Consumer Price Index for All Urban Consumers.

**79.1(7) Physicians.**

a. *Fee schedule.* The fee schedule is based on the definitions of medical and surgical procedures given in the most recent edition of Physician’s Current Procedural Terminology (CPT). Refer to 441—paragraph 78.1(2)“e” for the guidelines for immunization replacement.

b. *Payment reduction for services rendered in facility settings.* The fee schedule amount paid to physicians based on paragraph 79.1(7)“a” shall be reduced by an adjustment factor, as determined by the department and published with the Iowa Medicaid fee schedule, to reflect the lower cost of providing physician services in a facility setting, as opposed to the physician’s office. For the purpose of this provision, a “facility” place of service (POS) is defined as any of the following (consistent with “POS” definitions under Medicare, per the Medicare Claims Processing Manual, Chapter 12, Section 20.4.2, revised as of May 2017):

- (1) Telehealth (POS 02).
- (2) Outpatient hospital-off campus (POS 19).
- (3) Inpatient hospital (POS 21).
- (4) Outpatient hospital-on campus (POS 22).
- (5) Emergency room-hospital (POS 23).
- (6) Ambulatory surgical center (POS 24).
- (7) Military treatment center (POS 26).
- (8) Skilled nursing facility (POS 31).
- (9) Hospice-for inpatient care (POS 34).
- (10) Ambulance-land (POS 41).
- (11) Ambulance-air or water (POS 42).
- (12) Inpatient psychiatric facility (POS 51).
- (13) Psychiatric facility-partial hospitalization (POS 52).
- (14) Community mental health center (POS 53).
- (15) Psychiatric residential treatment center (POS 56).

(16) Comprehensive inpatient rehabilitation (POS 61).

*c. Payment for primary care services.* To the extent required by 42 U.S.C. § 1396a(a)(13)(C), primary care services furnished in calendar year 2013 or 2014 by a qualified primary care physician or under the supervision of a qualified primary care physician shall be paid as provided pursuant to subparagraphs (1) to (4) and (6) of this paragraph (79.1(7)“c”). Primary care services furnished January 1, 2015, through June 30, 2017, by a qualified primary care physician or under the supervision of a qualified primary care physician shall be paid as provided pursuant to subparagraphs (1) to (3), (5), and (7) of this paragraph (79.1(7)“c”).

(1) Primary care services eligible for payment pursuant to this paragraph (79.1(7)“c”) include:

1. Evaluation and management (E & M) services covered by Iowa Medicaid and designated in the healthcare common procedure coding system (HCPCS) as codes 99201 through 99499, or their successor codes; and

2. Vaccine administration services covered by Iowa Medicaid and designated in the healthcare common procedure coding system (HCPCS) as codes 90460, 90461, 90471, 90472, 90473 and 90474, or their successor codes.

(2) For purposes of this paragraph (79.1(7)“c”), a qualified primary care physician is a physician who:

1. Is certified by the American Board of Medical Specialties (ABMS), the American Board of Physician Specialties (ABPS) or the American Osteopathic Association (AOA) with a specialty designation of family medicine, general internal medicine, or pediatric medicine or with a subspecialty designation recognized by the certifying organization as a subspecialty of family medicine, general internal medicine, or pediatric medicine; or

2. Has furnished primary care services eligible for payment pursuant to this paragraph (79.1(7)“c”) equal to at least 60 percent of the Iowa Medicaid services for which the qualified primary care physician has submitted claims during the most recently completed calendar year or, for newly eligible physicians, the prior month (excluding claims not paid and claims for which Medicare is the primary payer).

(3) For payment to be made under this paragraph (79.1(7)“c”), the qualified primary care physician must have certified that the physician is a qualified primary care physician by submitting Form 470-5138, Iowa Medicaid Primary Care Physician Certification and Attestation for Primary Care Rate Increase, prior to the date of service or by April 1, 2013, for services rendered January 1, 2013, through April 1, 2013.

(4) Primary care services rendered in calendar year 2013 or 2014. Primary care services rendered in calendar year 2013 or 2014 that are eligible for payment pursuant to this rule shall be paid at the greater of:

1. The otherwise applicable Iowa Medicaid rate;

2. The applicable rate under Medicare Part B, in effect for services rendered on the first day of the calendar year;

3. The rate that would be applicable under Medicare Part B, in effect for services rendered on the first day of the calendar year, if the conversion factor under 42 U.S.C. § 1395w-4(d) were the conversion factor for 2009; or

4. If there is no applicable rate under Medicare Part B, the rate specified in a fee schedule established and announced by the federal Centers for Medicare and Medicaid Services, pursuant to 42 CFR § 447.405(a)(1).

(5) Primary care services rendered on or after January 1, 2015. Primary care services rendered on or after January 1, 2015, that are eligible for payment pursuant to this rule shall be paid at the greater of:

1. The otherwise applicable Iowa Medicaid rate;

2. The applicable rate under Medicare Part B in effect for services rendered on January 1, 2014;

3. The rate that would be applicable under Medicare Part B, in effect for services rendered on January 1, 2014, if the conversion factor under 42 U.S.C. § 1395w-4(d) were the conversion factor for 2009; or

4. If there is no applicable rate under Medicare Part B, the rate specified in a fee schedule established and announced by the federal Centers for Medicare and Medicaid Services, pursuant to 42 CFR § 447.405(a)(1), and in effect on June 30, 2014.

(6) Notwithstanding the foregoing provisions of this paragraph (79.1(7)“c”), payment for the administration of vaccines provided under the Vaccines for Children Program in calendar year 2013 or 2014 shall be limited to the lesser of:

1. The regional maximum administration fee under the Vaccines for Children Program; or
2. The applicable Medicare fee schedule rate for HCPCS code 90460 (or, if higher, the Medicare fee schedule rate for HCPCS code 90460 that would apply if the conversion factor under 42 U.S.C. § 1395w-4(d) were the conversion factor for 2009).

(7) Notwithstanding the foregoing provisions of this paragraph (79.1(7)“c”), payment for the administration of vaccines provided under the Vaccines for Children Program on or after January 1, 2015, shall be the lesser of:

1. The regional maximum administration fee under the Vaccines for Children Program in effect on June 30, 2014; or
2. The applicable Medicare fee schedule rate in effect on June 30, 2014, for HCPCS code 90460 (or, if higher, the Medicare fee schedule rate for HCPCS code 90460 rate that would apply if the conversion factor under 42 U.S.C. § 1395w-4(d) were the conversion factor for 2009).

*d. Payment for anesthesia services.* Anesthesia services are paid pursuant to this paragraph and the Iowa Medicaid fee schedule published by the department pursuant to paragraph 79.1(1)“c.” Anesthesia procedures listed in the fee schedule with a factor code of “F” are paid at the dollar amount of the factor listed for the procedure in the fee schedule. Anesthesia procedures listed in the fee schedule with a factor code of “A” are paid a dollar amount equal to the Iowa Medicaid anesthesia conversion factor multiplied by the sum of the minutes of service provided and the factor listed for the procedure in the fee schedule. Beginning July 1, 2017, the Iowa Medicaid anesthesia conversion factor is the current Medicare anesthesia conversion factor for Iowa, converted to a per-minute amount. For 2017, that amount is \$1.40, which will be updated annually on January 1.

**79.1(8) Drugs.**

*a.* Except as provided below in paragraphs 79.1(8)“d” through “i,” all providers are reimbursed for covered drugs as follows:

(1) Reimbursement for covered generic prescription drugs and for covered nonprescription drugs shall be the lowest of the following, as of the date of dispensing:

1. The average state actual acquisition cost (AAC), determined pursuant to paragraph 79.1(8)“b,” plus the professional dispensing fee determined pursuant to paragraph 79.1(8)“c.”
2. The federal upper limit (FUL), defined as the upper limit for a multiple source drug established in accordance with the methodology of the Centers for Medicare and Medicaid Services as described in 42 CFR 447.514(a)-(c), plus the professional dispensing fee determined pursuant to paragraph 79.1(8)“c.”
3. The total submitted charge.
4. Providers’ usual and customary charge to the general public.

(2) Reimbursement for covered brand-name prescription drugs shall be the lowest of the following, as of the date of dispensing:

1. The average state AAC, determined pursuant to paragraph 79.1(8)“b,” plus the professional dispensing fee determined pursuant to paragraph 79.1(8)“c.”
2. The total submitted charge.
3. Providers’ usual and customary charge to the general public.

*b.* For purposes of this subrule, average state AAC is defined as retail pharmacies’ average prices paid to acquire drug products. Average state AAC shall be determined by the department based on a survey of invoice prices paid by Iowa Medicaid retail pharmacies. Surveys shall be conducted at least once every six months, or more often at the department’s discretion. The average state AAC shall be calculated as a statistical mean based on one reported cost per drug per pharmacy. The average state AAC determined by the department shall be published on the Iowa Medicaid enterprise website. If no current

average state AAC has been determined for a drug, the wholesale acquisition cost (WAC) published by Medi-Span shall be used as the average state AAC.

*c.* For purposes of this subrule, the professional dispensing fee shall be a fee schedule amount determined by the department based on a survey of Iowa Medicaid participating pharmacy providers' costs of dispensing drugs to Medicaid beneficiaries. The survey shall be conducted every two years beginning in state fiscal year 2014-2015.

*d.* For an oral solid dispensed to a patient in a nursing home in unit dose packaging prepared by the pharmacist, an additional one cent per dose shall be added to reimbursement based on acquisition cost or FUL.

*e.* 340B-purchased drugs.

(1) Notwithstanding paragraph 79.1(8)“*a*” above, reimbursement to a covered entity as defined in 42 U.S.C. 256b(a)(4) for covered outpatient drugs acquired by the entity through the 340B drug pricing program will be the lowest of:

1. The submitted 340B covered entity actual acquisition cost (not to exceed the 340B ceiling price) plus the professional dispensing fee pursuant to paragraph 79.1(8)“*c*”;

2. The average state AAC determined pursuant to paragraph 79.1(8)“*b*” plus the professional dispensing fee pursuant to paragraph 79.1(8)“*c*”;

3. For generic prescription drugs and nonprescription drugs only, the FUL pursuant to 79.1(8)“*a*”(1)“2” plus the professional dispensing fee pursuant to paragraph 79.1(8)“*c*”;

4. The total submitted charge; or

5. Providers' usual and customary charge to the general public.

(2) Reimbursement for covered outpatient drugs to a 340B contract pharmacy, under contract with a covered entity described in 42 U.S.C. 256b(a)(4), will be according to paragraph 79.1(8)“*a*” because covered outpatient drugs purchased through the 340B drug pricing program cannot be billed to Medicaid by a 340B contract pharmacy.

*f.* Federal supply schedule (FSS) drugs. Notwithstanding paragraph 79.1(8)“*a*” above, reimbursement for drugs acquired by a provider through the FSS program managed by the federal General Services Administration will be the lowest of:

(1) The provider's actual acquisition cost, not to exceed the FSS price, plus the professional dispensing fee pursuant to paragraph 79.1(8)“*c*”;

(2) The average state AAC determined pursuant to paragraph 79.1(8)“*b*” plus the professional dispensing fee pursuant to paragraph 79.1(8)“*c*”;

(3) For generic prescription drugs and nonprescription drugs only, the FUL pursuant to 79.1(8)“*a*”(1)“2” plus the professional dispensing fee pursuant to paragraph 79.1(8)“*c*”;

(4) The total submitted charge; or

(5) Providers' usual and customary charge to the general public.

*g.* Nominal-price drugs. Notwithstanding paragraph 79.1(8)“*a*” above, reimbursement for drugs acquired by providers at nominal prices and excluded from the calculation of the drug's “best price” pursuant to 42 CFR 447.508 will be the lowest of:

(1) The provider's actual acquisition cost (not to exceed the nominal price paid) plus the professional dispensing fee pursuant to paragraph 79.1(8)“*c*”;

(2) The average state AAC determined pursuant to paragraph 79.1(8)“*b*” plus the professional dispensing fee pursuant to paragraph 79.1(8)“*c*”;

(3) For generic prescription drugs and nonprescription drugs only, the FUL pursuant to 79.1(8)“*a*”(1)“2” plus the professional dispensing fee pursuant to paragraph 79.1(8)“*c*”;

(4) The total submitted charge; or

(5) Providers' usual and customary charge to the general public.

*h.* Indian health facilities enrolled pursuant to rule 441—77.45(249A). For all drugs provided to American Indians or Alaskan natives by Indian health facilities enrolled pursuant to rule 441—77.45(249A), reimbursement is one pharmacy encounter payment per date of service, notwithstanding paragraphs 79.1(8)“*a*” through “*f*.” The pharmacy encounter rate is the current “outpatient per visit rate (excluding Medicare)” approved by the U.S. Indian Health Service (IHS) for

services provided by IHS facilities to Medicaid beneficiaries, as published in the Federal Register, and includes reimbursement for the dispensing fees, ingredient cost, and any necessary counseling by the pharmacist.

*i.* Vaccines for Children Program. All providers administering vaccines available through the Vaccines for Children Program to Medicaid members shall enroll in the Vaccines for Children Program. In lieu of payment, vaccines available through the Vaccines for Children Program shall be accessed from the department of public health for Medicaid members. Providers may receive Medicaid reimbursement for the administration of vaccines to Medicaid members through the otherwise applicable reimbursement for inpatient or outpatient services.

*j.* Physician-administered drugs. Notwithstanding paragraphs 79.1(8) “a” through “f,” payment to physicians for physician-administered drugs billed with healthcare common procedure coding system (HCPCS) Level II “J” codes, as a physician service, shall be pursuant to the physician payment policy under subrule 79.1(2).

*k.* Under this subrule, no payment shall be made for sales tax.

*l.* For purposes of this subrule, the Medicaid program relies on information published by Medi-Span to classify drugs as brand-name or generic.

**79.1(9)** *HCBS consumer choices financial management.* Rescinded IAB 5/8/19, effective 7/1/19.

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

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

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

be the lowest charge levels determined by the department according to the Medicare reimbursement method.

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

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

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

*a.* The member shall pay a copayment of \$1 for each covered prescription or refill of any covered drug.

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

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

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

(1) Total covered service rendered on a given date for dental services and hearing aids.

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

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

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

*g.* Copayment charges are not applicable for a member receiving inpatient care in a hospital, nursing facility, state mental health institution, or other medical institution if the person is required, as a condition of receiving services in the institution, to spend for costs of necessary medical care all but a minimal amount of income for personal needs.

*h.* The member shall pay \$1 for each federal Medicare Part B crossover claim submitted to the Medicaid program when the services provided have a Medicaid copayment as set forth above.

*i.* Copayment charges are not applicable to services furnished pregnant women.

*j.* All providers are prohibited from offering or providing copayment related discounts, rebates, or similar incentives for the purpose of soliciting the patronage of Medicaid members.

*k.* Copayment charges are not applicable for emergency services. Emergency services are defined as services provided in a hospital, clinic, office, or other facility that is equipped to furnish the required care, after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain), that the absence of immediate medical attention could reasonably be expected to result in:

(1) Placing the patient's health in serious jeopardy,

(2) Serious impairment to bodily functions, or

(3) Serious dysfunction of any bodily organ or part.

*l.* Copayment charges are not applicable for services rendered by a health maintenance organization in which the member is enrolled.

*m.* No provider of service participating in the Medicaid program may deny care or services to a person eligible for care or services under the program because of the person's inability to pay a copayment. However, this rule does not change the fact that a member is liable for the charges and it does not preclude the provider from attempting to collect them.

*n.* The member shall pay a \$3 copayment for each visit to a hospital emergency room for treatment that does not meet the criteria for an emergency service as defined in paragraph 79.1(13)“*k.*” This \$3 copayment shall not apply if the visit to the emergency room results in a hospital admission.

**79.1(14) Reimbursement for hospice services.**

*a.* Medicaid hospice rates. The Medicaid hospice rates are based on the methodology used in setting Medicare rates, adjusted to disregard cost offsets attributable to Medicare coinsurance amounts, and with application of the appropriate area wage adjustments for the categories of care provided.

Hospices are reimbursed at one of four predetermined rates based on the level of care furnished to the individual for that day. Payments to a hospice for inpatient care are subject to the limitations imposed by Medicare. The levels of care into which each day of care is classified are as follows:

- (1) Routine home care.
- (2) Continuous home care.
- (3) Inpatient respite care.
- (4) General inpatient care.

*b.* Adjustment to hospice rates. An adjustment to hospice reimbursement is made when a recipient residing in a nursing facility elects the hospice benefit. The adjustment will be a room and board rate that is equal to the rate at which the facility is paid for reserved bed days or 95 percent of the facility’s Medicaid reimbursement rate, whichever is greater. Room and board services include the performance of personal care services, including assistance in activities of daily living, socializing activities, administration of medication, maintaining the cleanliness of a resident’s room and supervising and assisting in the use of durable medical equipment and prescribed therapies.

For hospice recipients entering a nursing facility the adjustment will be effective the date of entry. For persons in nursing facilities prior to hospice election, the adjustment rate shall be effective the date of election.

For individuals who have client participation amounts attributable to their cost of care, the adjustment to the hospice will be reduced by the amount of client participation as determined by the department. The hospice will be responsible for collecting the client participation amount due the hospice unless the hospice and the nursing facility jointly determine the nursing facility is to collect the client participation.

*c.* Payment for day of discharge. For the day of discharge from an inpatient unit, the appropriate home care rate is to be paid unless the recipient dies as an inpatient. When the recipient is discharged as deceased, the inpatient rate (general or respite) is to be paid for the discharge date.

*d.* Hospice cap. Overall aggregate payments made to a hospice during a hospice cap period are limited or capped. The hospice cap year begins November 1 and ends October 31 of the next year. The cap amount for each hospice is calculated by multiplying the number of beneficiaries electing hospice care from that hospice during the cap period by the base statutory amount, adjusted to reflect the percentage increase or decrease in the medical care expenditure category of the Consumer Price Index for all urban consumers published by the Bureau of Labor Statistics. Payments made to a hospice but not included in the cap include room and board payment to a nursing home. Any payment in excess of the cap must be refunded to the department by the hospice.

*e.* Limitation of payments for inpatient care. Payments to a hospice for inpatient care shall be limited according to the number of days of inpatient care furnished to Medicaid patients. During the 12-month period beginning November 1 of each year and ending October 31, the aggregate number of inpatient days (both for general inpatient care and inpatient respite care) shall not exceed 20 percent of the aggregate total number of days of hospice care provided to all Medicaid recipients during that same period. Medicaid recipients afflicted with acquired immunodeficiency syndrome (AIDS) are excluded in calculating this inpatient care limitation. This limitation is applied once each year, at the end of the hospices’ “cap period” (November 1 to October 31). For purposes of this computation, if it is determined that the inpatient rate should not be paid, any days for which the hospice receives payment at a home care rate will not be counted as inpatient days. The limitation is calculated as follows:

(1) The maximum allowable number of inpatient days will be calculated by multiplying the total number of days of Medicaid hospice care by 0.2.

(2) If the total number of days of inpatient care furnished to Medicaid hospice patients is less than or equal to the maximum, no adjustment will be necessary.

(3) If the total number of days of inpatient care exceeded the maximum allowable number, the limitation will be determined by:

1. Calculating a ratio of the maximum allowable days to the number of actual days of inpatient care, and multiplying this ratio by the total reimbursement for inpatient care (general inpatient and inpatient respite reimbursement) that was made.

2. Multiplying excess inpatient care days by the routine home care rate.

3. Adding together the amounts calculated in “1” and “2.”

4. Comparing the amount in “3” with interim payments made to the hospice for inpatient care during the “cap period.”

Any excess reimbursement shall be refunded by the hospice.

f. Location of services. Claims must identify the geographic location where the service is provided (as distinct from the location of the hospice).

**79.1(15) HCBS retrospectively limited prospective rates.** This methodology applies to reimbursement for HCBS brain injury waiver supported community living; HCBS intellectual disability waiver supported community living for 15-minute services; HCBS family and community support services; and HCBS interim medical monitoring and treatment when provided by an HCBS-certified supported community agency.

a. *Reporting requirements.*

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

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

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

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

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

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

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

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

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

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

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

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

- (4) Mileage costs shall be reimbursed according to state employee rate.
- (5) Consumer transportation, consumer consulting, consumer instruction, consumer environmental modification and repairs and consumer environmental furnishings shall not exceed \$1,570 per consumer per year for supported community living services in the brain injury waiver.
- (6) For respite care provided in the consumer's home, only the cost of care is reimbursed.
- (7) For respite care provided outside the consumer's home, charges may include room and board.
- (8) Transportation and therapeutic resources reimbursement shall not exceed \$1,500 per child per year for family and community support services.
- (9) The reasonable costs of direct care staff training shall be treated as direct care costs, rather than as indirect administrative costs.

*c. Prospective rates for new providers.*

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

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

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

*d. Prospective rates for established providers.*

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

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

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

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

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

*e. Prospective rates for respite. Rescinded IAB 5/1/13, effective 7/1/13.*

*f. Retrospective adjustments.*

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

(2) For services provided from July 1, 2015, through June 30, 2016, revenues exceeding adjusted actual costs by more than 4.5 percent shall be remitted to the department. Payment will be due upon notice of the new rates and retrospective rate adjustment.

(3) For services provided from July 1, 2015, through June 30, 2016, providers who do not reimburse revenues exceeding 104.5 percent of actual costs 30 days after notice is given by the department will have the revenues over 104.5 percent of the actual costs deducted from future payments.

(4) For services provided on or after July 1, 2016, revenues exceeding adjusted actual costs by more than 5.5 percent shall be remitted to the department. Payment will be due upon notice of the new rates and retrospective rate adjustment.

(5) For services provided on or after July 1, 2016, providers who do not reimburse revenues exceeding 105.5 percent of actual costs 30 days after notice is given by the department will have the revenues over 105.5 percent of the actual costs deducted from future payments.

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

**79.1(16) Outpatient reimbursement for hospitals.**

*a. Definitions.*

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

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

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

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

*"APC service"* means a service that is priced and paid using the APC system.

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

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

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

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

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

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

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

*"Direct medical education rate"* shall mean a rate calculated for a hospital reporting medical education costs on the Medicare cost report (CMS 2552). The rate is calculated using the following

formula: Direct medical education costs are multiplied by the percentage of valid claims to total claims, further multiplied by inflation factors, then divided by outpatient visits.

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

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

“*GME/DSH fund implementation year*” means 2009.

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

“*Healthcare common procedures coding system*” or “*HCPCS*” means the national uniform coding method that is maintained by the Centers for Medicare and Medicaid Services (CMS) and that incorporates the American Medical Association publication Physicians Current Procedural Terminology (CPT) and the three HCPCS unique coding levels I, II, and III.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

“*Status indicator*” or “*SI*” means a payment indicator that identifies whether a service represented by a CPT or HCPCS code is payable under the OPSS APC or another payment system. Only one status indicator is assigned to each CPT or HCPCS code.

*b. Outpatient hospital services.* Medicaid adopts the Medicare categories of hospitals and services subject to and excluded from the hospital outpatient prospective payment system (OPSS) at 42 CFR 419.20 through 419.22 as amended to October 1, 2007, except as indicated in this subrule.

(1) A teaching hospital that has approval from the Centers for Medicare and Medicaid Services to receive reasonable cost reimbursement for physician services under 42 CFR 415.160 through 415.162 as amended to October 1, 2007, is eligible for combined billing status if the hospital has filed the approval notice with the Iowa Medicaid enterprise provider cost audit and rate setting unit. If a teaching hospital elects to receive reasonable cost payment for physician direct medical and surgical services furnished to Medicaid members, those services and the supervision of interns and residents furnishing the care to members are covered as hospital services and are combined with the bill for hospital service. Cost settlement for the reasonable costs related to physician direct medical and surgical services shall be made after receipt of the hospital’s financial and statistical report.

(2) A hospital-based ambulance service must be an enrolled Medicaid ambulance provider and must bill separately for ambulance services. EXCEPTION: If the member’s condition results in an inpatient admission to the hospital, the reimbursement for ambulance services is included in the hospital’s DRG reimbursement rate for the inpatient services.

*c. Payment for outpatient hospital services.*

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

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

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

(3) The APC payment is calculated as follows:

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

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

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

Indicator	Item, Code, or Service	OPPS Payment Status
F	Certified registered nurse anesthetist services Corneal tissue acquisition Hepatitis B vaccines	If covered by Iowa Medicaid, the item or service is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)“c.”  If not covered by Iowa Medicaid, the item or service is not paid under OPPS APC or any other Medicaid payment system.
G	Pass-through drugs and biologicals	If covered by Iowa Medicaid, the item is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)“c.”  If not covered by Iowa Medicaid, the item is not paid under OPPS APC or any other Medicaid payment system.
H	Pass-through device categories	If covered by Iowa Medicaid, the device is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)“c.”  If not covered by Iowa Medicaid, the device is not paid under OPPS APC or any other Medicaid payment system.
K	Non-pass-through drugs and biologicals Therapeutic radiopharmaceuticals	If covered by Iowa Medicaid, the item is: <ul style="list-style-type: none"> <li>● Paid under OPPS APC with a separate APC payment when both an APC and an APC weight are established.</li> <li>● Paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)“c” when either no APC or APC weight is established.</li> </ul> If not covered by Iowa Medicaid, the item is not paid under OPPS APC or any other Medicaid payment system.
L	Influenza vaccine Pneumococcal pneumonia vaccine	If covered by Iowa Medicaid, the vaccine is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)“c.”  If not covered by Iowa Medicaid, the vaccine is not paid under OPPS APC or any other Medicaid payment system.
M	Items and services not billable to the Medicare fiscal intermediary	If covered by Iowa Medicaid, the item or service is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)“c.”  If not covered by Iowa Medicaid, the item or service is not paid under OPPS APC or any other Medicaid payment system.

Indicator	Item, Code, or Service	OPPS Payment Status
N	Packaged services not subject to separate payment under Medicare OPPS payment criteria	Paid under OPPS APC. Payment, including outliers, is included with payment for other services; therefore, no separate payment is made.
P	Partial hospitalization	Not a covered service under Iowa Medicaid.
Q1	STVX-packaged codes	Paid under OPPS APC. <ul style="list-style-type: none"> <li>● Packaged APC payment if billed on the same date of service as HCPCS code assigned status indicator “S,” “T,” “V,” or “X.”</li> <li>● In all other circumstances, payment is made through a separate APC payment.</li> </ul>
Q2	T-packaged codes	Paid under OPPS APC. <ul style="list-style-type: none"> <li>● Packaged APC payment if billed on the same date of service as HCPCS code assigned status indicator “T.”</li> <li>● In all other circumstances, payment is made through a separate APC payment.</li> </ul>
Q3	Codes that may be paid through a composite APC	If covered by Iowa Medicaid, the code is paid under OPPS APC with separate APC payment.  If not covered by Iowa Medicaid, the code is not paid under OPPS APC or any other Medicaid payment system.
R	Blood and blood products	If covered by Iowa Medicaid, the item is paid under OPPS APC with separate APC payment.  If not covered by Iowa Medicaid, the item is not paid under OPPS APC or any other Medicaid payment system.
S	Significant procedure, not discounted when multiple	If covered by Iowa Medicaid, the procedure is paid under OPPS APC with separate APC payment.  If not covered by Iowa Medicaid, the procedure is not paid under OPPS APC or any other Medicaid payment system.
T	Significant procedure, multiple reduction applies	If covered by Iowa Medicaid, the procedure is paid under OPPS APC with separate APC payment subject to multiple reduction.  If not covered by Iowa Medicaid, the procedure is not paid under OPPS APC or any other Medicaid payment system.
U	Brachytherapy sources	If covered by Iowa Medicaid, the procedure is paid under OPPS APC with separate APC payment.  If not covered by Iowa Medicaid, the procedure is not paid under OPPS APC or any other Medicaid payment system.

Indicator	Item, Code, or Service	OPPS Payment Status
V	Clinic or emergency department visit	<p>If covered by Iowa Medicaid, the service is paid under OPPS APC with separate APC payment, subject to limits on nonemergency services provided in an emergency room pursuant to 79.1(16)“r.”</p> <p>If not covered by Iowa Medicaid, the service is not paid under OPPS APC or any other Medicaid payment system.</p>
X	Ancillary services	<p>If covered by Iowa Medicaid, the service is paid under OPPS APC with separate APC payment.</p> <p>If not covered by Iowa Medicaid, the service is not paid under OPPS APC or any other Medicaid payment system.</p>
Y	Nonimplantable durable medical equipment	<p>For items covered by Iowa Medicaid as an outpatient hospital service, the item is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)“c.”</p> <p>For items not covered by Iowa Medicaid as an outpatient hospital service, the item is not paid as an outpatient hospital service, but may be paid by Iowa Medicaid under the specific rate or methodology established by other rules (other than outpatient hospital).</p>

*d. Calculation of case-mix indices.* Hospital-specific and statewide case-mix indices shall be calculated using the Medicaid claim set.

(1) Hospital-specific case-mix indices are calculated by summing the relative weights for each APC service at that hospital and dividing the total by the number of APC services for that hospital.

(2) The statewide case-mix index is calculated by summing the relative weights for each APC service for all claims and dividing the total by the statewide total number of APC services. Claims for hospitals receiving reimbursement as critical access hospitals during any of the period included in the base-year cost report are not used in calculating the statewide case-mix index.

*e. Calculation of the hospital-specific base APC rates.*

(1) Using the hospital’s base-year cost report, hospital-specific outpatient cost-to-charge ratios are calculated for each ancillary and outpatient cost center of the Medicare cost report, Form CMS 2552-96.

(2) The cost-to-charge ratios are applied to each line item charge reported on claims from the Medicaid claim set to calculate the Medicaid cost per service. The hospital’s total outpatient Medicaid cost is the sum of the Medicaid cost per service for all line items.

(3) The following items are subtracted from the hospital’s total outpatient Medicaid costs:

1. The total calculated Medicaid direct medical education cost for interns and residents based on the hospital’s base-year cost report.

2. The total calculated Medicaid cost for services listed at 441—subrule 78.31(1), paragraphs “g” to “n.”

3. The total calculated Medicaid cost for ambulance services.

4. The total calculated Medicaid cost for services paid based on the Iowa Medicaid fee schedule.

(4) The remaining amount is multiplied by a factor to limit aggregate expenditures to available funding, divided by the hospital-specific case-mix index, and then divided by the total number of APC services for that hospital from the Medicaid claim set.

(5) Hospital-specific base APC rates are not computed for hospitals receiving reimbursement as critical access hospitals during any of the period included in the base-year cost report.

*f. Calculation of statewide base APC rate.*

(1) The statewide average base APC rate is calculated by summing the outpatient Medicaid cost for all hospitals and subtracting the following:

1. The total calculated Medicaid direct medical education cost for interns and residents for all hospitals.
2. The total calculated Medicaid cost for services listed at 441—subrule 78.31(1), paragraphs “g” to “n,” for all hospitals.
3. The total calculated Medicaid cost for ambulance services for all hospitals.
4. The total calculated Medicaid cost for services paid based on the Iowa Medicaid fee schedule for all hospitals.

(2) The resulting amount is multiplied by a factor to limit aggregate expenditures to available funding, divided by the statewide case-mix index, and then divided by the statewide total number of APC services from the Medicaid claim set.

(3) Data for hospitals receiving reimbursement as critical access hospitals during any of the period included in the base-year cost report is not used in calculating the statewide average base APC rate.

*g. Cost outlier payment policy.* Additional payment is made for services provided during a single visit that exceed the following Medicaid criteria of cost outliers for each APC. Outlier payments are determined on an APC-by-APC basis.

(1) An APC qualifies as a cost outlier when the cost of the service exceeds both the multiple threshold and the fixed-dollar threshold.

(2) The multiple threshold is met when the cost of furnishing an APC service exceeds 1.75 times the APC payment amount.

(3) The fixed-dollar threshold is met when the cost of furnishing an APC service exceeds the APC payment amount plus \$2,000.

(4) If both the multiple threshold and the fixed-dollar threshold are met, the outlier payment is calculated as 50 percent of the amount by which the hospital’s cost of furnishing the APC service or procedure exceeds the multiple threshold.

(5) The cost of furnishing the APC service or procedure is calculated using a single overall hospital-specific cost-to-charge ratio determined from the base-year cost report. Costs appearing on a claim that are attributable to packaged APC services for which no separate payment is made are allocated to all nonpackaged APC services that appear on that claim. The amount allocated to each nonpackaged APC service is based on the proportion the APC payment rate for that APC service bears to the total APC rates for all nonpackaged APC services on the claim.

*h. Payment to critical access hospitals.* Initial, interim payments to critical access hospitals as defined in paragraph 79.1(5)“a” shall be the hospital’s line-item charge multiplied by the hospital’s Medicaid outpatient cost-to-charge ratio. These interim payments are subject to annual retrospective adjustment equal to the difference between the reasonable costs of covered services provided to eligible fee-for-service Medicaid members (excluding members in managed care) and the Medicaid reimbursement received. The department shall determine the reasonable costs of services based on the hospital’s annual cost reports and Medicare cost principles. When the interim amounts paid exceed reasonable costs, the department shall recover the difference.

(1) After any retrospective adjustment, the department shall update the cost-to-charge ratio to reflect as accurately as is possible the reasonable costs of providing the covered service to eligible fee-for-service Medicaid members for the coming year. The department shall base these changes on the most recent utilization as submitted to the Iowa Medicaid enterprise provider cost audit and rate setting unit and Medicare cost principles.

(2) Once a hospital begins receiving reimbursement as a critical access hospital, the cost-to-charge ratio is not subject to rebasing as provided in paragraph 79.1(16)“j.”

*i. Cost-reporting requirements.* Hospitals shall prepare annual cost reports in accordance with generally accepted accounting principles as defined by the American Institute of Certified Public Accountants and in accordance with Medicare Provider Reimbursement Manual, CMS Publication 15, subject to the exceptions and limitations provided in this rule.

- (1) Using electronic media, each hospital shall submit the following:

1. The hospital's Medicare cost report (Form CMS 2552-96, Hospitals and Healthcare Complex Cost Report);

2. Either Form 470-4515, Critical Access Hospital Supplemental Cost Report, or Form 470-4514, Hospital Supplemental Cost Report; and

3. A copy of the revenue code crosswalk used to prepare the Medicare cost report.

- (2) The cost reports and supporting documentation shall be sent to the Iowa Medicaid Enterprise, Provider Cost Audit and Rate Setting Unit, 100 Army Post Road, P.O. Box 36450, Des Moines, Iowa 50315.

- (3) The cost reports shall be submitted on or before the last day of the fifth calendar month following the close of the period covered by the report. For fiscal periods ending on a day other than the last day of the month, cost reports are due 150 days after the last day of the cost-reporting period. Extensions of the due date for filing a cost report granted by the Medicare fiscal intermediary shall be accepted by Iowa Medicaid.

*j. Rebasing.*

- (1) Effective January 1, 2009, and annually thereafter, the department shall update the OPPS APC relative weights using the most current calendar update as published by the Centers for Medicare and Medicaid Services.

- (2) Effective January 1, 2009, and every three years thereafter, blended base APC rates shall be rebased. Cost reports used in rebasing shall be the hospital fiscal year-end Form CMS 2552-96, Hospital and Healthcare Complex Cost Report, as submitted to Medicare in accordance with Medicare cost report submission time lines for the hospital fiscal year ending during the preceding calendar year. If a hospital does not provide this cost report, including the Medicaid cost report and revenue code crosswalk, to the Iowa Medicaid enterprise provider cost audit and rate setting unit by May 31 of a year in which rebasing occurs, the most recent submitted cost report will be used.

- (3) Effective January 1, 2009, and every three years thereafter, case-mix indices shall be recalculated using valid claims most nearly matching each hospital's fiscal year end.

- (4) The graduate medical education and disproportionate share fund shall be updated as provided in subparagraph 79.1(16) "v"(3).

*k. Payment to out-of-state hospitals.* Out-of-state hospitals providing care to members of Iowa's Medicaid program shall be reimbursed in the same manner as Iowa hospitals, except as provided in subparagraphs (1) and (2).

- (1) For out-of-state hospitals that submit a cost report no later than May 31 in the most recent rebasing year, APC payment amounts will be based on the blended base APC rate using hospital-specific, Iowa-only Medicaid data. For other out-of-state hospitals, APC payment amounts will be based on the Iowa statewide base APC rate.

- (2) Out-of-state hospitals do not qualify for direct medical education payments pursuant to paragraph 79.1(16) "v."

*l. Preadmission, preauthorization or inappropriate services.* Inpatient or outpatient services that require preadmission or preprocedure approval by the quality improvement organization (QIO) are updated yearly and are available from the QIO.

- (1) The hospital shall provide the QIO authorization number on the claim form to receive payment. Claims for services requiring preadmission or preprocedure approval that are submitted without this authorization number will be denied.

- (2) To safeguard against other inappropriate practices, the department, through the QIO, will monitor admission practices and quality of care. If an abuse of the prospective payment system is identified, payments for abusive practices may be reduced or denied. In reducing or denying payment, Medicaid adopts the Medicare QIO regulations.

*m. Health care access assessment inflation factor.* Effective with the implementation of the health care access assessment paid pursuant to 441—Chapter 36, Division III, a health care access assessment inflation factor shall be applied to the Medicaid blended base APC rate as otherwise calculated pursuant to this subrule for all "participating hospitals" as defined in 441—subrule 36.10(1).

(1) Calculation of inflation factor. The health care access assessment inflation factor for participating hospitals shall be calculated by dividing the amount allowed under the Medicare outpatient upper payment limit for the fiscal year beginning July 1, 2010, by the sum of the projected expenditures for participating hospitals for the fiscal year beginning July 1, 2010, as determined by the fiscal management division of the department, and the amount allowed under the Medicare outpatient upper payment limit.

(2) Implementation date. The health care access assessment inflation factor shall not be implemented until federal financial participation to match money collected from the health care access assessment pursuant to 441—Chapter 36, Division III, has been approved by the federal Centers for Medicare and Medicaid Services.

(3) End date. Application of the health care access assessment inflation factor shall terminate if the health care access assessment is terminated pursuant to rule 441—36.12(83GA,SF2388). If federal match money is unavailable for a retroactive period or the authority to collect the assessment is rescinded for a retroactive period, the department shall:

1. Recalculate Medicaid rates in effect during that period without the application of the health care access assessment inflation factor;
2. Recompute Medicaid payments due based on the recalculated Medicaid rates;
3. Recoup any previous overpayments; and
4. Determine for each hospital the amount of health care access assessment collected during that period and refund that amount to the facility.

*n. Determination of inpatient admission.* A person is considered to be an inpatient when a formal inpatient admission occurs, when a physician intends to admit a person as an inpatient, or when a physician determines that a person being observed as an outpatient in an observation or holding bed should be admitted to the hospital as an inpatient. In cases involving outpatient observation status, the determinant of patient status is not the length of time the patient was being observed, rather whether the observation period was medically necessary to determine whether a patient should be admitted to the hospital as an inpatient. Outpatient observation lasting greater than a 24-hour period will be subject to review by the QIO to determine the medical necessity of each case. For those outpatient observation cases where medical necessity is not established, reimbursement shall be denied for the services found to be unnecessary for the provision of that care, such as the use of the observation room.

*o. Inpatient admission after outpatient services.* If a patient is admitted as an inpatient within three days of the day in which outpatient services were rendered, all outpatient services related to the principal diagnosis are considered inpatient services for billing purposes. The day of formal admission as an inpatient is considered as the first day of hospital inpatient services. EXCEPTION: This requirement does not apply to critical access hospitals.

*p. Cost report adjustments.* Rescinded IAB 6/11/03, effective 7/16/03.

*q. Determination of payment amounts for mental health noninpatient (NIP) services.* Mental health NIP services are limited as set forth at 441—subparagraph 78.31(4)“d”(7) and are reimbursed on a fee schedule basis. Mental health NIP services are the responsibility of the managed mental health care and substance abuse (Iowa Plan) contractor for persons eligible for managed mental health care.

*r. Services delivered in the emergency room.* Payment to a hospital for assessment of any Medicaid member in an emergency room shall be made pursuant to fee schedule. Payment for treatment of a Medicaid member in an emergency room shall be made as follows:

(1) If the emergency room visit results in an inpatient hospital admission, the treatment provided in the emergency room is paid for as part of the payment for the inpatient services provided.

(2) If the emergency room visit does not result in an inpatient hospital admission but involves emergency services as defined in paragraph 79.1(13)“k,” payment for treatment provided in the emergency room shall be made at the full APC payment for the treatment provided.

(3) If the emergency room visit does not result in an inpatient hospital admission and does not involve emergency services as defined in paragraph 79.1(13)“k,” payment for treatment provided in the emergency room depends on whether the member had a referral to the emergency room.

1. For members who were referred to the emergency room by appropriate medical personnel, payment for treatment provided in the emergency room shall be made at 75 percent of the APC payment for the treatment provided.

2. For members who were not referred to the emergency room by appropriate medical personnel, payment for treatment provided in the emergency room shall be made at 50 percent of the APC payment for the treatment provided.

*s. Limit on payments.* Payments under the ambulatory payment classification (APC) methodology, as well as other payments for outpatient services, are subject to upper limit rules set forth in 42 CFR 447.321 as amended to September 5, 2001, and 447.325 as amended to January 26, 1993. Requirements under these sections state that, in general, Medicaid may not make payments to providers that would exceed the amount that would be payable to providers under comparable circumstances under Medicare.

*t. Government-owned facilities.* Rescinded IAB 6/30/10, effective 7/1/10.

*u. QIO review.* The QIO will review a yearly random sample of hospital outpatient service cases performed for Medicaid members and identified on claims data from all Iowa and bordering state hospitals in accordance with the terms in the contract between the department and the QIO. The QIO contract is available for review at the Iowa Medicaid Enterprise Office, 100 Army Post Road, Des Moines, Iowa 50315.

*v. Graduate medical education and disproportionate share fund.* Payment shall be made to hospitals qualifying for direct medical education directly from the graduate medical education and disproportionate share fund. The requirements to receive payments from the fund, the amount allocated to the fund and the methodology used to determine the distribution amounts from the fund are as follows:

(1) Qualifying for direct medical education. Iowa hospitals qualify for direct medical education payments if direct medical education costs that qualify for payment as medical education costs under the Medicare program are contained in the hospital's base year cost report and in the most recent cost report submitted before the start of the state fiscal year for which payments are being made. Out-of-state hospitals do not qualify for direct medical education payments.

(2) Allocation to fund for direct medical education. The total annual state fiscal year funding that is allocated to the graduate medical education and disproportionate share fund for direct medical education related to outpatient services is \$2,766,718.25. If a hospital fails to qualify for direct medical education payments from the fund because the hospital does not report direct medical education costs that qualify for payment as medical education costs under the Medicare program in the most recent cost report submitted before the start of the state fiscal year for which payments are being made, the amount of money that would have been paid to that hospital shall be removed from the fund.

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

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

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

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

*w. Final settlement for state-owned teaching hospital.*

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

1. Payments for inpatient hospital services calculated in accordance with subrule 79.1(5), plus
2. Payment for outpatient hospital services calculated in accordance with subrule 79.1(16), plus

3. \$9,900,000.

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

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

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

**79.1(17) Reimbursement for home- and community-based services home and vehicle modification and equipment.** Payment is made for home and vehicle modifications, assistive devices, specialized medical equipment, and environmental modifications and adaptive devices at the amount authorized by the department through a quotation, contract, or invoice submitted by the provider.

a. The case manager shall submit the service plan and the contract, invoice or quotations from the providers to the Iowa Medicaid enterprise for prior approval before the modification is initiated or the equipment is purchased. Payment shall not be approved for duplicate items.

b. Whenever possible, three itemized bids for the modification or quotations for equipment purchase shall be presented for review. The amount payable shall be based on the least expensive item that meets the member's medical needs.

c. Payment for most items shall be based on a fee schedule and shall conform to the limitations set forth in subrule 79.1(12).

(1) For services and items that are furnished under Part B of Medicare, the fee shall be the lowest charge allowed under Medicare.

(2) For services and items that are furnished only under Medicaid, the fee shall be the lowest charge determined by the department according to the Medicare reimbursement method described in Section 1834(a) of the Social Security Act (42 U.S.C. 1395m), Payment for Durable Medical Equipment.

(3) Payment for supplies with no established Medicare fee shall be at the average wholesale price for the item less 10 percent.

(4) Payment for items with no Medicare fee, Medicaid fee, or average wholesale price shall be made at the manufacturer's suggested retail price less 15 percent.

(5) Payment for items with no Medicare fee, Medicaid fee, average wholesale price, or manufacturer's suggested retail price shall be made at the dealer's cost plus 10 percent. The actual invoice for the item from the manufacturer must be submitted with the claim. Catalog pages or printouts supplied by the provider are not considered invoices.

(6) For selected medical services, supplies, and equipment, including equipment servicing, that generally do not vary significantly in quality from one provider to another, the payment shall be the lowest price for which such devices are widely and consistently available in a locality.

(7) Payment for used equipment shall not exceed 80 percent of the purchase allowance.

(8) No allowance shall be made for delivery, freight, postage, or other provider operating expenses for durable medical equipment, prosthetic devices, or sickroom supplies.

**79.1(18) Pharmaceutical case management services reimbursement.** Pharmacist and physician pharmaceutical case management (PCM) team members shall be equally reimbursed for participation in each of the four services described in rule 441—78.47(249A). The following table contains the amount each team member shall be reimbursed for the services provided and the maximum number of payments for each type of assessment. Payment for services beyond the maximum number of payments shall be considered on an individual basis after peer review of submitted documentation of medical necessity.

<u>Service</u>	<u>Payment amount</u>	<u>Number of payments</u>
Initial assessment	\$75	One per patient
New problem assessment	\$40	Two per patient per 12 months
Problem follow-up assessment	\$40	Four per patient per 12 months
Preventative follow-up assessment	\$25	One per patient per 6 months

**79.1(19) Reimbursement for translation and interpretation services.** Reimbursement for translation and interpretation services shall be made to providers based on the reimbursement methodology for the provider category as defined in subrule 79.1(2).

*a.* For those providers whose basis of reimbursement is cost-related, translation and interpretation services shall be considered an allowable cost.

*b.* For those providers whose basis of reimbursement is a fee schedule, a fee shall be established for translation and interpretation services, which shall be treated as a reimbursable service. In order for translation or interpretation to be covered, it must be provided by separate employees or contractors solely performing translation or interpretation activities.

**79.1(20) Dentists.** The dental fee schedule is based on the definitions of dental and surgical procedures given in the current version of the Code on Dental Procedures and Nomenclature (CDT) published by the American Dental Association.

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

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

*a. Definitions.* For purposes of this subrule:

“*Coinsurance*” means a percentage of costs of a covered health care service that has to be paid.

“*Copayment*” means a fixed amount a member pays for a covered health care service.

“*Deductible*” means the amount paid for covered health care services before the insurance plan will effect payment.

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

“*Medicare-allowed amount*” means the total reimbursement allowed by Medicare for the service(s) rendered, for a participating Medicare provider who has accepted Medicare assignment of claims for services rendered, including any portion to be paid by the Medicare beneficiary as a deductible or coinsurance.

“*Medicare cost sharing*” means the Medicare member's responsibility to pay for a Medicare-covered service. “Medicare cost sharing” includes coinsurance, copayments, and deductibles.

“*Medicare crossover claim*” means a claim for Medicaid payment for services covered by Medicare Part A or Part B rendered to a Medicare beneficiary who is also eligible for Medicaid. Medicare crossover claims include claims for services rendered to beneficiaries who are eligible for Medicaid in any category, including, but not limited to, qualified Medicare beneficiaries and beneficiaries who are eligible for full Medicaid coverage.

“*Medicare deductible and coinsurance amounts*” means the portion of the Medicare-allowed amount to be paid by the Medicare beneficiary as a deductible or coinsurance.

“*Medicare provider reimbursement*” means the Medicare-allowed amount less any portion thereof to be paid by the Medicare beneficiary as a deductible or coinsurance.

“*Qualified Medicare beneficiary*” or “*QMB*” means an individual who has been determined eligible for the QMB program pursuant to 441—subrule 75.1(29). Under the QMB program, Medicaid pays the individual’s Medicare Part A and B premiums; coinsurance; copayment; and deductible (except for Part D).

“*Third-party payment*” means payment from any source other than Medicaid, Medicare, or the Medicaid and Medicare beneficiary.

*b. Reimbursement of Medicare crossover claims.* Covered Medicare crossover claims shall be paid by Medicaid at the lesser of:

(1) Applicable Medicare deductible and coinsurance amounts, less any third-party payment available to the provider for the Medicare deductible and coinsurance amounts and any Medicaid copayment or spenddown; or

(2) Either:

1. For Medicaid-covered services: the Medicaid-allowed amount less the Medicare provider reimbursement, any third-party payment available to the provider in addition to the Medicare provider reimbursement, and any Medicaid copayment or spenddown; or

2. For non-Medicaid-covered services: 50 percent of the Medicare-allowed amount less the Medicare provider reimbursement, any third-party payment available to the provider in addition to the Medicare provider reimbursement, and any Medicaid copayment or spenddown.

**79.1(23) *Reimbursement for remedial services.*** Reimbursement for remedial services provided before July 1, 2011, shall be made on the basis of a unit rate that is calculated retrospectively for each provider, considering reasonable and proper costs of operation. The unit rate shall not exceed the established unit-of-service limit on reasonable costs pursuant to subparagraph 79.1(23)“c”(1). The unit of service may be a quarter hour, a half hour, an hour, a half day, or a day, depending on the service provided.

*a. Interim rate.* Providers shall be reimbursed through a prospective interim rate equal to the previous year’s retrospectively calculated unit-of-service rate. On an interim basis, pending determination of remedial services provider costs, the provider may bill for and shall be reimbursed at a unit-of-service rate that the provider and the Iowa Medicaid enterprise may reasonably expect to produce total payments to the provider for the provider’s fiscal year that are consistent with Medicaid’s obligation to reimburse that provider’s reasonable costs. The interim unit-of-service rate is subject to the established unit-of-service limit on reasonable costs pursuant to subparagraph 79.1(23)“c”(1).

*b. Cost reports.* Reasonable and proper costs of operation shall be determined based on cost reports submitted by the provider.

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

(2) The provider shall complete Form 470-4414, Financial and Statistical Report for Remedial Services, and submit it to the IME Provider Cost Audit and Rate Setting Unit, P.O. Box 36450, Des Moines, Iowa 50315, within three months of the end of the provider’s fiscal year.

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

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

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

(1) A reasonable cost for a member is one that does not exceed 110 percent of the average allowable costs reported by Iowa Medicaid providers for providing similar remedial services to members who have similar diagnoses and live in similar settings, less 5 percent.

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

**79.1(24) Reimbursement for home- and community-based habilitation services.** Reimbursement for all home- and community-based habilitation services provided on or after January 1, 2016, shall be as provided in paragraph 79.1(24) "d." All rates are subject to the upper limits established in subrule 79.1(2).

*a. Units of service.*

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

(2) A unit of home-based habilitation is a 15-minute unit (for up to 31 units per day) or one day (for 8 or more hours per day), based on the average hours of service provided during a 24-hour period as an average over a calendar month. Reimbursement for services shall not exceed the upper limit for daily home-based habilitation services set in 79.1(2).

1. The daily unit of service shall be used when a member receives services for 8 or more hours provided during a 24-hour period as an average over a calendar month. The 15-minute unit shall be used when the member receives services for 1 to 31 15-minute units provided during a 24-hour period as an average over a calendar month.

2. The member's comprehensive service plan must identify and reflect the need for the amount of supervision and skills training requested. The provider's documentation must support the number of direct support hours identified in the comprehensive service plan.

(3) A unit of day habilitation is 15 minutes (up to 16 units per day) or a full day (4.25 to 8 hours).

(4) A unit of supported employment habilitation supports to maintain employment is a 15-minute unit.

*b. Submission of cost reports.* For services provided prior to July 1, 2013, the department shall determine reasonable and proper costs of operation for home-based habilitation, day habilitation, prevocational habilitation, and supported employment based on cost reports submitted by the provider on Form 470-4425, Financial and Statistical Report for HCBS Habilitation Services.

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

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

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

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

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

(6) If a provider fails to submit a cost report for services provided through June 30, 2013, that meets the requirements of this paragraph, the Iowa Medicaid enterprise or the Iowa Plan for Behavioral Health contractor shall reduce the provider's rate to 76 percent of the current rate. The reduced rate shall be paid until the provider's cost report has been received by the Iowa Medicaid enterprise's provider cost audit and rate setting unit pursuant to subparagraph 79.1(24) "b"(4) but for not longer than three months, after which time no further payments will be made.

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

*c. Rate determination based on cost reports.* For services provided prior to July 1, 2013, reimbursement shall be made using a unit rate that is calculated retrospectively for each provider, considering reasonable and proper costs of operation.

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

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

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

*d. Reimbursement for services provided on or after January 1, 2016.*

(1) For dates of services on or after January 1, 2016, habilitation services, except for case management, shall be reimbursed by fee schedule. Case management will continue to be reimbursed by retrospective cost settlement.

(2) For dates of services on or after July 1, 2018, case management services shall be reimbursed by fee schedule.

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

*a. Reimbursement methodology for providers of mental health services to county residents pursuant to a waiver approved under Iowa Code section 225C.7(3).* Effective for services rendered on or after October 1, 2006, providers of mental health services to county residents pursuant to a waiver approved under Iowa Code section 225C.7(3) that provide clinic services are paid on a reasonable-cost basis as determined by Medicare reimbursement principles.

*b. Reimbursement methodology for community mental health centers.* Effective for services rendered on or after July 1, 2014, community mental health centers may elect to be paid on either a 100 percent of reasonable costs basis, as determined by Medicare reimbursement principles, or in accordance with an alternative reimbursement rate methodology approved by the department of human services. Once a community mental health center chooses the alternative reimbursement rate methodology, the community mental health center may not change its elected reimbursement methodology to 100 percent of reasonable costs.

*c. Cost-based reimbursement.* For providers of mental health services to county residents pursuant to a waiver approved under Iowa Code section 225C.7(3) and CMHCs that elect the 100 percent of reasonable costs basis of reimbursement, rates are initially paid on an interim basis and then are adjusted retroactively based on submission of a financial and statistical report, pursuant to the following.

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

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

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

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

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

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

*d. Reporting requirements.* All providers other than CMHCs that have elected the alternative reimbursement rate methodology established by the Medicaid program's managed care contractor for mental health services shall submit cost reports using Form 470-4419, Financial and Statistical Report. Hospital-based providers required to submit a cost report shall also submit the Medicare cost report, CMS Form 2552-96. The following requirements apply to all required cost reports.

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

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

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

(4) Providers shall submit completed cost reports to the IME Provider Cost Audit and Rate Setting Unit, P.O. Box 36450, Des Moines, Iowa 50315. A provider that is not hospital-based shall submit Form 470-4419 on or before the last day of the third month after the end of the provider's fiscal year. A hospital-based provider shall submit both Form 470-4419 and CMS Form 2552-96 on or before the last day of the fifth month after the end of the provider's fiscal year.

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

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

**79.1(26) Home health services.**

*a.* Services included under the home health services program are reimbursed on the low utilization payment amount (LUPA) methodology, with state geographic adjustments.

b. Medicare LUPA per-visit rates in effect on July 1, 2013, are the basis for establishing the LUPA methodology for the initial reimbursement schedule.

c. Medicare LUPA per-visit rates shall be increased July 1 every two years to reflect the most recent Medicare LUPA rates.

d. Home health services subject to this methodology are skilled nursing, home health aide, physical therapy, occupational therapy, speech therapy, and medical social services provided by Medicare-certified home health agencies.

**79.1(27) Reimbursement for early periodic screening, diagnosis, and treatment private duty nursing and personal cares program.**

a. *Rate determination based on cost reports.* Reimbursement shall be made using an hourly rate that is calculated retrospectively for each provider, considering reasonable and proper costs of operation not to exceed the upper limit as provided in subrule 79.1(2).

(1) Interim rates. Providers shall be reimbursed through a prospective interim rate equal to the previous year's retrospectively calculated 15-minute and hourly rate. Pending determination of private duty nursing and personal cares program costs, the provider may bill for and shall be reimbursed at an hourly rate that the provider and the Iowa Medicaid enterprise (IME) may reasonably expect to produce total payments to the provider for the provider's fiscal year that are consistent with Medicaid's obligation to reimburse that provider's reasonable costs.

(2) Audit of cost reports. Cost reports as filed shall be subject to review or audit or both by the Iowa Medicaid enterprise to determine the actual cost of services in accordance with generally accepted accounting principles, Medicare cost principles published in Centers for Medicare and Medicaid Services Publication §15-1, and the Office of Management and Budget Circular A-87, Attachment B, subject to the exceptions and limitations in the department's administrative rules.

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

b. *Financial and statistical report submission and reporting requirements.*

(1) The provider shall submit the complete Financial and Statistical Report, Form 1728-94, in an electronic format approved by the department to the IME provider cost audit and rate setting unit within five months of the end of the provider's fiscal year.

(2) The submission of the financial and statistical report must include a working trial balance that corresponds to the data contained on the financial and statistical report and the Medicare cost report. Financial and statistical reports submitted without a working trial balance and the Medicare cost report will be considered incomplete.

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

(4) Providers shall submit a completed financial and statistical report to the IME provider cost audit and rate setting unit in an electronic format that can be opened using the extension xls or xlsx. The supplemental documentation shall be submitted in a generally accepted business format. The report and required supplemental information shall be emailed to [costaudit@dhs.state.ia.us](mailto:costaudit@dhs.state.ia.us) on or before the last day of the fifth month after the end of the provider's fiscal year. One signed copy of the certification page of the Medicaid and Medicare cost reports shall be mailed to the IME Provider Cost Audit and Rate Setting Unit, P.O. Box 36450, Des Moines, Iowa 50315, no later than the due date of the required electronic submissions.

(5) If a provider fails to submit a cost report that meets the requirement of subparagraph 79.1(27) "b"(4), the department shall reduce payment to 75 percent of the current rate(s).

1. The reduced rate(s) shall be effective the first day of the sixth month following the provider's fiscal year end and shall remain in effect until the first day of the month after the delinquent report is received by the IME provider cost audit and rate setting unit.

2. The reduced rate(s) shall be paid for no longer than three months, after which time no further payments will be made until the first day of the month after the delinquent report is received by the IME provider cost audit and rate setting unit.

(6) Financial information shall be based on the provider's financial records. When the records are not kept on an accrual basis of accounting, the provider shall make the adjustments necessary to convert the information to an accrual basis for reporting and provide documentation detailing these adjustments. Failure to maintain records to support the cost report may result in the following, but not limited to:

1. Recoupment of Medicaid payments.
2. Penalties.
3. Sanctions pursuant to rule 441—79.3(249A).

(7) The department, in its sole discretion, may on its own initiative reopen a review of a financial and statistical report at any time. No other entity or person has the right to request that the department or its contractor reopen a review of a financial and statistical report, or to submit an amended financial and statistical report for review by the department, after the provider is notified of its reimbursement rates following review of a financial and statistical report.

(8) A projected cost report shall be submitted when a home health agency enters the program or adds private duty nursing and the personal cares program. Prospective interim rates shall be established using the projected cost report. The effective date of the rate shall be the day the provider becomes certified as a Medicaid provider or the day the new program is added.

(9) A provider of services under multiple programs shall submit a cost allocation schedule that was used during the preparation of the financial and statistical report.

(10) Costs reported under private duty nursing and the personal cares program shall not be reported as reimbursable costs under any other funding source. Costs incurred for other services shall not be reported as reimbursable costs under private duty nursing and the personal cares program.

(11) When a provider continues to include as an item of cost an item or items which had in a prior period been removed by an adjustment by the department or its contractor, in the total program costs, the contractor shall recommend to the department that the reimbursement rates be reduced to 75 percent of the current reimbursement rate for the entire quarter beginning the first day of the sixth month after the provider's fiscal year end. The department may, after considering the seriousness of the exception, make the reduction.

(12) Nothing in this subrule relieves a provider of its obligation to immediately inform the department that it has retained Medicaid funds to which it is not entitled as a result of any cost report process. A provider must notify the Iowa Medicaid enterprise when the provider notes that funds are incorrectly paid or when an overpayment has been detected.

*c. Terminated home health agencies.*

(1) A participating home health agency contemplating termination of private duty nursing and the personal cares program shall provide the department of human services with at least 60 days' prior notice. The person responsible for the termination is responsible for submission of a final financial and statistical report through the date of the termination. The final home health cost report shall meet the reporting requirements in paragraph 79.1(27) "b."

(2) For facilities that terminate activity with the Iowa Medicaid enterprise, a financial and statistical report from the beginning of the fiscal year to the date of termination will be required, regardless if termination is voluntary, involuntary or due to a change in ownership. All documentation in paragraph 79.1(27) "a" shall be submitted 45 days after the date of termination, by the terminated (closed) entity. If no report is received within 45 days, the Iowa Medicaid enterprise will begin the process to recoup all funds for dates of service beginning from the last filed cost report to the date of termination.

**79.1(28) Reimbursement for community-based neurobehavioral rehabilitation residential services and community-based neurobehavioral rehabilitation intermittent services.**

*a. New providers.* Providers who are newly enrolled shall be paid prospective rates based on projected reasonable and proper costs of operation based on the statewide average rate paid to community-based neurobehavioral rehabilitation service providers in effect June 30 each fiscal year.

*b. Established providers.* After establishment of the initial rate for a provider, the rate will be adjusted annually, effective July 1 each year. The provider's new rate shall be the previously established rate adjusted by the consumer price index for all urban consumers for the preceding 12-month period ending June 30, not to exceed the limit in effect June 30.

**79.1(29)** *Reimbursement for health insurance premium payment (HIPP) program providers.* Reimbursement for HIPP program providers shall be provided only when such provider is enrolled with Iowa Medicaid for the sole purpose of billing HIPP-eligible in-network coinsurance, copayments, and deductibles.

*a. Definitions.* For purposes of this subrule:

"*Coinsurance*" means a percentage of costs of a covered health care service that has to be paid.

"*Copayment*" means a fixed amount a member pays for a covered health care service.

"*Deductible*" means the amount paid for covered health care services before the insurance plan starts to pay.

"*Eligible member*" means an individual eligible for Medicaid pursuant to rule 441—75.1(249A) et seq. and who qualifies for and is participating in the department's HIPP program prescribed under rule 441—75.21(249A).

"*Health insurance premium payment (HIPP) program*" or "*HIPP program*" has the same meaning as provided in rule 441—75.21(249A).

*b. Claim submission.* To submit a claim for reimbursement, a HIPP provider shall use Form 470-5475, Health Insurance Premium Payment (HIPP) Provider Invoice.

(1) Payment shall be made to eligible providers for a HIPP-eligible member's coinsurance, copayment, and deductible, when the HIPP-eligible member is active on the date of service.

(2) Member responsibility. The eligible member may be responsible for a copayment pursuant to subrule 79.1(13).

**79.1(30)** *Tiered rates.* For supported community living services, residential-based supported community living services, day habilitation services, and adult day care services provided under the intellectual disability waiver, the fee schedule published by the department pursuant to paragraph 79.1(1) "*c*" provides rates based on the acuity tier of the member, as determined pursuant to this subrule.

*a.* Acuity tiers are based on the results of the Supports Intensity Scale® (SIS) core standardized assessment. The SIS assessment tool and scoring criteria are available on request from the Iowa Medicaid enterprise, bureau of long-term care.

*b.* The assignment of members to acuity tiers is based on a mathematically valid process that identifies meaningful differences in the support needs of the members based on the SIS scores.

*c.* For supported community living daily services paid through a per diem, there are two reimbursement sublevels within each tier based on the number of hours of day services a member receives monthly. Day services include enhanced job search services, supported employment, prevocational services, adult day care, day habilitation and employment outside of Medicaid reimbursable services. The two reimbursement sublevels reflect reimbursement for:

(1) Members who receive an average of 40 hours or more of day services per month.

(2) Members who receive an average of less than 40 hours of day services per month.

*d.* For this purpose, the "SIS activities score" is the sum total of the subscale raw SIS scores converted to standard scores on the following subsections:

(1) Subsection 2A: Home Living Activities;

(2) Subsection 2B: Community Living Activities;

(3) Subsection 2E: Health and Safety Activities; and

(4) Subsection 2F: Social Activities.

*e.* Also used in determining a member's acuity tier, as provided in paragraphs 79.1(30) "*f*" and "*g*," are the subtotal scores on the following subsections:

(1) Subsection 1A: Exceptional Medical Support Needs, excluding questions 16 through 19; and

(2) Subsection 1B: Exceptional Behavioral Support Needs, excluding question 13.

*f.* Subject to adjustment pursuant to paragraph 79.1(30) "*g*," acuity tiers are the highest applicable tier pursuant to the following:

- (1) Tier 1: SIS activities score of 0 – 25.
- (2) Tier 2: SIS activities score of 26 – 40.
- (3) Tier 3: SIS activities score of 41 – 44 or SIS activities score of 0 – 40 and a SIS subsection 1B subtotal score of 6 or higher.
- (4) Tier 4: SIS activities score of 45 or higher.
- (5) Tier 5: SIS activities score of 41 or higher and a subsection 1B subtotal score of 7 or higher.
- (6) Tier 6: SIS subsection 1A or 1B subtotal score of 14 or higher.
- (7) RCF tier: Members residing in a residential care facility (RCF) licensed for six or more beds.
- (8) RBSCCL tier: Members residing in a residential-based supported community living (RBSCCL) facility.
- (9) Enhanced tier: An individual member rate negotiated between the department and the provider.
  - g. The tier determined pursuant to paragraph 79.1(30)“f” shall be adjusted as follows:
    - (1) For members with a subsection 1A subtotal score of 2 or 3, as provided in subparagraph 79.1(30)“e”(1), but with a response of “extensive support needed” (score = 2) in response to any prompt in subsection 1A, as provided in subparagraph 79.1(30)“e”(1) and an otherwise applicable tier of 1 to 4 pursuant to paragraph 79.1(30)“f,” the tier is increased by one tier.
    - (2) For members with a subsection 1A subtotal score of 4 – 9, and an otherwise applicable tier of 1 to 4 pursuant to paragraph 79.1(30)“f,” the tier is increased by one tier.
    - (3) For members with a subsection 1A subtotal score of 10 – 13, and an otherwise applicable tier of 1 to 3 pursuant to paragraph 79.1(30)“f,” the tier is increased by two tiers.
    - (4) For members with a subsection 1A subtotal score of 10 – 13, and an otherwise applicable tier of 4 pursuant to paragraph 79.1(30)“f,” the tier is increased by one tier.
    - (5) Any member may receive an enhanced tier rate when approved by the department for fee-for-service members.
  - h. Tier redetermination. A member’s acuity tier may be changed in the following circumstances:
    - (1) There is a change in the member’s SIS activity scores as determined in the annual level of care redetermination process pursuant to rule 441—83.64(249A).
    - (2) A completed DHS Form 470-5486, Emergency Needs Assessment, indicates a change in the member’s support needs. A member’s case manager may request an emergency needs assessment when a significant change in the member’s needs is identified. When a completed emergency needs assessment indicates significant changes that are likely to continue in three of the five domains assessed, a full SIS core standardized assessment shall be conducted and any change in the SIS scores will be used to determine the member’s acuity tier.
  - i. New providers, provider acquisitions, mergers and change in ownership. Any change in provider enrollment status including, but not limited to, new providers, enrolled providers merging into one or more consolidated provider entities, acquisition or takeover of existing HCBS providers,

or change in the majority ownership of a provider on or after December 1, 2017, shall require the new provider entity to use the tiered rate fee schedule in accordance with paragraph 79.1(1)“c.”

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

[ARC 7835B, IAB 6/3/09, effective 7/8/09; ARC 7937B, IAB 7/1/09, effective 7/1/09; ARC 7957B, IAB 7/15/09, effective 7/1/09 (See Delay note at end of chapter); ARC 8205B, IAB 10/7/09, effective 11/11/09; ARC 8206B, IAB 10/7/09, effective 11/11/09; ARC 8344B, IAB 12/2/09, effective 12/1/09; ARC 8643B, IAB 4/7/10, effective 3/11/10; ARC 8647B, IAB 4/7/10, effective 3/11/10; ARC 8649B, IAB 4/7/10, effective 3/11/10; ARC 8894B, IAB 6/30/10, effective 7/1/10; ARC 8899B, IAB 6/30/10, effective 7/1/10; ARC 9046B, IAB 9/8/10, effective 8/12/10; ARC 9127B, IAB 10/6/10, effective 11/10/10; ARC 9134B, IAB 10/6/10, effective 10/1/10; ARC 9132B, IAB 10/6/10, effective 11/1/10; ARC 9176B, IAB 11/3/10, effective 12/8/10; ARC 9316B, IAB 12/29/10, effective 2/2/11; ARC 9403B, IAB 3/9/11, effective 5/1/11; ARC 9440B, IAB 4/6/11, effective 4/1/11; ARC 9487B, IAB 5/4/11, effective 7/1/11; ARC 9588B, IAB 6/29/11, effective 9/1/11; ARC 9706B, IAB 9/7/11, effective 8/17/11; ARC 9708B, IAB 9/7/11, effective 8/17/11; ARC 9710B, IAB 9/7/11, effective 8/17/11; ARC 9704B, IAB 9/7/11, effective 9/1/11; ARC 9712B, IAB 9/7/11, effective 9/1/11; ARC 9714B, IAB 9/7/11, effective 9/1/11; ARC 9719B, IAB 9/7/11, effective 9/1/11; ARC 9722B, IAB 9/7/11, effective 9/1/11; ARC 9884B, IAB 11/30/11, effective 1/4/12; ARC 9886B, IAB 11/30/11, effective 1/4/12; ARC 9887B, IAB 11/30/11, effective 1/4/12; ARC 9958B, IAB 1/11/12, effective 2/15/12; ARC 9959B, IAB 1/11/12, effective 2/15/12; ARC 9960B, IAB 1/11/12, effective 2/15/12; ARC 9996B, IAB 2/8/12, effective 1/19/12; ARC 0028C, IAB 3/7/12, effective 4/11/12; ARC 0029C, IAB 3/7/12, effective 4/11/12; ARC 9959B nullified (See nullification note at end of chapter); ARC 0191C, IAB 7/11/12, effective 7/1/12; ARC 0194C, IAB 7/11/12, effective 7/1/12; ARC 0196C, IAB 7/11/12, effective 7/1/12; ARC 0198C, IAB 7/11/12, effective 7/1/12; ARC 0358C, IAB 10/3/12, effective 11/7/12; ARC 0359C, IAB 10/3/12, effective 12/1/12; ARC 0355C, IAB 10/3/12, effective 12/1/12; ARC 0354C, IAB 10/3/12, effective 12/1/12; ARC 0360C, IAB 10/3/12, effective 12/1/12; ARC 0485C, IAB 12/12/12, effective 2/1/13; ARC 0545C, IAB 1/9/13, effective 3/1/13; ARC 0548C, IAB 1/9/13, effective 1/1/13; ARC 0581C, IAB 2/6/13, effective 4/1/13; ARC 0585C, IAB 2/6/13, effective 1/9/13; ARC 0665C, IAB 4/3/13, effective 6/1/13; ARC 0708C, IAB 5/1/13, effective 7/1/13; ARC 0710C, IAB 5/1/13, effective 7/1/13; ARC 0713C, IAB 5/1/13, effective 7/1/13; ARC 0757C, IAB 5/29/13, effective 8/1/13; ARC 0823C, IAB 7/10/13, effective 9/1/13; ARC 0838C, IAB 7/24/13, effective 7/1/13; ARC 0840C, IAB 7/24/13, effective 7/1/13; ARC 0842C, IAB 7/24/13, effective 7/1/13; ARC 0848C, IAB 7/24/13, effective 7/1/13; ARC 0864C, IAB 7/24/13, effective 7/1/13; ARC 0994C, IAB 9/4/13, effective 11/1/13; ARC 1051C, IAB 10/2/13, effective 11/6/13; ARC 1056C, IAB 10/2/13, effective 11/6/13; ARC 1057C, IAB 10/2/13, effective 11/6/13; ARC 1058C, IAB 10/2/13, effective 11/6/13; ARC 1071C, IAB 10/2/13, effective 10/1/13; ARC 1150C, IAB 10/30/13, effective 1/1/14; ARC 1152C, IAB 10/30/13, effective 1/1/14; ARC 1154C, IAB 10/30/13, effective 1/1/14; ARC 1481C, IAB 6/11/14, effective 8/1/14; ARC 1519C, IAB 7/9/14, effective 7/1/14; ARC 1521C, IAB 7/9/14, effective 7/1/14; ARC 1610C, IAB 9/3/14, effective 8/13/14; ARC 1608C, IAB 9/3/14, effective 10/8/14; ARC 1609C, IAB 9/3/14, effective 10/8/14; ARC 1699C, IAB 10/29/14, effective 1/1/15; ARC 1697C, IAB 10/29/14, effective 1/1/15; ARC 1977C, IAB 4/29/15, effective 7/1/15; ARC 2026C, IAB 6/10/15, effective 8/1/15; ARC 2075C, IAB 8/5/15, effective 7/15/15; ARC 2164C, IAB 9/30/15, effective 10/1/15; ARC 2167C, IAB 9/30/15, effective 11/4/15; ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 2341C, IAB 1/6/16, effective 2/10/16; ARC 2471C, IAB 3/30/16, effective 5/4/16; ARC 2846C, IAB 12/7/16, effective 11/15/16; ARC 2848C, IAB 12/7/16, effective 11/15/16; ARC 2930C, IAB 2/1/17, effective 4/1/17; ARC 2932C, IAB 2/1/17, effective 3/8/17; ARC 2936C, IAB 2/1/17, effective 3/8/17; ARC 3158C, IAB 7/5/17, effective 7/1/17; ARC 3161C, IAB 7/5/17, effective 7/1/17; ARC 3162C, IAB 7/5/17, effective 7/1/17; ARC 3160C, IAB 7/5/17, effective 7/1/17; ARC 3159C, IAB 7/5/17, effective 7/1/17; ARC 3294C, IAB 8/30/17, effective 10/4/17; ARC 3295C, IAB 8/30/17, effective 10/4/17; ARC 3296C, IAB 8/30/17, effective 10/4/17; ARC 3292C, IAB 8/30/17, effective 10/4/17; ARC 3293C, IAB 8/30/17, effective 10/4/17; ARC 3481C, IAB 12/6/17, effective 12/1/17; ARC 3494C, IAB 12/6/17, effective 1/10/18; ARC 3551C, IAB 1/3/18, effective 2/7/18; ARC 3716C, IAB 3/28/18, effective 5/2/18; ARC 3790C, IAB 5/9/18, effective 6/13/18; ARC 4067C, IAB 10/10/18, effective 11/14/18; ARC 4065C, IAB 10/10/18, effective 12/1/18; ARC 4066C, IAB 10/10/18, effective 12/1/18; ARC 4068C, IAB 10/10/18, effective 12/1/18; ARC 4430C, IAB 5/8/19, effective 7/1/19; see Delay note at end of chapter]

#### 441—79.2(249A) Sanctions.

##### 79.2(1) Definitions.

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

“*Iowa Medicaid enterprise*” means the entity comprised of department staff and contractors responsible for the management and reimbursement of Medicaid services for the benefit of Medicaid members.

“*Person*” means any individual human being or any company, firm, association, corporation, institution, or other legal entity. “*Person*” includes but is not limited to a provider and any affiliate of a provider.

“*Probation*” means a specified period of conditional participation in the medical assistance program.

“*Provider*” means an individual human being, firm, corporation, association, institution, or other legal entity, which is providing or has been approved to provide medical assistance to a member pursuant to the state medical assistance program.

“*Suspension from participation*” means an exclusion from participation for a specified period of time.

“*Suspension of payments*” means the temporary cessation of payments due a person until the resolution of a matter in dispute between a person and the department.

*“Termination from participation”* means a permanent exclusion from participation in the medical assistance program.

*“Withholding of payments”* means a reduction or adjustment of the amounts paid to a person on pending and subsequently submitted bills for purposes of offsetting payments made to, received by, or in the possession of a person.

**79.2(2) Grounds for sanctions.** The department may impose sanctions against any person when appropriate. Appropriate grounds for the department to impose sanctions include, but are not limited to, the following:

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

b. Submitting or causing to be submitted false, intentionally misleading, or fraudulent information for the purpose of obtaining greater compensation than that to which the person is legally entitled, including charges in excess of usual and customary charges.

c. Submitting or causing to be submitted false, intentionally misleading, or fraudulent information for the purpose of meeting prior authorization or level of care requirements.

d. Upon lawful demand, failing to disclose or make available to the department, the department’s authorized agent, any law enforcement or peace officer, any agent of the department of inspections and appeals’ Medicaid fraud control unit, any agent of the auditor of state, the Iowa department of justice, any false claims investigator as defined under Iowa Code chapter 685, or any other duly authorized federal or state agent or agency records of services provided to medical assistance members or records of payments made for those services.

e. Failing to provide or maintain quality services, or a requisite assurance of a framework of quality services to medical assistance recipients within accepted medical community standards as adjudged by professional peers if applicable. For purposes of this subrule, “quality services” means services provided in accordance with the applicable rules and regulations governing the services.

f. Engaging in a course of conduct or performing an act which is in violation of any federal, state, or local statute, rule, regulation, or ordinance, or an applicable contractual provision, that relates to, or arises out of, any publicly or privately funded health care program, including but not limited to any state medical assistance program.

g. Submitting a false, intentionally misleading, or fraudulent certification or statement, whether the certification or statement is explicit or implied, to the department or the department’s representative or to any other publicly or privately funded health care program.

h. Overutilization of the medical assistance program by inducing, furnishing or otherwise causing a member to receive services or merchandise not required or requested.

i. Violating any provision of Iowa Code chapter 249A, or any rule promulgated pursuant thereto, or violating any federal or state false claims Act, including but not limited to Iowa Code chapter 685.

j. Submitting or causing to be submitted false, intentionally misleading, or fraudulent information in an application for provider status under the medical assistance program or any quality review or other submission required to maintain good standing in the program.

k. Violating any law, regulation, or code of ethics governing the conduct of an occupation, profession, or other regulated business activity, when the violation relates to, or arises out of, the delivery of services under the state medical assistance program.

l. Breaching any settlement or similar agreement with the department, or failing to abide by the terms of any agreement with any other entity relating to, or arising out of, the state medical assistance program.

m. Failing to meet standards required by state or federal law for participation, including but not limited to licensure.

n. Exclusion from Medicare or any other state or federally funded medical assistance program.

o. Except as authorized by law, charging a person for covered services over and above what the department paid or would pay or soliciting, offering, or receiving a kickback, bribe, or rebate, or accepting or rebating a fee or a charge for medical assistance or patient referral, or a portion thereof. This ground does not include the collection of a copayment or deductible if otherwise allowed by law.

- p.* Failing to correct a deficiency in provider operations after receiving notice of the deficiency from the department or other federal or state agency.
- q.* Formal reprimand or censure by an association of the provider's peers or similar entity related to professional conduct.
- r.* Suspension or termination for cause from participation in another program, including but not limited to workers' compensation or any publicly or privately funded health care program.
- s.* Indictment or other institution of criminal charges for, or plea of guilty or nolo contendere to, or conviction of, any crime punishable by a term of imprisonment greater than one year, any crime of violence, any controlled substance offense, or any crime involving an allegation of dishonesty or negligent practice resulting in death or injury to a provider's patient.
- t.* Violation of a condition of probation, suspension of payments, or other sanction.
- u.* Loss, restriction, or lack of hospital privileges for cause.
- v.* Negligent, reckless, or intentional endangerment of the health, welfare, or safety of a person.
- w.* Billing for services provided by an excluded, nonenrolled, terminated, suspended, or otherwise ineligible provider or person.
- x.* Failing to submit a self-assessment, corrective action plan, or other requirement for continued participation in the medical assistance program, or failing to repay an overpayment of medical assistance funds, in a timely manner, as set forth in a rule or other order.
- y.* Attempting, aiding or abetting, conspiring, or knowingly advising or encouraging another person in the commission of one or more of the grounds specified herein.

**79.2(3) Sanctions.**

- a.* The department may impose any of the following sanctions on any person:
  - (1) A term of probation for participation in the medical assistance program.
  - (2) Termination from participation in the medical assistance program.
  - (3) Suspension from participation in the medical assistance program.
  - (4) Suspension of payments in whole or in part.
  - (5) Prior authorization of services.
  - (6) Review of claims prior to payment.
- b.* The withholding of a payment or a recoupment of medical assistance funds is not, in itself, a sanction. Overpayments, civil monetary penalties, and interest may also be withheld from payments without imposition of a sanction.
- c.* Mandatory suspensions and terminations.
  - (1) Suspension or termination from participation in the medical assistance program is mandatory when a person is suspended or terminated from participation in the Medicare program, another state's medical assistance program, or by any licensing body. The suspension or termination from participation in the medical assistance program shall be retroactive to the date established by the Centers for Medicare and Medicaid Services or other state or body and, in the case of a suspension, must continue until at least such time as the Medicare or other state's or body's suspension ends.
  - (2) Termination is mandatory upon entry of final judgment, in the Iowa district court or a federal district court of the United States, of liability of the person in a false claims action.
  - (3) Suspension from participation is mandatory whenever a person, or an affiliate of the person, has an outstanding overpayment of medical assistance funds, as defined in Iowa Code chapter 249A.
  - (4) Upon notification from the U.S. Department of Justice, the Iowa department of justice, the department of inspections and appeals, or a similar agency, that a person has failed to respond to a civil investigative demand or other subpoena in a timely manner as set forth in governing law and the demand or other subpoena itself, the department shall immediately suspend the person from participation and suspend all payments to the person. The suspension and payment suspension shall end upon notification that the person has responded to the demand in full.

**79.2(4) Imposition and extent of sanction.** The department shall consider the totality of the circumstances in determining the sanctions to be imposed. The factors the department may consider include, but are not limited to:

- a.* Seriousness of the offense.

- b. Extent of violations.
- c. History of prior violations.
- d. Prior imposition of sanctions.
- e. Prior provision of provider education (technical assistance).
- f. Provider willingness to obey program rules.
- g. Whether a lesser sanction will be sufficient to remedy the problem.
- h. Actions taken or recommended by peer review groups or licensing boards.

**79.2(5) Scope of sanction.**

a. Suspension or termination from participation shall preclude the person from submitting claims for payment, whether personally or through claims submitted by any other person or affiliate, for any services or supplies except for those services provided before the suspension or termination.

b. No person may submit claims for payment for any services or supplies provided by a person or affiliate who has been suspended or terminated from participation in the medical assistance program except for those services provided before the suspension or termination.

c. When the provisions of this subrule are violated, the department may sanction any person responsible for the violation.

**79.2(6) Notice to third parties.** When a sanction is imposed, the department may notify third parties of the findings made and the sanction imposed, including but not limited to law enforcement or peace officers and federal or state agencies. The imposition of a sanction is not required before the department may notify third parties of a person's conduct. In accordance with 42 CFR § 1002.212, the department must notify other state agencies, applicable licensing boards, the public, and Medicaid members, as provided in 42 CFR §§ 1001.2005 and 1001.2006, whenever the department initiates an exclusion under 42 CFR § 1002.210.

**79.2(7) Notice of violation.**

a. Any order of sanction shall be in writing and include the name of the person subject to sanction, identify the ground for the sanction and its effective date, and be sent to the person's last-known address. If the department sanctions a provider, the order of sanction shall also include the national provider identification number of the provider and be sent to the provider's last address on file within the medical assistance program. Proof of mailing to such address shall be conclusive evidence of proper service of the sanction upon the provider. The department of inspections and appeals is not required to comply with the additional notification provisions of 441—paragraph 7.10(7)“c” for appeals certified for hearing under this chapter.

b. In the case of a currently enrolled provider otherwise in good standing with all program requirements, the provider shall have 15 days subsequent to the date of the notice prior to the department action to show cause why the action should not be taken. If the provider fails to do so, the sanction shall remain effective pending any subsequent appeal under 441—Chapter 7. If the provider attempts to show cause but the department determines the sanction should remain effective pending any subsequent appeal under 441—Chapter 7, the provider may seek a temporary stay of the department's action from the director or the director's designee by filing an application for stay with the appeals section. The director or the director's designee shall consider the factors listed in Iowa Code section 17A.19(5)“c.”

**79.2(8) Suspension or withholding of payments.** The department may withhold payments on pending and subsequently received claims in an amount reasonably calculated to approximate the amounts in question due to a sanction, incorrect payment, civil monetary penalty, or other adverse action and may also suspend payment or participation pending a final determination. If the department withholds or suspends payments, it shall notify the person in writing within the time frames prescribed by federal law for cases related to a credible allegation of fraud, and within ten days for all other cases.

**79.2(9) Civil monetary penalties and interest.** Civil monetary penalties and interest assessed in accordance with 2013 Iowa Acts, Senate File 357, section 5 or section 11, are not allowable costs for any aspect of determining payment to a person within the medical assistance program. Under no circumstance shall the department reimburse a person for such civil monetary penalties or interest.

**79.2(10) Report and return of identified overpayment.**

*a.* If a person has identified an overpayment, the person must report and return the overpayment in the form and manner set forth in this subrule.

*b.* A person has identified an overpayment if the person has actual knowledge of the existence of the overpayment or acts in reckless disregard or deliberate ignorance of the existence of the overpayment.

*c.* An overpayment required to be reported under 2013 Iowa Acts, Senate File 357, section 3, must be made in writing, addressed to the Program Integrity Unit of the Iowa Medicaid Enterprise, and contain all of the following:

- (1) Person's name.
- (2) Person's tax identification number.
- (3) How the error was discovered.
- (4) The reason for the overpayment.
- (5) Claim number(s), as appropriate.
- (6) Date(s) of service.
- (7) Member identification number(s).
- (8) National provider identification (NPI) number.
- (9) Description of the corrective action plan to ensure the error does not occur again, if applicable.
- (10) Whether the person has a corporate integrity agreement with the Office of the Inspector General (OIG) or is under the OIG Self-Disclosure Protocol or is presently under sanction by the department.
- (11) The time frame and the total amount of refund for the period during which the problem existed that caused the refund.
- (12) If a statistical sample was used to determine the overpayment amount, a description of the statistically valid methodology used to determine the overpayment.
- (13) A refund in the amount of the overpayment.

This rule is intended to implement Iowa Code section 249A.4.  
[ARC 1155C, IAB 10/30/13, effective 1/1/14; ARC 1695C, IAB 10/29/14, effective 1/1/15]

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

**79.3(1) Financial (fiscal) records.**

- a.* A provider of service shall maintain records as necessary to:
- (1) Support the determination of the provider's reimbursement rate under the medical assistance program; and
  - (2) Support each item of service for which a charge is made to the medical assistance program.
- These records include financial records and other records as may be necessary for reporting and accountability.

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

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

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

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

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

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

*c. Components.*

- (1) Identification. Each page or separate electronic document of the medical record shall contain the member's first and last name. In the case of electronic documents, the member's first and last name

must appear on each screen when viewed electronically and on each page when printed. As part of the medical record, the medical assistance identification number and the date of birth must also be identified and associated with the member's first and last name.

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

1. The member's complaint, symptoms, and diagnosis.
2. The member's medical or social history.
3. Examination findings.
4. Diagnostic test reports, laboratory test results, or X-ray reports.
5. Goals or needs identified in the member's plan of care.
6. Physician orders and any prior authorizations required for Medicaid payment.
7. Medication records, pharmacy records for prescriptions, or providers' orders.
8. Related professional consultation reports.
9. Progress or status notes for the services or activities provided.
10. All forms required by the department as a condition of payment for the services provided.
11. Any treatment plan, care plan, service plan, individual health plan, behavioral intervention plan, or individualized education program.
12. The provider's assessment, clinical impression, diagnosis, or narrative, including the complete date thereof and the identity of the person performing the assessment, clinical impression, diagnosis, or narrative.
13. Any additional documentation necessary to demonstrate the medical necessity of the service provided or otherwise required for Medicaid payment.

(3) Service documentation. The record for each service provided shall include information necessary to substantiate that the service was provided. Service documentation shall include narrative documentation and may also include documentation in checkbox format. The service record shall include the following:

1. The specific procedures or treatments performed.
2. The complete date of the service, including the beginning and ending date if the service is rendered over more than one day.
3. The complete time of the service, including the beginning and ending time if the service is billed on a time-related basis. For those non-time-related services billed using Current Procedural Terminology (CPT) codes, the total time of the service shall be recorded, rather than the beginning and ending time.
4. The location where the service was provided if otherwise required on the billing form or in 441—paragraph 77.30(5)“c” or “d,”441—paragraph 77.33(6)“d,”441—paragraph 77.34(5)“d,”441—paragraph 77.37(15)“d,”441—paragraph 77.39(13)“e,”441—paragraph 77.39(14)“d,” or 441—paragraph 77.46(5)“i,” or 441—subparagraph 78.9(10)“a”(1).
5. The name, dosage, and route of administration of any medication dispensed or administered as part of the service.
6. Any supplies dispensed as part of the service.
7. The first and last name and professional credentials, if any, of the person providing the service.
8. The signature of the person providing the service, or the initials of the person providing the service if a signature log indicates the person's identity.
9. For 24-hour care, documentation for every shift of the services provided, the member's response to the services provided, and the person who provided the services.

(4) Outcome of service. The medical record shall indicate the member's progress in response to the services rendered, including any changes in treatment, alteration of the plan of care, or revision of the diagnosis.

*d. Basis for service requirements for specific services.* The medical record for the following services must include, but is not limited to, the items specified below (unless the listed item is not routinely received or created in connection with the particular service or activity and is not required to document the reason for performing the service or activity, its medical necessity, or the level of care associated with it). These items will be specified on Form 470-4479, Documentation Checklist, when the Iowa Medicaid enterprise program integrity unit requests providers to submit records for review. (See paragraph 79.4(2) "b.")

- (1) Physician (MD and DO) services:
  1. Service or office notes or narratives.
  2. Procedure, laboratory, or test orders and results.
- (2) Pharmacy services:
  1. Prescriptions.
  2. Nursing facility physician order.
  3. Telephone order.
  4. Pharmacy notes.
  5. Prior authorization documentation.
- (3) Dentist services:
  1. Treatment notes.
  2. Anesthesia notes and records.
  3. Prescriptions.
- (4) Podiatrist services:
  1. Service or office notes or narratives.
  2. Certifying physician statement.
  3. Prescription or order form.
- (5) Certified registered nurse anesthetist services:
  1. Service notes or narratives.
  2. Preanesthesia physical examination report.
  3. Operative report.
  4. Anesthesia record.
  5. Prescriptions.
- (6) Other advanced registered nurse practitioner services:
  1. Service or office notes or narratives.
  2. Procedure, laboratory, or test orders and results.
  3. Other service documentation as applicable.
- (7) Optometrist and optician services:
  1. Notes or narratives supporting eye examinations, medical services, and auxiliary procedures.
  2. Original prescription or updated prescriptions for corrective lenses or contact lenses.
  3. Prior authorization documentation.
- (8) Psychologist services:
  1. Service or office psychotherapy notes or narratives.
  2. Psychological examination report and notes.
  3. Other service documentation as applicable.
- (9) Clinic services:
  1. Service or office notes or narratives.
  2. Procedure, laboratory, or test orders and results.
  3. Nurses' notes.
  4. Prescriptions.
  5. Medication administration records.
- (10) Services provided by rural health clinics or federally qualified health centers:
  1. Service or office notes or narratives.
  2. Form 470-2942, Prenatal Risk Assessment.
  3. Procedure, laboratory, or test orders and results.

4. Immunization records.
- (11) Services provided by community mental health centers:
  1. Service referral documentation.
  2. Initial evaluation.
  3. Individual treatment plan.
  4. Service or office notes or narratives.
  5. Narratives related to the peer review process and peer review activities related to a member's treatment.
  6. Written plan for accessing emergency services.
  7. Other service documentation as applicable.
- (12) Screening center services:
  1. Service or office notes or narratives.
  2. Immunization records.
  3. Laboratory reports.
  4. Results of health, vision, or hearing screenings.
- (13) Family planning services:
  1. Service or office notes or narratives.
  2. Procedure, laboratory, or test orders and results.
  3. Nurses' notes.
  4. Immunization records.
  5. Consent forms.
  6. Prescriptions.
  7. Medication administration records.
- (14) Maternal health center services:
  1. Service or office notes or narratives.
  2. Procedure, laboratory, or test orders and results.
  3. Form 470-2942, Prenatal Risk Assessment.
- (15) Birthing center services:
  1. Service or office notes or narratives.
  2. Form 470-2942, Prenatal Risk Assessment.
- (16) Ambulatory surgical center services:
  1. Service notes or narratives (history and physical, consultation, operative report, discharge summary).
  2. Physician orders.
  3. Consent forms.
  4. Anesthesia records.
  5. Pathology reports.
  6. Laboratory and X-ray reports.
- (17) Hospital services:
  1. Physician orders.
  2. Service notes or narratives (history and physical, consultation, operative report, discharge summary).
  3. Progress or status notes.
  4. Diagnostic procedures, including laboratory and X-ray reports.
  5. Pathology reports.
  6. Anesthesia records.
  7. Medication administration records.
- (18) State mental hospital services:
  1. Service referral documentation.
  2. Resident assessment and initial evaluation.
  3. Individual comprehensive treatment plan.
  4. Service notes or narratives (history and physical, therapy records, discharge summary).

5. Form 470-0042, Case Activity Report.
  6. Medication administration records.
- (19) Services provided by skilled nursing facilities, nursing facilities, and nursing facilities for persons with mental illness:
1. Physician orders.
  2. Progress or status notes.
  3. Service notes or narratives.
  4. Procedure, laboratory, or test orders and results.
  5. Nurses' notes.
  6. Physical therapy, occupational therapy, and speech therapy notes.
  7. Medication administration records.
  8. Form 470-0042, Case Activity Report.
- (20) Services provided by intermediate care facilities for persons with mental retardation:
1. Physician orders.
  2. Progress or status notes.
  3. Preliminary evaluation.
  4. Comprehensive functional assessment.
  5. Individual program plan.
  6. Form 470-0374, Resident Care Agreement.
  7. Program documentation.
  8. Medication administration records.
  9. Nurses' notes.
  10. Form 470-0042, Case Activity Report.
- (21) Services provided by psychiatric medical institutions for children:
1. Physician orders or court orders.
  2. Independent assessment.
  3. Individual treatment plan.
  4. Service notes or narratives (history and physical, therapy records, discharge summary).
  5. Form 470-0042, Case Activity Report.
  6. Medication administration records.
- (22) Hospice services:
1. Physician certifications for hospice care.
  2. Form 470-2618, Election of Medicaid Hospice Benefit.
  3. Form 470-2619, Revocation of Medicaid Hospice Benefit.
  4. Plan of care.
  5. Physician orders.
  6. Progress or status notes.
  7. Service notes or narratives.
  8. Medication administration records.
  9. Prescriptions.
- (23) Services provided by rehabilitation agencies:
1. Physician orders.
  2. Initial certification, recertifications, and treatment plans.
  3. Narratives from treatment sessions.
  4. Treatment and daily progress or status notes and forms.
- (24) Home- and community-based habilitation services:
1. Notice of decision for service authorization.
  2. Service plan (initial and subsequent).
  3. Service notes or narratives.
  4. Other service documentation as applicable.
- (25) Behavioral health intervention:
1. Order for services.

2. Comprehensive treatment or service plan (initial and subsequent).
  3. Service notes or narratives.
  4. Other service documentation as applicable.
- (26) Services provided by area education agencies and local education agencies:
1. Service notes or narratives.
  2. Individualized education program (IEP).
  3. Individual health plan (IHP).
  4. Behavioral intervention plan.
- (27) Home health agency services:
1. Plan of care or plan of treatment.
  2. Certifications and recertifications.
  3. Service notes or narratives.
  4. Physician orders or medical orders.
- (28) Services provided by independent laboratories:
1. Laboratory reports.
  2. Physician order for each laboratory test.
- (29) Ambulance services:
1. Documentation on the claim or run report supporting medical necessity of the transport.
  2. Documentation supporting mileage billed.
- (30) Services of lead investigation agencies:
1. Service notes or narratives.
  2. Child's lead level logs (including laboratory results).
  3. Written investigation reports to family, owner of building, child's medical provider, and local childhood lead poisoning prevention program.
  4. Health education notes, including follow-up notes.
- (31) Medical supplies:
1. Prescriptions.
  2. Certificate of medical necessity.
  3. Prior authorization documentation.
  4. Medical equipment invoice or receipt.
- (32) Orthopedic shoe dealer services:
1. Service notes or narratives.
  2. Prescriptions.
  3. Certifying physician's statement.
- (33) Case management services, including HCBS case management services:
1. Form 470-3956, MR/CMI/DD Case Management Service Authorization Request, for services authorized before May 1, 2007.
  2. Notice of decision for service authorization.
  3. Service notes or narratives.
  4. Social history.
  5. Comprehensive service plan.
  6. Reassessment of member needs.
  7. Incident reports in accordance with 441—subrule 24.4(5).
  8. Other service documentation as applicable.
- (34) Early access service coordinator services:
1. Individualized family service plan (IFSP).
  2. Service notes or narratives.
- (35) Home- and community-based waiver services, other than case management:
1. Notice of decision for service authorization.
  2. Service plan.
  3. Service logs, notes, or narratives.
  4. Mileage and transportation logs.

5. Log of meal delivery.
  6. Invoices or receipts.
  7. Forms 470-3372, HCBS Consumer-Directed Attendant Care Agreement, and 470-4389, Consumer-Directed Attendant Care (CDAC) Service Record.
  8. Other service documentation as applicable.
- (36) Physical therapist services:
1. Physician order for physical therapy.
  2. Initial physical therapy certification, recertifications, and treatment plans.
  3. Treatment notes and forms.
  4. Progress or status notes.
- (37) Chiropractor services:
1. Service or office notes or narratives.
  2. X-ray results.
- (38) Hearing aid dealer and audiologist services:
1. Physician examinations and audiological testing (Form 470-0361, Sections A, B, and C).
  2. Documentation of hearing aid evaluation and selection (Form 470-0828).
  3. Waiver of informed consent.
  4. Prior authorization documentation.
  5. Service or office notes or narratives.
- (39) Behavioral health services:
1. Assessment.
  2. Individual treatment plan.
  3. Service or office notes or narratives.
  4. Other service documentation as applicable.
- (40) Health home services:
1. Comprehensive care management plan.
  2. Care coordination and health promotion plan.
  3. Comprehensive transitional care plan, including appropriate follow-up, from inpatient to other settings.
  4. Documentation of member and family support (including authorized representatives).
  5. Documentation of referral to community and social support services, if relevant.
- (41) Services of public health agencies:
1. Service or office notes or narratives.
  2. Immunization records.
  3. Results of communicable disease testing.
- (42) Community-based neurobehavioral rehabilitation residential services and community-based neurobehavioral rehabilitation intermittent services:
1. Department-approved standardized neurobehavioral assessment tool.
  2. Community-based neurobehavioral treatment order.
  3. Treatment plan.
  4. Clinical records documenting diagnosis and treatment history.
  5. Progress or status notes.
  6. Service notes or narratives.
  7. Procedure, laboratory, or test orders and results.
  8. Therapy notes including but not limited to occupational therapy, physical therapy, and speech-language pathology services as applicable.
  9. Medication administration records.
  10. Other service documentation as applicable.
- (43) Child care medical services:
1. Plan of care.
  2. Certification and recertification.
  3. Service notes or narratives.

4. Physician orders or medical orders.
5. Abbreviation list (a copy of the abbreviation list utilized within the member's record).
6. If initials or incomplete signatures are noted within the member's record, a signature log (a typed listing of each provider's name, including initials, professional credentials and title, followed by the individual provider's signature).

(44) Subacute mental health services.

1. Physician orders or court orders.
2. Independent assessment.
3. Individual treatment plan.
4. Service notes or narratives (history and physical, therapy records, discharge summary).
5. Medication administration records (residential services).

(45) Crisis response services, crisis stabilization community-based services and crisis stabilization residential services.

1. Assessment.
2. Individual stabilization plan.
3. Service notes or narratives (history and physical, therapy records, discharge summary).
4. Medication administration records (residential services).

*e. Corrections.* A provider may correct the medical record before submitting a claim for reimbursement.

(1) Corrections must be made or authorized by the person who provided the service or by a person who has first-hand knowledge of the service.

(2) A correction to a medical record must not be written over or otherwise obliterate the original entry. A single line may be drawn through erroneous information, keeping the original entry legible. In the case of electronic records, the original information must be retained and retrievable.

(3) Any correction must indicate the person making the change and any other person authorizing the change, must be dated and signed by the person making the change, and must be clearly connected with the original entry in the record.

(4) If a correction made after a claim has been submitted affects the accuracy or validity of the claim, an amended claim must be submitted.

**79.3(3) Maintenance requirement.** The provider shall maintain records as required by this rule:

- a.* During the time the member is receiving services from the provider.
- b.* For a minimum of five years from the date when a claim for the service was submitted to the medical assistance program for payment.
- c.* As may be required by any licensing authority or accrediting body associated with determining the provider's qualifications.

**79.3(4) Availability.** Rescinded IAB 1/30/08, effective 4/1/08.

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

[ARC 7957B, IAB 7/15/09, effective 7/1/09; ARC 8262B, IAB 11/4/09, effective 12/9/09; ARC 9440B, IAB 4/6/11, effective 4/1/11; ARC 9487B, IAB 5/4/11, effective 7/1/11; ARC 0198C, IAB 7/11/12, effective 7/1/12; ARC 0358C, IAB 10/3/12, effective 11/7/12; ARC 0711C, IAB 5/1/13, effective 7/1/13; ARC 1695C, IAB 10/29/14, effective 1/1/15; ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 2341C, IAB 1/6/16, effective 2/10/16; ARC 3358C, IAB 10/11/17, effective 10/1/17; ARC 3551C, IAB 1/3/18, effective 2/7/18; ARC 3554C, IAB 1/3/18, effective 2/7/18; ARC 3716C, IAB 3/28/18, effective 5/2/18]

#### 441—79.4(249A) Reviews and audits.

**79.4(1) Definitions.**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

b. Extension of time limit for submission.

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

1. Establish good cause for the delay in submitting the records; and

2. Be received by the department before the date the records are due to be submitted.
- (2) For purposes of these rules, “good cause” has the same meaning as in Iowa Rule of Civil Procedure 1.977.
  - (3) The department may grant a request for an extension of the time limit for submitting records at its discretion. The department shall issue a written notice of its decision.
  - (4) The provider may appeal the department’s denial of a request to extend the time limit for submission of requested records according to the procedures in 441—Chapter 7.
- c.* The department may elect to conduct announced or unannounced on-site reviews or audits. Records must be provided upon request and before the end of the on-site review or audit.
- (1) For an announced on-site review or audit, the department’s employee or authorized agent may give as little as one day’s advance notice of the review or audit and the records and supporting documentation to be reviewed.
  - (2) Notice is not required for unannounced on-site reviews and audits.
  - (3) In an on-site review or audit, the conclusion of that review or audit shall be considered the end of the period within which to produce records.
- d.* Audit or review procedures may include, but are not limited to, the following:
- (1) Comparing clinical and fiscal records with each claim.
  - (2) Interviewing members who received goods or services and employees of providers.
  - (3) Examining third-party payment records.
  - (4) Comparing Medicaid charges with private-patient charges to determine that the charge to Medicaid is not more than the customary and prevailing fee.
  - (5) Examining all documents related to the services for which Medicaid was billed.
- e.* Use of statistical sampling techniques. The department’s procedures for auditing or reviewing Medicaid providers may include the use of random sampling and extrapolation.
- (1) A statistically valid random sample will be selected from the universe of records to be audited or reviewed. The sample size shall be selected using accepted sample size estimation methods. The confidence level of the sample size calculation shall not be less than 95 percent.
  - (2) Following the sample audit or review, the statistical margin of error of the sample will be computed, and a confidence interval will be determined. The estimated error rate will be extrapolated to the universe from which the sample was drawn within the computed margin of error of the sampling process.
  - (3) Commonly accepted statistical analysis programs may be used to estimate the sample size and calculate the confidence interval, consistent with the sampling parameters.
  - (4) The audit or review findings generated through statistical sampling procedures shall constitute prima facie evidence in all department proceedings regarding the number and amount of overpayments or underpayments received by the provider.
- f.* Self-audit. The department may require a provider to conduct a self-audit and report the results of the self-audit to the department.
- 79.4(4) Preliminary report of audit or review findings.** If the department concludes from an audit or review that an overpayment has occurred, the department will issue a preliminary finding of a tentative overpayment and inform the provider of the opportunity to request a reevaluation.
- 79.4(5) Disagreement with audit or review findings.** If a provider disagrees with the preliminary finding of a tentative overpayment, the provider may request a reevaluation by the department and may present clarifying information and supplemental documentation.
- a.* *Reevaluation request.* A request for reevaluation must be submitted in writing within 15 calendar days of the date of the notice of the preliminary finding of a tentative overpayment. The request must specify the issues of disagreement.
- (1) If the audit or review is being performed by the Iowa Medicaid enterprise surveillance and utilization review services unit, the request should be addressed to: IME SURS Unit, P.O. Box 36390, Des Moines, Iowa 50315.

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

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

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

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

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

**79.4(7) Appeal by provider of care.** A provider may appeal the finding and order of repayment and withholding of payments pursuant to 441—Chapter 7. However, an appeal shall not stay the withholding of payments or other action to collect the overpayment. Records not provided to the department during the review process set forth in subrule 79.4(3) or 79.4(5) shall not be admissible in any subsequent contested case proceeding arising out of a finding and order for repayment of any overpayment identified under subrule 79.4(6). This provision does not preclude providers that have provided records to the department during the review process set forth in subrule 79.4(3) or 79.4(5) from presenting clarifying information or supplemental documentation in the appeals process in order to defend against any overpayment identified under subrule 79.4(6). This provision is intended to minimize potential duplication of effort and delay in the audit or review process, minimize unnecessary appeals, and otherwise forestall fraud, waste, and abuse in the Iowa Medicaid program.

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

[ARC 0712C, IAB 5/1/13, effective 7/1/13; ARC 1155C, IAB 10/30/13, effective 1/1/14]

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

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

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

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

In these agreements, the provider agrees to the following:

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

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

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

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

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

**79.7(1) Officers.**

*a. Definitions.*

*“Co-chairpersons”* means the public health director co-chairperson and the public co-chairperson.

*“Public co-chairperson”* means the individual selected by the other publicly appointed members of the council to serve as a co-chairperson of the council.

*“Public health director co-chairperson”* means the director of the department of public health, who serves as a co-chairperson of the council.

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

*c.* The public co-chairperson shall have the right to vote on any issue before the council. The public health director co-chairperson serves as a nonvoting member of the council.

*d.* The position of public co-chairperson shall be held by one of the ten publicly appointed council members. Ballots will be distributed to the public council members at the quarterly meeting closest to the beginning of the next state fiscal year and will be collected in paper and electronic format and administered by department of human services staff.

*e.* The co-chairpersons shall appoint members to other committees approved by the council.

*f.* The co-chairpersons shall also serve on the executive committee and will serve as the co-chairpersons of that committee.

*g. Responsibilities.*

(1) The co-chairpersons shall be responsible for development of the agendas for meetings of the full council. Agendas will be developed and distributed in compliance with the advance notice requirements of Iowa Code section 21.4. Agendas will be developed in consultation with the staff and director of human services, taking into consideration the following:

1. Workplans. Items will be added to the council's agenda as various tasks for the council are due to be discussed based on calendar requirements. Council deliberations are to be conducted within a time frame to allow the executive committee to receive the council's feedback and make recommendations to the director and for the director to consider those recommendations as budgets and policy for the medical assistance program are developed for the review of the council on human services and the governor, as well as for the upcoming legislative session.

2. Requests from the director of human services.

3. Discussion and action items from council members. The co-chairpersons will review any additional suggestions from council members at any time, including after the draft agenda has been distributed. The agenda will be distributed in draft form five business days prior to the council meeting, and the final agenda will be distributed no later than 24 hours prior to the council meeting.

(2) The co-chairpersons shall preside over all council and executive committee meetings, calling roll, determining a quorum, counting votes, and following the agenda for the meeting.

(3) The co-chairpersons shall consult with the department of human services on other administrative tasks to oversee the council and shall participate in workgroups and subcommittees as appropriate.

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

*a. Council membership.*

(1) Council membership of professional and business entities shall consist of those entities outlined in Iowa Code section 249A.4B(2). Professional and business entities shall identify their representatives and report information to the department of human services.

1. If an entity's representative does not attend more than three consecutive meetings, the department of human services will notify the entity and representative and verify whether an alternate contact is needed.

2. Professional and business entities shall determine the length of appointment of their representatives. The department of human services will confirm each representative's participation every two years, regardless of the representative's meeting attendance.

3. All professional and business entities will be voting members of the council.

(2) Council membership of public representatives shall consist of ten representatives which may include members of consumer groups, including recipients of medical assistance or their families, consumer organizations, and others, appointed by the governor for staggered terms of two years each, none of whom shall be members of, or practitioners of, or have a pecuniary interest in any of the professional or business entities specifically represented in Iowa Code sections 249A.4B(2) and 249A.4B(3) and a majority of whom shall be current or former recipients of medical assistance or members of the families of current or former recipients. All public representatives will be voting members of the council.

(3) A member of the HAWK-I board, created in Iowa Code section 514I.5, selected by the members of the HAWK-I board, shall be a member of the council. The HAWK-I board member representative will be a voting member of the council.

(4) Council membership shall also consist of state agency and medical school partners, including representatives from the department of public health, the department on aging, the office of the long-term care ombudsman, Des Moines University and the University of Iowa College of Medicine.

1. Partner agency and medical school representatives will be nonvoting members of the council.

2. If an agency's or school's representative does not attend more than three consecutive meetings, the department of human services will notify the agency or school.

3. Partner agencies and medical schools shall determine the length of appointment of their representatives. The department of human services will confirm each representative's participation every two years, regardless of the representative's meeting attendance.

(5) The following members of the general assembly shall be members of the council, each for a term of two years as provided in Iowa Code section 69.16B. Members appointed from the general assembly will serve as nonvoting members of the council.

1. Two members of the house of representatives, one appointed by the speaker of the house of representatives and one appointed by the minority leader of the house of representatives from their respective parties.

2. Two members of the senate, one appointed by the president of the senate after consultation with the majority leader of the senate and one appointed by the minority leader of the senate.

*b. Executive committee membership.* Executive committee membership shall consist of the following:

(1) Five professional and business entities identified in Iowa Code section 249A.4B(2). The entity, not the individual representative, is selected for membership on the executive committee. Each selected entity shall appoint its individual representative. Professional and business entities of the council vote to select the business and professional entities of the executive committee.

(2) Five individuals appointed to the council as public members, pursuant to Iowa Code section 249A.4B(2).

1. One of the five public member positions on the executive committee will be held by the co-chairperson identified in subrule 79.7(1).

2. At least one public member shall be a recipient of medical assistance.

3. Public members of the council vote to select the public members of the executive committee.

(3) The co-chairpersons identified in subrule 79.7(1), who shall serve as the co-chairpersons of the executive committee.

(4) The executive committee will be elected for two-year terms, beginning at the start of a state fiscal year.

1. All voting members of the council will be eligible for election to the executive committee, based on the criteria outlined in this paragraph.

2. Ballots will be distributed at the quarterly meeting closest to the beginning of the next state fiscal year and will be collected in paper and electronic format and administered by department of human services staff.

3. Should any vacancy occur on the executive committee, a special election will be held following the standards outlined in this paragraph.

4. Ballots should include the professional and business entity name but omit the name of the representative of the entity.

**79.7(3) Responsibilities, duties and meetings.** The responsibility of the medical assistance advisory council is to provide recommendations on the medical assistance program to the department of human services through the executive committee of the council.

*a. Recommendations.* Recommendations made by the executive committee from the council shall be advisory and not binding upon the department of human services or the professional and business entities represented. The director of the department of human services shall consider the recommendations in the director's preparation of medical assistance budget recommendations to the council on human services, pursuant to Iowa Code section 217.3 and implementation of medical assistance program policies.

*b. Council.* The council shall be provided with information to deliberate and provide input on the medical assistance program. The executive committee will use that input in making final recommendations to the department of human services.

(1) Council meetings.

1. The council will meet no more than quarterly.

2. Meetings may be called by the co-chairpersons; upon written request of at least 50 percent of members; or by the director of the department of human services.

3. Meetings shall be held in the Des Moines, Iowa, area unless other notification is given. Meetings will also be made available via teleconference, when available.

4. Written notice of council meetings shall be electronically mailed at least five business days in advance of the meeting. Each notice shall include an agenda for the meeting. The final agenda will be distributed no later than 24 hours prior to the meeting.

(2) The council shall advise the professional and business entities represented and act as liaison between them and the department.

(3) The council shall perform other functions as may be provided by state or federal law or regulation.

(4) Pursuant to 2016 Iowa Acts, chapter 1139, section 93, the council shall regularly review Medicaid managed care. The council shall submit an executive summary of pertinent information regarding deliberations during the prior year relating to Medicaid managed care to the department of human services no later than November 15 annually.

(5) Pursuant to 2016 Iowa Acts, chapter 1139, section 94, the council shall submit to the chairpersons and ranking members of the human resources committees of the senate and house of representatives and to the chairpersons and ranking members of the joint appropriations subcommittee on health and human services, on a quarterly basis, minutes of the council meetings during which the council addressed Medicaid managed care.

(6) The council shall review the recommendations submitted by the executive committee regarding feedback received at the IA Health Link statewide public comment meetings outlined in 2016 Iowa Acts, chapter 1139, section 102.

*c. Executive committee.*

(1) Executive committee meetings.

1. The executive committee shall meet on a monthly basis.
2. Meetings may be called by the co-chairpersons; upon written request of at least 50 percent of executive committee members; or by the director of the department of human services.
3. Meetings shall be held in the Des Moines, Iowa, area unless other notification is given. Meetings will also be made available via teleconference, when available.
4. In a month when a council meeting is held, the executive committee shall meet after the council meeting, allowing committee members to discuss and make recommendations based on the topics discussed by council members.
  - (2) Based on the deliberations of the full council, the executive committee shall make recommendations to the director of human services regarding the budget, policy, and administration of the medical assistance program. Such recommendations may include:
    1. Recommendations on the reimbursement for medical services rendered by providers of services.
    2. Identification of unmet medical needs and maintenance needs which affect health.
    3. Recommendations for objectives of the program and for methods of program analysis and evaluation, including utilization review.
    4. Recommendations for ways in which needed medical supplies and services can be made available most effectively and economically to program recipients.
    5. Advice on such administrative and fiscal matters as the director of human services may request.
  - (3) Pursuant to 2016 Iowa Acts, chapter 1139, section 102, the executive committee shall review the compilation of the input and recommendations from the public meetings convened statewide and shall submit recommendations based upon the compilation to the director of human services on a quarterly basis through December 31, 2017.

**79.7(4) Procedures.**

- a. Procedures shall apply to both the council and the executive committee.
- b. A quorum shall consist of 50 percent of the current voting members.
- c. Where a quorum is present, a position is carried by two-thirds of the council members present.
- d. Minutes of council meetings and other written materials developed by the council shall be distributed by the department to each member of the full council.
- e. In cases not covered by these rules, Robert's Rules of Order shall govern.

**79.7(5) Expenses, staff support, and technical assistance.** Expenses of the council and executive committee, such as those for clerical services, mailing, telephone, and meeting place, shall be the responsibility of the department of human services. The department shall arrange for a meeting place, related services, and accommodations. The department shall provide staff support and independent technical assistance to the council and the executive committee.

- a. The department shall provide reports, data, and proposed and final amendments to rules, laws, and guidelines to the council for its information, review, and comment.
- b. The department shall present the annual budget for the medical assistance program for review and comment.
- c. The department shall permit staff members to appear before the council to review and discuss specific information and problems.
- d. The department shall maintain a current list of members on the council and executive committee.
- e. The department shall be responsible for the organization of all council and executive committee meetings and notice of meetings.
- f. As required in Iowa Code section 21.3, minutes of the meetings of the council and of the executive committee will be kept by the department. The co-chairpersons will review minutes before distribution.
- g. The department shall compile input and recommendations received at the public meetings established in 2016 Iowa Acts, chapter 1139, section 102, and submit the information to the executive committee for review.

[ARC 8263B, IAB 11/4/09, effective 12/9/09; ARC 3006C, IAB 3/29/17, effective 6/1/17]

**441—79.8(249A) Requests for prior authorization.** This rule governs requests for prior authorization for services not provided through a managed care organization. For services provided through a managed care organization, the prior authorization request is submitted, reviewed, and authorized by the managed care organization.

**79.8(1) Making the request.**

*a.* Providers may submit requests for prior authorization for any items or procedures by mail or by facsimile transmission (fax) using Form 470-0829, Request for Prior Authorization, or electronically using the Accredited Standards Committee (ASC) X12N 278 transaction, Health Care Services Request for Review and Response. Requests for prior authorization for drugs must be submitted on any Request for Prior Authorization form designated for the drug being requested in the preferred drug list published pursuant to Iowa Code chapter 249A.

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

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

- (1) Use Form 470-3970, Prior Authorization Attachment Control, as the cover sheet for the paper attachments or supporting clinical documentation; and
- (2) Reference on Form 470-3970 the attachment control number submitted on the ASC X12N 278 electronic transaction.

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

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

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

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

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

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

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

**79.8(7)** Requests for prior approval of services shall be reviewed according to rule 441—79.9(249A) and the conditions for payment as established by rule in 441—Chapter 78.

*a.* Where ambiguity exists as to whether a particular item or service is covered, requests for prior approval shall be reviewed according to the following criteria in order of priority:

- (1) The conditions for payment outlined in the provider manual with reference to coverage and duration.
- (2) The determination made by the Medicare program unless specifically stated differently in state law or rule.
- (3) The recommendation to the department from the appropriate advisory committee.
- (4) Whether there are other less expensive procedures which are covered and which would be as effective.
- (5) The advice of an appropriate professional consultant.

*b.* When the Iowa Medicaid enterprise has not reached a decision on a request for prior authorization after 60 days from the date of receipt, the request will be approved.

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

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

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

This rule is intended to implement Iowa Code section 249A.4.  
[ARC 2361C, IAB 1/6/16, effective 1/1/16]

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

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

**79.9(2)** The services covered by Medicaid shall:

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

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

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

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

**79.9(6)** The acceptance of Medicaid funds by means of a prospective or interim rate creates an express trust. The Medicaid funds received constitute the trust res. The trust terminates when the rate is retrospectively adjusted or otherwise finalized and, if applicable, any Medicaid funds determined to be owed are repaid in full to the department.

**79.9(7)** Incorrect payment.

a. Except as provided in paragraph 79.9(7)“b,” medical assistance funds are incorrectly paid whenever an individual who provided the service to the member for which the department paid was at the time service was provided the parent of a minor child, spouse, or legal representative of the member.

b. Notwithstanding paragraph 79.9(7)“a,” medical assistance funds are not incorrectly paid when an individual who serves as a member's legal representative provides services to the member under a home- and community-based services waiver consumer-directed attendant care agreement or under a consumer choices option employment agreement in effect on or after December 31, 2013. For purposes of this paragraph, “legal representative” means a person, including an attorney, who is authorized by law to act on behalf of the medical assistance program member but does not include the spouse of a member or the parent or stepparent of a member aged 17 or younger.

**79.9(8)** The rules of the medical assistance program shall not be construed to require payment of medical assistance funds, in whole or in part, directly or indirectly, overtly or covertly, for the provision of non-Medicaid services. The rules of the medical assistance program shall be interpreted in such a manner to minimize any risk that medical assistance funds might be used to subsidize services to persons other than members of the medical assistance program.

This rule is intended to implement Iowa Code section 249A.4 and 2014 Iowa Acts, Senate File 2320. [ARC 1155C, IAB 10/30/13, effective 1/1/14; ARC 1610C, IAB 9/3/14, effective 8/13/14]

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

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

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

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

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

**79.10(5)** The requirement to obtain preadmission review is waived when the patient is enrolled in the managed health care option known as patient management and proper authorization for the admission has been obtained from the patient manager as described in 441—Chapter 73.

This rule is intended to implement Iowa Code section 249A.4. [ARC 2361C, IAB 1/6/16, effective 1/1/16]

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

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

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

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

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

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

**79.11(6)** The requirement to obtain preprocedure surgical review is waived when the patient is enrolled in the managed health care option known as patient management and proper authorization for the procedure has been obtained from the patient manager as described in 441—Chapter 73.

This rule is intended to implement Iowa Code section 249A.4.  
[ARC 2361C, IAB 1/6/16, effective 1/1/16]

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

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

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

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

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

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

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

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

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

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

**441—79.14(249A) Provider enrollment.**

**79.14(1)** Application request. Iowa Medicaid providers, including those enrolled with a managed care organization, shall begin the enrollment process by completing the appropriate application on the Iowa Medicaid enterprise website. Managed care organizations and fiscal agents are exempt from completing an application.

*a.* Providers of home- and community-based waiver services shall submit Form 470-2917, Medicaid HCBS Provider Application, at least 90 days before the planned service implementation date.

*b.* Providers enrolling as ordering or referring providers shall submit Form 470-5111, Iowa Medicaid Ordering/Referring Provider Enrollment Application.

c. All other providers shall submit Form 470-0254, Iowa Medicaid Provider Enrollment Application.

d. A nursing facility shall also complete the process set forth in 441—subrule 81.13(1).

e. An intermediate care facility for persons with an intellectual disability shall also complete the process set forth in 441—subrule 82.3(1).

f. Qualified Medicare beneficiary (QMB) providers shall enroll using Form 470-5262, Qualified Medicare Beneficiaries (QMB) or Health Insurance Premium Payment (HIPP) Program Provider Enrollment Application.

g. Health insurance premium payment (HIPP) providers shall enroll using Form 470-5262, Qualified Medicare Beneficiaries (QMB) or Health Insurance Premium Payment (HIPP) Program Provider Enrollment Application.

**79.14(2)** Submittal of application. The provider shall submit the appropriate application forms, including the application fee, if required, to the Iowa Medicaid enterprise provider services unit by personal delivery, by email, via online enrollment systems, or by mail to P.O. Box 36450, Des Moines, Iowa 50315.

a. The application shall include the provider's national provider identifier number or shall indicate that the provider is an atypical provider that is not issued a national provider identifier number.

b. With the application form, an assertive community treatment program shall submit Form 470-4842, Assertive Community Services (ACT) Provider Agreement Addendum, and agree to file with the department an annual report containing information to be used for rate setting, including:

(1) Data by practitioner on the utilization by Medicaid members of all the services included in assertive community treatment, and

(2) Cost information by practitioner type and by type of service actually delivered as part of assertive community treatment.

c. With the application form, or as a supplement to a previously submitted application, providers of health home services shall submit Form 470-5100, Health Home Provider Agreement.

d. Application fees.

(1) Providers who are enrolling or reenrolling in the Iowa Medicaid program shall submit an application fee with their application unless they are exempt as set forth in this paragraph.

(2) Fee amount. The application fee shall be in the amount prescribed by the Secretary of the U.S. Department of Health and Human Services (the Secretary) for the calendar year in which the application is submitted and in accordance with 42 U.S.C. 1395cc(j)(2)(C).

(3) Nonrefundable. The application fee is nonrefundable, except if submitted with one of the following:

1. A hardship exception request that is subsequently approved by the Secretary.

2. An application that is subsequently denied as a result of a temporary moratorium under 2013 Iowa Acts, Senate File 357, section 12.

3. An application or other transaction in which the application fee is not required.

(4) The process for enrolling or reenrolling a provider will not begin until the application fee has been received by the department or a hardship exception request has been approved by the Secretary.

(5) Exempt providers. The following providers shall not be required to submit an application fee:

1. Individual physicians or nonphysician practitioners.

2. Providers that are enrolled in Medicare, another state's Medicaid program or another state's children's health insurance program.

3. Providers that have paid the applicable application fee within 12 months of the date of application submission to a Medicare contractor or another state.

(6) All application fees collected shall be used for the costs associated with the screening procedures as described in subrule 79.14(4). Any unused portion of the application fees collected shall be returned to the federal government in accordance with 42 CFR § 455.460.

**79.14(3)** Program integrity information requirements.

a. All providers, including but not limited to managed care organizations and Medicaid fiscal agents, applying for participation in the Iowa Medicaid program must disclose all information required

to be submitted pursuant to 42 CFR Part 455. In addition, all providers shall disclose any current, or previous, direct or indirect affiliation with a present or former Iowa Medicaid provider that:

- (1) Has any uncollected debt owed to Medicaid or any other health care program funded by any governmental entity, including but not limited to the federal and state of Iowa governments;
- (2) Has been or is subject to a payment suspension under a federally funded health care program;
- (3) Has been excluded from participation under Medicaid, Medicare, or any other federally funded health care program;
- (4) Has had its billing privileges denied or revoked;
- (5) Has been administratively dissolved by the Iowa secretary of state, or similar action has been taken by a comparable agency in another state; or
- (6) Shares a national provider identification (NPI) number or tax ID number with another provider that meets the criteria specified in subparagraph 79.14(3)“a”(1), (2), (3), (4), or (5).

*b.* The Iowa Medicaid enterprise may deny enrollment to a provider applicant or disenroll a current provider that has any affiliation as set forth in this rule if the department determines that the affiliation poses a risk of fraud, waste, or abuse. Such denial or disenrollment is appealable under 441—Chapter 7 but, notwithstanding any provision to the contrary in that chapter, the provider shall bear the burden to prove by clear and convincing evidence that the affiliation does not pose any risk of fraud, waste, or abuse. The Iowa Medicaid enterprise shall deny enrollment to or shall immediately disenroll any person that the Iowa Medicaid enterprise, Medicare, or any other state Medicaid program has ever terminated under rule 441—79.2(249A) or a similar provision and shall deny enrollment to any person presently suspended from participation, or who would be subject to a suspension, under paragraph 79.2(3)“c.” Further, a person sanctioned under rule 441—79.2(249A) or a similar provision may not manage consumer choices option (CCO) funds for a member.

*c.* For purposes of this rule, the term “direct or indirect affiliation” includes but is not limited to relationships between individuals, business entities, or a combination of the two. The term includes but is not limited to direct or indirect business relationships that involve:

- (1) A compensation arrangement;
- (2) An ownership arrangement;
- (3) Managerial authority over any member of the affiliation;
- (4) The ability of one member of the affiliation to control or influence any other; or
- (5) The ability of a third party to control or influence any member of the affiliation.

*d.* Notwithstanding any previous successful enrollment in the medical assistance program, the passing of any background check by the department or any other entity, or similar prior approval for participation as a provider in the medical assistance program, in whole or in part, disenrollment from the medical assistance program is mandatory when, in the case of a corporation or similar entity, 5 percent or more of the corporation or similar entity is owned, controlled, or directed by a person who (1) has within the last five years been listed on any dependent adult abuse registry, child abuse registry, or sex offender registry; (2) has pled guilty or nolo contendere to, or was convicted of, any crime punishable by a term of imprisonment greater than five years; (3) has, within the last five years, pled guilty or nolo contendere to, or was convicted of, any controlled substance offense; (4) has, within the last ten years, pled guilty or nolo contendere to, or was convicted of, any crime involving an allegation of dishonesty punishable by a term of imprisonment greater than one year but not more than five years; or (5) within the last ten years, has on more than one occasion pled guilty or nolo contendere to, or was convicted of, any crime involving an allegation of dishonesty.

**79.14(4)** Screening procedures and requirements. Providers applying for participation in the Iowa Medicaid program shall be subject to the “limited,” “moderate,” or “high” categorical risk screening procedures and requirements in accordance with 42 CFR §455.450.

*a.* For the types of providers that are recognized as a provider under the Medicare program, the Iowa Medicaid enterprise shall use the same categorical risk screening procedures and requirements assigned to that provider type by Medicare pursuant to 42 CFR §424.518.

*b.* Provider types not assigned a screening level by the Medicare program shall be subject to the procedures of the “limited” risk screening level pursuant to 42 CFR §455.450.

*c.* Adjustment of risk level. The Iowa Medicaid enterprise shall adjust the categorical risk screening procedures and requirements from “limited” or “moderate” to “high” when any of the following occurs:

(1) The Iowa Medicaid enterprise imposes a payment suspension on a provider based on a credible allegation of fraud, waste, or abuse; the provider has an existing Medicaid overpayment; or within the previous ten years, the provider has been excluded by the Office of the Inspector General or another state’s Medicaid program; or

(2) The Iowa Medicaid enterprise or the Centers for Medicare and Medicaid Services in the previous six months lifted a temporary moratorium for the particular provider type, and a provider that was prevented from enrolling based on the moratorium applies for enrollment as a provider at any time within six months from the date the moratorium was lifted.

**79.14(5)** Notification. A provider shall be notified of the decision on the provider’s application within 30 calendar days of receipt by the Iowa Medicaid enterprise provider services unit of a complete and correct application with all required documents, including, but not limited to, if applicable, any application fees or screening results.

**79.14(6)** A provider that is not approved as the Medicaid provider type requested shall have the right to appeal under 441—Chapter 7.

**79.14(7)** Effective date of approval. An application shall be approved retroactive to the date requested by the provider or the date the provider meets the applicable participation criteria, whichever is later, not to exceed 12 months retroactive from the receipt of the application with all required documents by the Iowa Medicaid enterprise provider services unit.

**79.14(8)** A provider approved for certification as a Medicaid provider shall complete a provider participation agreement as required by rule 441—79.6(249A).

**79.14(9)** No payment shall be made to a provider for care or services provided prior to the effective date of the Iowa Medicaid enterprise’s approval of an application.

**79.14(10)** Payment rates dependent on the nature of the provider or the nature of the care or services provided shall be based on information on the application, together with information on claim forms, or on rates paid the provider prior to April 1, 1993.

**79.14(11)** An amendment to an application shall be submitted to the Iowa Medicaid enterprise provider services unit and shall be approved or denied within 30 calendar days. Approval of an amendment shall be retroactive to the date requested by the provider or the date the provider meets all applicable criteria, whichever is later, not to exceed 30 days prior to the receipt of the amendment by the Iowa Medicaid enterprise provider services unit. Denial of an amendment may be appealed under 441—Chapter 7.

**79.14(12)** A provider that has not submitted a claim in the last 24 months will be sent a notice asking if the provider wishes to continue participation. A provider that fails to reply to the notice within 30 calendar days of the date on the notice will be terminated as a provider. Providers that do not submit any claims in 48 months will be terminated as providers without further notification.

**79.14(13)** Report of changes. The provider shall inform the Iowa Medicaid enterprise of all pertinent changes to enrollment information within 35 days of the change. Pertinent changes include, but are not limited to, changes to the business entity name, individual provider name, tax identification number, mailing address, telephone number, or any information required to be disclosed by subrule 79.14(3).

*a.* When a provider reports false, incomplete, or misleading information on any application or reapplication, or fails to provide current information within the 35-day period, the Iowa Medicaid enterprise may immediately terminate the provider’s Medicaid enrollment. The termination may be appealed under 441—Chapter 7. Such termination remains in effect notwithstanding any pending appeal.

*b.* When the department incurs an informational tax-reporting fine or is required to repay the federal share of medical assistance paid to the provider because a provider submitted inaccurate information or failed to submit changes to the Iowa Medicaid enterprise in a timely manner, the fine or repayment shall be the responsibility of the individual provider to the extent that the fine or repayment relates to or arises out of the provider’s failure to keep all provider information current.

(1) The provider shall remit the amount of the fine or repayment to the department within 30 days of notification by the department that the fine has been imposed.

(2) Payment of the fine or repayment may be appealed under 441—Chapter 7.

**79.14(14)** Provider termination or denial of enrollment. The Iowa Medicaid enterprise must terminate or deny any provider enrollment when the provider has violated any requirements identified in 42 CFR §455.416.

**79.14(15)** Temporary moratoria. The Iowa Medicaid enterprise must impose any temporary moratorium pursuant to 2013 Iowa Acts, Senate File 357, section 12.

**79.14(16)** Provider revalidation. Providers are required to complete the application process and screening requirements as detailed in this rule every five years.

**79.14(17)** Recoupment. A provider is strictly liable for any failure to disclose the information required by subrule 79.14(3) or any failure to report a change required by subrule 79.14(13). The department shall recoup as incorrectly paid all funds paid to the provider before a complete disclosure or report of change was made. The department shall also recoup as incorrectly paid all funds to any provider that billed the Iowa Medicaid enterprise while the provider was administratively dissolved by the Iowa secretary of state or comparable agency of another state, even if the provider subsequently obtains a retroactive reinstatement from the Iowa secretary of state or similar action was taken against the provider by a comparable agency of another state.

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

[ARC 9440B, IAB 4/6/11, effective 4/1/11; ARC 0198C, IAB 7/11/12, effective 7/1/12; ARC 0580C, IAB 2/6/13, effective 4/1/13; ARC 1153C, IAB 10/30/13, effective 1/1/14; ARC 1695C, IAB 10/29/14, effective 1/1/15; ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 3494C, IAB 12/6/17, effective 1/10/18]

**441—79.15(249A) Education about false claims recovery.** The provisions in this rule apply to any entity that has received medical assistance payments totaling at least \$5 million during a federal fiscal year (ending on September 30). For entities whose payments reach this threshold, compliance with this rule is a condition of receiving payments under the medical assistance program during the following calendar year.

**79.15(1) Policy requirements.** Any entity whose medical assistance payments meet the threshold shall:

a. Establish written policies for all employees of the entity and for all employees of any contractor or agent of the entity, including management, which provide detailed information about:

(1) The False Claims Act established under Title 31, United States Code, Sections 3729 through 3733;

(2) Administrative remedies for false claims and statements established under Title 31, United States Code, Chapter 38;

(3) Any state laws pertaining to civil or criminal penalties for false claims and statements;

(4) Whistle blower protections under the laws described in subparagraphs (1) to (3) with respect to the role of these laws in preventing and detecting fraud, waste, and abuse in federal health care programs, as defined in Title 42, United States Code, Section 1320a-7b(f); and

(5) The entity's policies and procedures for detecting and preventing fraud, waste, and abuse.

b. Include in any employee handbook a specific discussion of:

(1) The laws described in paragraph 79.15(1) "a";

(2) The rights of employees to be protected as whistle blowers; and

(3) The entity's policies and procedures for detecting and preventing fraud, waste, and abuse.

**79.15(2) Reporting requirements.**

a. Any entity whose medical assistance payments meet the specified threshold during a federal fiscal year shall provide the following information to the Iowa Medicaid enterprise by the following December 31:

(1) The name, address, and national provider identification numbers under which the entity receives payment;

(2) Copies of written or electronic policies that meet the requirements of subrule 79.15(1); and

(3) A written description of how the policies are made available and disseminated to all employees of the entity and to all employees of any contractor or agent of the entity.

*b.* The information may be provided by:

(1) Mailing the information to the IME Program Integrity Unit, P.O. Box 36390, Des Moines, Iowa 50315; or

(2) Faxing the information to (515)725-1354.

**79.15(3) Enforcement.** Any entity that fails to comply with the requirements of this rule shall be subject to sanction under rule 441—79.2(249A), including probation, suspension or withholding of payments, and suspension or termination from participation in the medical assistance program.

This rule is intended to implement Iowa Code section 249A.4 and Public Law 109-171, Section 6032.

[ARC 9440B, IAB 4/6/11, effective 4/1/11]

**441—79.16(249A) Electronic health record incentive program.** The department has elected to participate in the electronic health record (EHR) incentive program authorized under Section 4201 of the American Recovery and Reinvestment Act of 2009 (ARRA), Public Law No. 111-5. The electronic health record incentive program provides incentive payments to eligible hospitals and professionals participating in the Iowa Medicaid program that adopt and successfully demonstrate meaningful use of certified electronic health record technology.

**79.16(1) State elections.** In addition to the statutory provisions in ARRA Section 4201, the electronic health record incentive program is governed by federal regulations at 42 CFR Part 495 as amended to September 4, 2012. In compliance with the requirements of federal law, the department establishes the following state options under the Iowa electronic health record incentive program:

*a.* For purposes of the term “hospital-based eligible professional (EP)” as set forth in 42 CFR Section 495.4 as amended to September 4, 2012, the department elects the calendar year preceding the payment year as the period used to gather data to determine whether or not an eligible professional is “hospital-based” for purposes of the regulation.

*b.* For purposes of calculating patient volume as required by 42 CFR Section 495.306 as amended to September 4, 2012, the department has elected that eligible providers may use either:

(1) The patient encounter methodology found in 42 CFR Section 495.306(c) as amended to September 4, 2012, or

(2) The patient panel methodology found in 42 CFR Section 495.306(d) as amended to September 4, 2012.

*c.* For purposes of 42 CFR Section 495.310(g)(1)(i)(B) as amended to September 4, 2012, the “12-month period selected by the state” shall mean the hospital fiscal year.

*d.* For purposes of 42 CFR Section 495.310(g)(2)(i) as amended to September 4, 2012, the “12-month period selected by the state” shall mean the hospital fiscal year.

**79.16(2) Eligible providers.** To be deemed an “eligible provider” for the electronic health record incentive program, a provider must satisfy the applicable criterion in each paragraph of this subrule:

*a.* The provider must be currently enrolled as an Iowa Medicaid provider.

*b.* The provider must be one of the following:

(1) An eligible professional, listed as:

1. A physician,
2. A dentist,
3. A certified nurse midwife,
4. A nurse practitioner, or
5. A physician assistant practicing in a federally qualified health center or a rural health clinic

when the physician assistant is the primary provider, clinical or medical director, or owner of the site.

(2) An acute care hospital, as defined in 42 CFR Section 495.302 as amended to September 4, 2012.

(3) A children’s hospital, as defined in 42 CFR Section 495.302 as amended to September 4, 2012.

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

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

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

1. A pediatrician must have at least 20 percent Medicaid patient volume. For purposes of this subrule, a "pediatrician" is a physician who is board-certified in pediatrics by the American Board of Pediatrics or the American Osteopathic Board of Pediatrics or who is eligible for board certification.

2. When a professional has at least 50 percent of patient encounters in a federally qualified health center or rural health clinic, patients who were furnished services either at no cost or at a reduced cost based on a sliding scale or ability to pay, patients covered by the HAWK-I program, and Medicaid members may be counted to meet the 30 percent threshold.

**79.16(3) Application and agreement.** Any eligible provider that intends to participate in the Iowa electronic health record incentive program must declare the intent to participate by registering with the CMS Registration and Attestation website, as developed by the Centers for Medicare and Medicaid Services (CMS). CMS will notify the department of an eligible provider's application for the incentive payment.

a. Upon receipt of an application for participation in the program, the department will contact the applicant with instructions for accessing the Iowa EHR Medicaid incentive payment administration website at [www.imeincentives.com](http://www.imeincentives.com). The applicant shall use the website to:

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

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

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

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

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

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

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

(1) Eligibility,

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

(3) Meaningful use of electronic health record technology.

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

a. Provider eligibility determination.

b. Incentive payments.

c. Demonstration of adopting, implementing, upgrading and meaningful use of technology.

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

[ARC 9254B, IAB 12/1/10, effective 1/1/11; ARC 9531B, IAB 6/1/11, effective 5/12/11; ARC 0824C, IAB 7/10/13, effective 9/1/13]

**441—79.17(249A) 2013 reimbursement rate increases.** Rescinded ARC 1056C, IAB 10/2/13, effective 11/6/13.

- [Filed March 11, 1970]
- [Filed 6/25/76, Notice 5/17/76—published 7/12/76, effective 8/16/76]
- [Filed 3/25/77, Notice 12/1/76—published 4/20/77, effective 5/25/77]
- [Filed 6/10/77, Notice 5/4/77—published 6/29/77, effective 8/3/77]
- [Filed 10/24/77, Notice 9/7/77—published 11/16/77, effective 12/21/77]
- [Filed 12/6/77, Notice 10/19/77—published 12/28/77, effective 2/1/78]
- [Filed 1/16/78, Notice 11/30/77—published 2/8/78, effective 4/1/78]
- [Filed 8/9/78, Notice 6/28/78—published 9/6/78, effective 10/11/78]
- [Filed 10/10/78, Notice 7/26/78—published 11/1/78, effective 12/6/78]
- [Filed 3/30/79, Notice 2/21/79—published 4/18/79, effective 5/23/79]
- [Filed 9/6/79, Notice 7/11/79—published 10/3/79, effective 11/7/79]
- [Filed 12/5/79, Notice 10/3/79—published 12/26/79, effective 1/30/80]
- [Filed emergency 6/30/80—published 7/23/80, effective 7/1/80]
- [Filed 11/21/80, Notice 9/3/80—published 12/10/80, effective 1/14/81]
- [Filed 3/24/81, Notice 2/4/81—published 4/15/81, effective 6/1/81]
- [Filed emergency 4/23/81—published 5/13/81, effective 4/23/81]
- [Filed 8/24/81, Notice 3/4/81—published 9/16/81, effective 11/1/81]
- [Filed 1/28/82, Notice 11/11/81—published 2/17/82, effective 4/1/82]
- [Filed emergency 3/26/82—published 4/14/82, effective 4/1/82]
- [Filed emergency 5/21/82—published 6/9/82, effective 7/1/82]
- [Filed 7/30/82, Notice 6/9/82—published 8/18/82, effective 10/1/82]
- [Filed emergency 8/20/82 after Notice of 6/23/82—published 9/15/82, effective 10/1/82]
- [Filed 11/19/82, Notice 9/29/82—published 12/8/82, effective 2/1/83]
- [Filed 2/25/83, Notice 1/5/83—published 3/16/83, effective 5/1/83]
- [Filed 5/20/83, Notice 3/30/83—published 6/8/83, effective 8/1/83]
- [Filed emergency 6/17/83—published 7/6/83, effective 7/1/83]
- [Filed emergency 10/7/83—published 10/26/83, effective 11/1/83]
- [Filed without Notice 10/7/83—published 10/26/83, effective 12/1/83]
- [Filed emergency 10/28/83—published 11/23/83, effective 12/1/83]
- [Filed emergency 11/18/83—published 12/7/83, effective 12/1/83]
- [Filed 11/18/83, Notice 10/12/83—published 12/7/83, effective 2/1/84]
- [Filed 1/13/84, Notice 11/23/84—published 2/1/84, effective 3/7/84]
- [Filed 2/10/84, Notice 12/7/83—published 2/29/84, effective 5/1/84]
- [Filed emergency 6/15/84—published 7/4/84, effective 7/1/84]
- [Filed 6/15/84, Notice 5/9/84—published 7/4/84, effective 9/1/84]
- [Filed emergency after Notice 11/1/84, Notice 7/18/84—published 11/21/84, effective 11/1/84]
- [Filed 4/29/85, Notice 2/27/85—published 5/22/85, effective 7/1/85]
- [Filed emergency 6/14/85—published 7/3/85, effective 7/1/85]
- [Filed 8/23/85, Notice 7/3/85—published 9/11/85, effective 11/1/85]
- [Filed emergency 10/1/85—published 10/23/85, effective 11/1/85]
- [Filed without Notice 10/1/85—published 10/23/85, effective 12/1/85]
- [Filed emergency 12/2/85—published 12/18/85, effective 1/1/86]
- [Filed 12/2/85, Notice 10/9/85—published 12/18/85, effective 2/1/86]
- [Filed 12/2/85, Notice 10/23/85—published 12/18/85, effective 2/1/86]
- [Filed 1/22/86, Notice 12/4/85—published 2/12/86, effective 4/1/86]
- [Filed 2/21/86, Notices 12/18/85, 1/15/86—published 3/12/86, effective 5/1/86]
- [Filed emergency 6/26/86—published 7/16/86, effective 7/1/86]
- [Filed 10/17/86, Notice 8/27/86—published 11/5/86, effective 1/1/87]
- [Filed emergency 1/15/87—published 2/11/87, effective 1/15/87]
- [Filed 3/3/87, Notice 12/31/86—published 3/25/87, effective 5/1/87]
- [Filed 4/29/87, Notice 3/11/87—published 5/20/87, effective 7/1/87]
- [Filed emergency 6/19/87—published 7/15/87, effective 7/1/87]

- [Filed 7/24/87, Notice 5/20/87—published 8/12/87, effective 10/1/87]
- [Filed emergency 8/28/87—published 9/23/87, effective 9/1/87]
- [Filed 10/23/87, Notice 7/15/87—published 11/18/87, effective 1/1/88]
- [Filed 10/23/87, Notice 8/26/87—published 11/18/87, effective 1/1/88]
- [Filed without Notice 11/25/87—published 12/16/87, effective 2/1/88]
- [Filed 11/30/87, Notice 10/7/87—published 12/16/87, effective 2/1/88]
- [Filed 12/10/87, Notice 10/21/87—published 12/30/87, effective 3/1/88]<sup>1</sup>
- [Filed 1/21/88, Notice 12/16/87—published 2/10/88, effective 4/1/88]
- [Filed emergency 4/28/88 after Notice 3/23/88—published 5/18/88, effective 6/1/88]
- [Filed emergency 6/9/88—published 6/29/88, effective 7/1/88]<sup>2,4</sup>
- [Filed 9/2/88, Notice 6/29/88—published 9/21/88, effective 11/1/88]
- [Filed emergency 10/28/88—published 11/16/88, effective 11/1/88]
- [Filed emergency 11/23/88 after Notices 7/13/88, 9/21/88—published 12/14/88, effective 12/1/88, 1/1/89]
- [Filed emergency 12/22/88 after Notice of 11/16/88—published 1/11/89, effective 1/1/89]
- [Filed 12/22/88, Notices 11/16/88<sup>2,4</sup>—published 1/11/89, effective 3/1/89]
- [Filed emergency 6/9/89—published 6/28/89, effective 7/1/89]
- [Filed 7/14/89, Notice 4/19/89—published 8/9/89, effective 10/1/89]
- [Filed 8/17/89, Notice 6/28/89—published 9/6/89, effective 11/1/89]
- [Filed 9/15/89, Notice 8/9/89—published 10/4/89, effective 12/1/89]
- [Filed emergency 1/10/90 after Notice of 10/4/89—published 1/10/90, effective 1/1/90]
- [Filed 1/17/90, Notice 8/23/90—published 2/7/90, effective 4/1/90]<sup>3</sup>
- [Filed emergency 2/14/90—published 3/7/90, effective 4/1/90]
- [Filed 4/13/90, Notices 2/21/90, 3/7/90—published 5/2/90, effective 7/1/90]
- [Filed 4/13/90, Notice 11/29/89—published 5/2/90, effective 8/1/90]
- [Filed emergency 5/11/90—published 5/30/90, effective 6/1/90]
- [Filed 5/11/90, Notice 4/4/90—published 5/30/90, effective 8/1/90]
- [Filed emergency 6/14/90 after Notice 5/2/90—published 7/11/90, effective 7/1/90]
- [Filed emergency 6/20/90—published 7/11/90, effective 7/1/90]
- [Filed 7/13/90, Notice 5/30/90—published 8/8/90, effective 10/1/90]
- [Filed 8/16/90, Notices 7/11/90<sup>2,4</sup>—published 9/5/90, effective 11/1/90]
- [Filed 10/12/90, Notice 8/8/90—published 10/31/90, effective 2/1/91]
- [Filed emergency 1/17/91 after Notice 11/28/90—published 2/6/91, effective 2/1/91]
- [Filed emergency 1/17/91—published 2/6/91, effective 2/1/91]
- [Filed 1/17/91, Notices 11/14/90, 11/28/90—published 2/6/91, effective 4/1/91]
- [Filed emergency 2/22/91—published 3/20/91, effective 3/1/91]
- [Filed 3/14/91, Notice 2/6/91—published 4/3/91, effective 6/1/91]
- [Filed 5/17/91, Notice 4/3/91—published 6/12/91, effective 8/1/91]
- [Filed emergency 6/14/91—published 7/10/91, effective 7/1/91]
- [Filed 6/14/91, Notices 3/20/91, 5/1/91—published 7/10/91, effective 9/1/91]<sup>5</sup>
- [Filed 7/10/91, Notice 5/29/91—published 8/7/91, effective 10/1/91]
- [Filed emergency 9/18/91 after Notice 7/24/91—published 10/16/91, effective 10/1/91]
- [Filed 9/18/91, Notices 7/10/91, 7/24/91—published 10/16/91, effective 12/1/91]
- [Filed 12/11/91, Notice 10/16/91—published 1/8/92, effective 3/1/92]
- [Filed 12/11/91, Notice 10/30/91—published 1/8/92, effective 3/1/92]
- [Filed emergency 1/16/92 after Notice 11/27/91—published 2/5/92, effective 3/1/92]<sup>6</sup>
- [Filed 2/13/92, Notice 1/8/92—published 3/4/92, effective 4/8/92]
- [Filed emergency 4/15/92—published 5/13/92, effective 4/16/92]
- [Filed emergency 5/13/92 after Notice 4/1/92—published 6/10/92, effective 5/14/92]
- [Filed emergency 6/12/92—published 7/8/92, effective 7/1/92]
- [Filed 6/11/92, Notices 3/18/92, 4/29/92—published 7/8/92, effective 9/1/92]
- [Filed without Notice 6/11/92—published 7/8/92, effective 9/1/92]

- [Filed 8/14/92, Notice 7/8/92—published 9/2/92, effective 11/1/92]
- [Filed emergency 9/11/92—published 9/30/92, effective 10/1/92]
- [Filed 9/11/92, Notice 7/8/92—published 9/30/92, effective 12/1/92]
- [Filed 10/15/92, Notice 8/19/92—published 11/11/92, effective 1/1/93]
- [Filed 11/10/92, Notice 9/30/92—published 12/9/92, effective 2/1/93]
- [Filed emergency 12/30/92 after Notice 11/25/92—published 1/20/93, effective 1/1/93]
- [Filed 1/14/93, Notice 11/11/92—published 2/3/93, effective 4/1/93]
- [Filed 3/11/93, Notice 1/20/93—published 3/31/93, effective 6/1/93]
- [Filed 4/15/93, Notice 3/3/93—published 5/12/93, effective 7/1/93]
- [Filed emergency 5/14/93 after Notice 3/31/93—published 6/9/93, effective 6/1/93]
- [Filed 5/14/93, Notice 3/31/93—published 6/9/93, effective 8/1/93]
- [Filed emergency 6/11/93—published 7/7/93, effective 7/1/93]
- [Filed 6/11/93, Notice 4/28/93—published 7/7/93, effective 9/1/93]
- [Filed emergency 6/25/93—published 7/21/93, effective 7/1/93]
- [Filed emergency 7/13/93 after Notice 5/12/93—published 8/4/93, effective 8/1/93]
- [Filed without Notice 8/12/93—published 9/1/93, effective 11/1/93]
- [Filed 8/12/93, Notices 4/28/93, 7/7/93—published 9/1/93, effective 11/1/93]
- [Filed 9/17/93, Notice 7/21/93—published 10/13/93, effective 12/1/93]
- [Filed 10/14/93, Notice 8/18/93—published 11/10/93, effective 1/1/94]
- [Filed 11/12/93, Notice 9/29/93—published 12/8/93, effective 2/1/94]
- [Filed 12/16/93, Notice 9/1/93—published 1/5/94, effective 3/1/94]
- [Filed 1/12/94, Notice 11/10/93—published 2/2/94, effective 4/1/94]
- [Filed 3/10/94, Notices 1/19/94, 2/2/94—published 3/30/94, effective 6/1/94]<sup>24</sup>
- [Filed emergency 6/16/94—published 7/6/94, effective 7/1/94]
- [Filed 9/15/94, Notice 7/6/94—published 10/12/94, effective 12/1/94]
- [Filed 11/9/94, Notice 9/14/94—published 12/7/94, effective 2/1/95]
- [Filed 12/15/94, Notices 10/12/94, 11/9/94—published 1/4/95, effective 3/1/95]
- [Filed 3/20/95, Notice 2/1/95—published 4/12/95, effective 6/1/95]
- [Filed 5/11/95, Notice 3/29/95—published 6/7/95, effective 8/1/95]
- [Filed emergency 6/7/95—published 7/5/95, effective 7/1/95]
- [Filed 8/10/95, Notice 7/5/95—published 8/30/95, effective 11/1/95]
- [Filed 11/16/95, Notices 8/2/95, 9/27/95—published 12/6/95, effective 2/1/96]<sup>24</sup>
- [Filed 5/15/96, Notice 2/14/96—published 6/5/96, effective 8/1/96]
- [Filed emergency 6/13/96—published 7/3/96, effective 7/1/96]
- [Filed 7/10/96, Notice 6/5/96—published 7/31/96, effective 10/1/96]
- [Filed 8/15/96, Notice 7/3/96—published 9/11/96, effective 11/1/96]
- [Filed 9/17/96, Notice 7/31/96—published 10/9/96, effective 12/1/96]
- [Filed 11/13/96, Notice 9/11/96—published 12/4/96, effective 2/1/97]
- [Filed 2/12/97, Notice 12/18/96—published 3/12/97, effective 5/1/97]
- [Filed 3/12/97, Notices 1/1/97, 1/29/97—published 4/9/97, effective 6/1/97]
- [Filed 4/11/97, Notice 2/12/97—published 5/7/97, effective 7/1/97]
- [Filed emergency 5/14/97 after Notice 3/12/97—published 6/4/97, effective 7/1/97]
- [Filed emergency 6/12/97—published 7/2/97, effective 7/1/97]
- [Filed 6/12/97, Notice 4/23/97—published 7/2/97, effective 9/1/97]
- [Filed 9/16/97, Notice 7/2/97—published 10/8/97, effective 12/1/97]
- [Filed emergency 11/12/97—published 12/3/97, effective 11/12/97]
- [Filed 11/12/97, Notice 9/10/97—published 12/3/97, effective 2/1/98]
- [Filed 1/14/98, Notices 11/19/97, 12/3/97—published 2/11/98, effective 4/1/98]
- [Filed 3/11/98, Notice 1/14/98—published 4/8/98, effective 6/1/98]
- [Filed 4/8/98, Notice 2/11/98—published 5/6/98, effective 7/1/98]
- [Filed emergency 6/10/98—published 7/1/98, effective 7/1/98]
- [Filed 8/12/98, Notice 7/1/98—published 9/9/98, effective 11/1/98]

- [Filed 9/15/98, Notice 7/15/98—published 10/7/98, effective 12/1/98]
- [Filed 11/10/98, Notice 9/23/98—published 12/2/98, effective 2/1/99]
- [Filed 1/13/99, Notice 11/4/98—published 2/10/99, effective 4/1/99]
- [Filed 2/10/99, Notice 12/16/98—published 3/10/99, effective 5/1/99]
- [Filed 4/15/99, Notice 2/10/99—published 5/5/99, effective 7/1/99]
- [Filed emergency 6/10/99—published 6/30/99, effective 7/1/99]
- [Filed 6/10/99, Notice 5/5/99—published 6/30/99, effective 9/1/99]
- [Filed 7/15/99, Notice 5/19/99—published 8/11/99, effective 10/1/99]
- [Filed 8/12/99, Notice 6/30/99—published 9/8/99, effective 11/1/99]
- [Filed 11/10/99, Notice 9/22/99—published 12/1/99, effective 2/1/00]
- [Filed 4/12/00, Notice 2/9/00—published 5/3/00, effective 7/1/00]
- [Filed emergency 6/8/00—published 6/28/00, effective 7/1/00]
- [Filed 6/8/00, Notice 4/19/00—published 6/28/00, effective 8/2/00]
- [Filed 8/9/00, Notice 6/14/00—published 9/6/00, effective 11/1/00]
- [Filed emergency 9/12/00 after Notice 7/26/00—published 10/4/00, effective 10/1/00]
- [Filed 9/12/00, Notice 6/14/00—published 10/4/00, effective 12/1/00]
- [Filed 10/11/00, Notice 8/23/00—published 11/1/00, effective 1/1/01]
- [Filed 11/8/00, Notice 9/20/00—published 11/29/00, effective 2/1/01]
- [Filed emergency 12/14/00 after Notice 9/20/00—published 1/10/01, effective 1/1/01]
- [Filed 12/14/00, Notice 11/1/00—published 1/10/01, effective 3/1/01]
- [Filed 2/14/01, Notice 12/13/00—published 3/7/01, effective 5/1/01]
- [Filed 5/9/01, Notice 4/4/01—published 5/30/01, effective 8/1/01]
- [Filed emergency 6/13/01 after Notice 4/18/01—published 7/11/01, effective 7/1/01]
- [Filed emergency 6/13/01—published 7/11/01, effective 7/1/01]<sup>24</sup>
- [Filed 6/13/01, Notice 4/18/01—published 7/11/01, effective 9/1/01]
- [Filed 7/11/01, Notice 5/16/01—published 8/8/01, effective 10/1/01]
- [Filed 9/11/01, Notice 7/11/01—published 10/3/01, effective 12/1/01]
- [Filed 10/10/01, Notice 8/22/01—published 10/31/01, effective 1/1/02]<sup>24</sup>
- [Filed 11/14/01, Notice 10/3/01—published 12/12/01, effective 2/1/02]
- [Filed emergency 1/9/02 after Notice 11/14/01—published 2/6/02, effective 2/1/02]
- [Filed emergency 1/16/02—published 2/6/02, effective 2/1/02]<sup>7</sup>
- [Filed 3/13/02, Notice 1/23/02—published 4/3/02, effective 6/1/02]
- [Filed emergency 4/12/02—published 5/1/02, effective 4/12/02]
- [Filed 4/10/02, Notice 1/9/02—published 5/1/02, effective 7/1/02]
- [Filed 4/10/02, Notice 2/6/02—published 5/1/02, effective 7/1/02]
- [Filed 7/15/02, Notice 5/1/02—published 8/7/02, effective 10/1/02]<sup>8</sup>
- [Filed 7/15/02, Notice 5/29/02—published 8/7/02, effective 10/1/02]
- [Filed 8/15/02, Notice 6/12/02—published 9/4/02, effective 11/1/02]
- [Filed 8/15/02, Notice 6/26/02—published 9/4/02, effective 11/1/02]
- [Filed emergency 9/12/02—published 10/2/02, effective 9/12/02]
- [Filed emergency 11/18/02—published 12/11/02, effective 12/1/02]
- [Filed 11/18/02, Notice 10/2/02—published 12/11/02, effective 2/1/03]
- [Filed emergency 12/12/02 after Notice 10/16/02—published 1/8/03, effective 1/1/03]
- [Filed 2/13/03, Notice 12/11/02—published 3/5/03, effective 5/1/03]
- [Filed 5/16/03, Notice 4/2/03—published 6/11/03, effective 7/16/03]<sup>24</sup>
- [Filed emergency 6/12/03—published 7/9/03, effective 7/1/03]<sup>24</sup>
- [Filed 9/22/03, Notice 7/9/03—published 10/15/03, effective 12/1/03]<sup>24</sup>
- [Filed 10/10/03, Notice 8/20/03—published 10/29/03, effective 1/1/04]
- [Filed 3/11/04, Notice 1/21/04—published 3/31/04, effective 6/1/04]
- [Filed emergency 6/14/04 after Notice 4/28/04—published 7/7/04, effective 7/1/04]
- [Filed emergency 6/14/04—published 7/7/04, effective 7/1/04]<sup>24</sup>
- [Filed 8/12/04, Notice 6/23/04—published 9/1/04, effective 11/1/04]

- [Filed 9/23/04, Notice 7/7/04—published 10/13/04, effective 11/17/04]<sup>24</sup>
  - [Filed emergency 4/15/05—published 5/11/05, effective 5/1/05]
  - [Filed without Notice 5/4/05—published 5/25/05, effective 7/1/05]
  - [Filed emergency 6/17/05—published 7/6/05, effective 6/25/05]
  - [Filed emergency 6/17/05—published 7/6/05, effective 7/1/05]<sup>24</sup>
  - [Filed emergency 9/21/05—published 10/12/05, effective 10/1/05]
- [Filed emergency 10/21/05 after Notice 7/6/05—published 11/9/05, effective 10/21/05]
- [Filed 10/21/05, Notices 5/11/05 and 7/6/05<sup>2</sup>—published 11/9/05, effective 12/14/05]
- [Filed 10/21/05, Notice 7/6/05—published 11/9/05, effective 12/14/05]
- [Filed 3/10/06, Notice 10/12/05—published 3/29/06, effective 5/3/06]
- [Filed 4/17/06, Notice 2/15/06—published 5/10/06, effective 7/1/06]
- [Filed emergency 6/16/06—published 7/5/06, effective 7/1/06]
- [Filed 6/16/06, Notice 4/26/06—published 7/5/06, effective 9/1/06]
- [Filed emergency 8/10/06 after Notice 3/15/06—published 8/30/06, effective 10/1/06]
- [Filed 8/10/06, Notice 2/15/06—published 8/30/06, effective 11/1/06]
- [Filed emergency 9/14/06—published 10/11/06, effective 10/1/06]
- [Filed 9/19/06, Notice 7/5/06—published 10/11/06, effective 11/16/06]
- [Filed emergency 10/12/06 after Notice 8/30/06—published 11/8/06, effective 11/1/06]
- [Filed emergency 12/13/06—published 1/3/07, effective 1/1/07]
- [Filed 2/15/07, Notice 12/20/06—published 3/14/07, effective 5/1/07]
- [Filed emergency 3/14/07 after Notice 1/3/07—published 4/11/07, effective 4/1/07]
- [Filed 3/14/07, Notice 10/11/06—published 4/11/07, effective 5/16/07]
- [Filed 7/12/07, Notice 5/23/07—published 8/1/07, effective 9/5/07]
- [Filed emergency 8/9/07 after Notice 7/4/07—published 8/29/07, effective 8/10/07]
- [Filed 8/9/07, Notice 7/4/07—published 8/29/07, effective 10/3/07]
- [Filed 8/9/07, Notice 6/20/07—published 8/29/07, effective 11/1/07]
- [Filed 9/12/07, Notice 7/4/07—published 10/10/07, effective 11/14/07]
- [Filed emergency 10/10/07—published 11/7/07, effective 10/10/07]
- [Filed 1/9/08, Notice 11/7/07—published 1/30/08, effective 3/5/08]
- [Filed 1/9/08, Notice 11/7/07—published 1/30/08, effective 4/1/08]
- [Filed emergency 5/14/08 after Notice 3/26/08—published 6/4/08, effective 6/1/08]
- [Filed emergency 6/11/08 after Notice 3/12/08—published 7/2/08, effective 7/1/08]
- [Filed emergency 6/12/08—published 7/2/08, effective 7/1/08]
- [Filed 9/17/08, Notice 7/2/08—published 10/8/08, effective 11/12/08]
- [Filed emergency 10/14/08 after Notice 7/16/08—published 11/5/08, effective 12/1/08]
- [Filed 12/11/08, Notice 10/22/08—published 1/14/09, effective 3/1/09]
- [Filed ARC 7835B (Notice ARC 7627B, IAB 3/11/09), IAB 6/3/09, effective 7/8/09]
- [Filed Emergency ARC 7937B, IAB 7/1/09, effective 7/1/09]
- [Filed Emergency After Notice ARC 7957B (Notice ARC 7631B, IAB 3/11/09; Amended Notice ARC 7732B, IAB 4/22/09), IAB 7/15/09, effective 7/1/09]<sup>10</sup>
- [Filed ARC 8205B (Notice ARC 7827B, IAB 6/3/09), IAB 10/7/09, effective 11/11/09]
- [Filed ARC 8206B (Notice ARC 7938B, IAB 7/1/09), IAB 10/7/09, effective 11/11/09]
- [Filed ARC 8262B (Notice ARC 8084B, IAB 8/26/09), IAB 11/4/09, effective 12/9/09]
- [Filed ARC 8263B (Notice ARC 8059B, IAB 8/26/09), IAB 11/4/09, effective 12/9/09]
- [Filed Emergency ARC 8344B, IAB 12/2/09, effective 12/1/09]
- [Filed Emergency ARC 8647B, IAB 4/7/10, effective 3/11/10]
- [Filed Emergency ARC 8649B, IAB 4/7/10, effective 3/11/10]
- [Filed Emergency After Notice ARC 8643B (Notice ARC 8345B, IAB 12/2/09), IAB 4/7/10, effective 3/11/10]
- [Filed Emergency ARC 8894B, IAB 6/30/10, effective 7/1/10]
- [Filed Emergency ARC 8899B, IAB 6/30/10, effective 7/1/10]
- [Filed Emergency ARC 9046B, IAB 9/8/10, effective 8/12/10]

- [Filed ARC 9127B (Notice ARC 8896B, IAB 6/30/10), IAB 10/6/10, effective 11/10/10]  
[Filed Emergency ARC 9134B, IAB 10/6/10, effective 10/1/10]  
[Filed Emergency ARC 9132B, IAB 10/6/10, effective 11/1/10]  
[Filed ARC 9176B (Notice ARC 8900B, IAB 6/30/10), IAB 11/3/10, effective 12/8/10]  
[Filed Emergency ARC 9254B, IAB 12/1/10, effective 1/1/11]  
[Filed ARC 9316B (Notice ARC 9133B, IAB 10/6/10), IAB 12/29/10, effective 2/2/11]  
[Filed ARC 9403B (Notice ARC 9170B, IAB 10/20/10), IAB 3/9/11, effective 5/1/11]  
[Filed Emergency After Notice ARC 9440B (Notice ARC 9276B, IAB 12/15/10), IAB 4/6/11,  
effective 4/1/11]  
[Filed ARC 9487B (Notice ARC 9399B, IAB 2/23/11), IAB 5/4/11, effective 7/1/11]  
[Filed Emergency After Notice ARC 9531B (Notice ARC 9431B, IAB 3/23/11), IAB 6/1/11, effective  
5/12/11]  
[Filed ARC 9588B (Notice ARC 9367B, IAB 2/9/11; Amended Notice ARC 9448B, IAB 4/6/11),  
IAB 6/29/11, effective 9/1/11]  
[Filed Emergency ARC 9706B, IAB 9/7/11, effective 8/17/11]  
[Filed Emergency ARC 9708B, IAB 9/7/11, effective 8/17/11]  
[Filed Emergency ARC 9710B, IAB 9/7/11, effective 8/17/11]  
[Filed Emergency ARC 9704B, IAB 9/7/11, effective 9/1/11]  
[Filed Emergency ARC 9712B, IAB 9/7/11, effective 9/1/11]  
[Filed Emergency ARC 9714B, IAB 9/7/11, effective 9/1/11]  
[Filed Emergency ARC 9719B, IAB 9/7/11, effective 9/1/11]  
[Filed Emergency ARC 9722B, IAB 9/7/11, effective 9/1/11]  
[Filed ARC 9884B (Notice ARC 9705B, IAB 9/7/11), IAB 11/30/11, effective 1/4/12]  
[Filed ARC 9886B (Notice ARC 9713B, IAB 9/7/11), IAB 11/30/11, effective 1/4/12]  
[Filed ARC 9887B (Notice ARC 9715B, IAB 9/7/11), IAB 11/30/11, effective 1/4/12]  
[Filed ARC 9958B (Notice ARC 9707B, IAB 9/7/11), IAB 1/11/12, effective 2/15/12]  
[Filed ARC 9959B (Notice ARC 9721B, IAB 9/7/11), IAB 1/11/12, effective 2/15/12]  
[Filed ARC 9960B (Notice ARC 9723B, IAB 9/7/11), IAB 1/11/12, effective 2/15/12]  
[Filed Emergency ARC 9996B, IAB 2/8/12, effective 1/19/12]  
[Filed ARC 0028C (Notice ARC 9711B, IAB 9/7/11), IAB 3/7/12, effective 4/11/12]  
[Filed ARC 0029C (Notice ARC 9709B, IAB 9/7/11), IAB 3/7/12, effective 4/11/12]  
[Nullified amendment editorially removed, IAC Supplement 5/16/12]<sup>11</sup>  
[Filed Emergency ARC 0191C, IAB 7/11/12, effective 7/1/12]  
[Filed Emergency ARC 0194C, IAB 7/11/12, effective 7/1/12]  
[Filed Emergency ARC 0196C, IAB 7/11/12, effective 7/1/12]  
[Filed Emergency After Notice ARC 0198C (Notice ARC 0117C, IAB 5/2/12), IAB 7/11/12, effective  
7/1/12]  
[Filed ARC 0358C (Notice ARC 0231C, IAB 7/25/12), IAB 10/3/12, effective 11/7/12]  
[Filed ARC 0359C (Notice ARC 0193C, IAB 7/11/12), IAB 10/3/12, effective 12/1/12]  
[Filed ARC 0354C (Notice ARC 0195C, IAB 7/11/12), IAB 10/3/12, effective 12/1/12]  
[Filed ARC 0355C (Notice ARC 0197C, IAB 7/11/12), IAB 10/3/12, effective 12/1/12]  
[Filed ARC 0360C (Notice ARC 0203C, IAB 7/11/12), IAB 10/3/12, effective 12/1/12]  
[Filed ARC 0485C (Notice ARC 0259C, IAB 8/8/12), IAB 12/12/12, effective 2/1/13]  
[Filed ARC 0545C (Notice ARC 0366C, IAB 10/3/12), IAB 1/9/13, effective 3/1/13]  
[Filed Emergency ARC 0548C, IAB 1/9/13, effective 1/1/13]  
[Filed ARC 0580C (Notice ARC 0434C, IAB 10/31/12), IAB 2/6/13, effective 4/1/13]  
[Filed ARC 0581C (Notice ARC 0436C, IAB 10/31/12), IAB 2/6/13, effective 4/1/13]  
[Filed Emergency ARC 0585C, IAB 2/6/13, effective 1/9/13]  
[Filed ARC 0665C (Notice ARC 0547C, IAB 1/9/13), IAB 4/3/13, effective 6/1/13]  
[Filed ARC 0708C (Notice ARC 0568C, IAB 1/23/13), IAB 5/1/13, effective 7/1/13]  
[Filed ARC 0711C (Notice ARC 0570C, IAB 1/23/13), IAB 5/1/13, effective 7/1/13]  
[Filed ARC 0712C (Notice ARC 0569C, IAB 1/23/13), IAB 5/1/13, effective 7/1/13]

- [Filed ARC 0710C (Notice ARC 0588C, IAB 2/6/13), IAB 5/1/13, effective 7/1/13]
- [Filed ARC 0713C (Notice ARC 0584C, IAB 2/6/13), IAB 5/1/13, effective 7/1/13]
- [Filed ARC 0757C (Notice ARC 0615C, IAB 2/20/13), IAB 5/29/13, effective 8/1/13]
- [Filed ARC 0823C (Notice ARC 0649C, IAB 3/20/13), IAB 7/10/13, effective 9/1/13]
- [Filed ARC 0824C (Notice ARC 0669C, IAB 4/3/13), IAB 7/10/13, effective 9/1/13]
- [Filed Emergency After Notice ARC 0838C (Notice ARC 0667C, IAB 4/3/13; Amended Notice ARC 0748C, IAB 5/15/13), IAB 7/24/13, effective 7/1/13]
  - [Filed Emergency ARC 0840C, IAB 7/24/13, effective 7/1/13]
  - [Filed Emergency ARC 0842C, IAB 7/24/13, effective 7/1/13]
  - [Filed Emergency ARC 0848C, IAB 7/24/13, effective 7/1/13]
  - [Filed Emergency ARC 0864C, IAB 7/24/13, effective 7/1/13]
- [Filed ARC 0994C (Notice ARC 0789C, IAB 6/12/13), IAB 9/4/13, effective 11/1/13]
- [Filed Emergency After Notice ARC 1071C (Notice ARC 0887C, IAB 7/24/13), IAB 10/2/13, effective 10/1/13]
  - [Filed ARC 1058C (Notice ARC 0863C, IAB 7/24/13), IAB 10/2/13, effective 11/6/13]
  - [Filed ARC 1057C (Notice ARC 0839C, IAB 7/24/13), IAB 10/2/13, effective 11/6/13]
  - [Filed ARC 1056C (Notice ARC 0841C, IAB 7/24/13), IAB 10/2/13, effective 11/6/13]
  - [Filed ARC 1051C (Notice ARC 0847C, IAB 7/24/13), IAB 10/2/13, effective 11/6/13]
  - [Filed ARC 1150C (Notice ARC 0918C, IAB 8/7/13), IAB 10/30/13, effective 1/1/14]
  - [Filed ARC 1152C (Notice ARC 0910C, IAB 8/7/13), IAB 10/30/13, effective 1/1/14]
  - [Filed ARC 1154C (Notice ARC 0919C, IAB 8/7/13), IAB 10/30/13, effective 1/1/14]
  - [Filed ARC 1155C (Notice ARC 0912C, IAB 8/7/13), IAB 10/30/13, effective 1/1/14]
  - [Filed ARC 1153C (Notice ARC 0917C, IAB 8/7/13), IAB 10/30/13, effective 1/1/14]
  - [Filed ARC 1481C (Notice ARC 1391C, IAB 4/2/14), IAB 6/11/14, effective 8/1/14]
    - [Filed Emergency ARC 1519C, IAB 7/9/14, effective 7/1/14]
    - [Filed Emergency ARC 1521C, IAB 7/9/14, effective 7/1/14]
- [Filed Emergency After Notice ARC 1610C (Notice ARC 1510C, IAB 6/25/14), IAB 9/3/14, effective 8/13/14]
  - [Filed ARC 1609C (Notice ARC 1518C, IAB 7/9/14), IAB 9/3/14, effective 10/8/14]
  - [Filed ARC 1608C (Notice ARC 1520C, IAB 7/9/14), IAB 9/3/14, effective 10/8/14]
  - [Filed ARC 1695C (Notice ARC 1621C, IAB 9/3/14), IAB 10/29/14, effective 1/1/15]
  - [Filed ARC 1697C (Notice ARC 1619C, IAB 9/3/14), IAB 10/29/14, effective 1/1/15]
  - [Filed ARC 1699C (Notice ARC 1617C, IAB 9/3/14), IAB 10/29/14, effective 1/1/15]
  - [Filed ARC 1977C (Notice ARC 1818C, IAB 1/7/15), IAB 4/29/15, effective 7/1/15]
  - [Filed ARC 2026C (Notice ARC 1921C, IAB 3/18/15), IAB 6/10/15, effective 8/1/15]
    - [Filed Emergency ARC 2075C, IAB 8/5/15, effective 7/15/15]
- [Filed Emergency After Notice ARC 2164C (Notice ARC 2062C, IAB 7/22/15), IAB 9/30/15, effective 10/1/15]
  - [Filed ARC 2167C (Notice ARC 2076C, IAB 8/5/15), IAB 9/30/15, effective 11/4/15]
- [Filed Emergency After Notice ARC 2361C (Notice ARC 2242C, IAB 11/11/15), IAB 1/6/16, effective 1/1/16]
  - [Filed ARC 2341C (Notice ARC 2113C, IAB 8/19/15), IAB 1/6/16, effective 2/10/16]
- [Filed ARC 2471C (Notice ARC 2114C, IAB 8/19/15; Amended Notice ARC 2380C, IAB 2/3/16), IAB 3/30/16, effective 5/4/16]
  - [Filed Emergency ARC 2846C, IAB 12/7/16, effective 11/15/16]
  - [Filed Emergency ARC 2848C, IAB 12/7/16, effective 11/15/16]
- [Filed ARC 2930C (Notice ARC 2824C, IAB 11/23/16), IAB 2/1/17, effective 4/1/17]
- [Filed ARC 2932C (Notice ARC 2847C, IAB 12/7/16), IAB 2/1/17, effective 3/8/17]
- [Filed ARC 2936C (Notice ARC 2849C, IAB 12/7/16), IAB 2/1/17, effective 3/8/17]
- [Filed ARC 3006C (Notice ARC 2899C, IAB 1/18/17), IAB 3/29/17, effective 6/1/17]
  - [Filed Emergency ARC 3158C, IAB 7/5/17, effective 7/1/17]
  - [Filed Emergency ARC 3161C, IAB 7/5/17, effective 7/1/17]

- [Filed Emergency ARC 3162C, IAB 7/5/17, effective 7/1/17]  
 [Filed Emergency ARC 3160C, IAB 7/5/17, effective 7/1/17]  
 [Filed Emergency ARC 3159C, IAB 7/5/17, effective 7/1/17]  
 [Filed ARC 3292C (Notice ARC 3164C, IAB 7/5/17), IAB 8/30/17, effective 10/4/17]  
 [Filed ARC 3293C (Notice ARC 3166C, IAB 7/5/17), IAB 8/30/17, effective 10/4/17]  
 [Filed ARC 3294C (Notice ARC 3165C, IAB 7/5/17), IAB 8/30/17, effective 10/4/17]  
 [Filed ARC 3295C (Notice ARC 3167C, IAB 7/5/17), IAB 8/30/17, effective 10/4/17]  
 [Filed ARC 3296C (Notice ARC 3163C, IAB 7/5/17), IAB 8/30/17, effective 10/4/17]  
 [Filed Emergency ARC 3358C, IAB 10/11/17, effective 10/1/17]  
 [Filed Emergency ARC 3481C, IAB 12/6/17, effective 12/1/17]  
 [Filed ARC 3494C (Notice ARC 3321C, IAB 9/27/17), IAB 12/6/17, effective 1/10/18]  
 [Filed ARC 3551C (Notice ARC 3439C, IAB 11/8/17), IAB 1/3/18, effective 2/7/18]  
 [Filed ARC 3554C (Notice ARC 3357C, IAB 10/11/17), IAB 1/3/18, effective 2/7/18]  
 [Filed ARC 3716C (Notice ARC 3598C, IAB 1/31/18), IAB 3/28/18, effective 5/2/18]  
 [Filed ARC 3790C (Notice ARC 3476C, IAB 12/6/17; Amended Notice ARC 3602C, IAB 1/31/18),  
 IAB 5/9/18, effective 6/13/18]  
 [Filed ARC 4067C (Notice ARC 3923C, IAB 8/1/18), IAB 10/10/18, effective 11/14/18]  
 [Filed ARC 4065C (Notice ARC 3911C, IAB 8/1/18), IAB 10/10/18, effective 12/1/18]  
 [Filed ARC 4066C (Notice ARC 3909C, IAB 8/1/18), IAB 10/10/18, effective 12/1/18]  
 [Filed ARC 4068C (Notice ARC 3906C, IAB 8/1/18), IAB 10/10/18, effective 12/1/18]  
 [Filed ARC 4430C (Notice ARC 4288C, IAB 2/13/19), IAB 5/8/19, effective 7/1/19]<sup>12</sup>

- <sup>1</sup> Effective date of 79.1(2) and 79.1(5) “t” delayed 70 days by the Administrative Rules Review Committee at its January 1988, meeting.
- <sup>2</sup> Two ARCs
- <sup>3</sup> Effective date of 4/1/90 delayed 70 days by the Administrative Rules Review Committee at its March 12, 1990, meeting; delay lifted by this Committee, effective May 11, 1990.
- <sup>4</sup> Two or more ARCs
- <sup>5</sup> Effective date of subrule 79.1(13) delayed until adjournment of the 1992 Sessions of the General Assembly by the Administrative Rules Review Committee at its meeting held July 12, 1991.
- <sup>6</sup> 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.
- <sup>7</sup> 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**.
- <sup>8</sup> Effective date of October 1, 2002, delayed 70 days by the Administrative Rules Review Committee at its meeting held September 10, 2002. At its meeting held November 19, 2002, the Committee voted to delay the effective date until adjournment of the 2003 Session of the General Assembly.
- <sup>9</sup> Two ARCs
- <sup>10</sup> July 1, 2009, effective date of amendments to 79.1(1) “d,” 79.1(2), and 79.1(24) “a”(1) delayed 70 days by the Administrative Rules Review Committee at a special meeting held June 25, 2009.
- <sup>11</sup> See HJR 2008 of 2012 Session of the Eighty-fourth General Assembly regarding nullification of amendment to 79.1(7) “b” (ARC 9959B, IAB 1/11/12).
- <sup>12</sup> July 1, 2019, effective date of **ARC 4430C** [amendments to chs 78, 79] delayed until the adjournment of the 2020 session of the General Assembly by the Administrative Rules Review Committee at its meeting held June 11, 2019; delay lifted at the meeting held September 10, 2019.



**DENTAL BOARD[650]**

[Prior to 5/18/88, Dental Examiners, Board of[320]]

TITLE I  
*GENERAL PROVISIONS*CHAPTER 1  
ADMINISTRATION

- 1.1(153) Definitions
- 1.2(17A,147,153,272C) Purpose of the board
- 1.3(17A,147,153) Organization of the board
- 1.4(153) Organization of the dental hygiene committee
- 1.5(17A,153) Information
- 1.6(17A,147,153) Meetings

CHAPTERS 2 to 4  
ReservedTITLE II  
*ADMINISTRATION*CHAPTER 5  
ReservedCHAPTER 6  
PUBLIC RECORDS AND FAIR INFORMATION PRACTICES  
(Uniform Rules)

- 6.1(153,147,22) Definitions
- 6.3(153,147,22) Requests for access to records
- 6.6(153,147,22) Procedure by which additions, dissents, or objections may be entered into certain records
- 6.9(153,147,22) Disclosures without the consent of the subject
- 6.10(153,147,22) Routine use
- 6.11(153,147,22) Consensual disclosure of confidential records
- 6.12(153,147,22) Release to subject
- 6.13(153,147,22) Availability of records
- 6.14(153,147,22) Personally identifiable information
- 6.15(153,147,22) Other groups of records
- 6.16(153,147,22) Data processing system
- 6.17(153,147,22) Purpose and scope

CHAPTER 7  
RULES

- 7.1(17A,147,153) Petition for rule making
- 7.2(17A,147,153) Oral presentations for rule making
- 7.3 Reserved
- 7.4(17A,147,153) Waivers
- 7.5(17A,147,153) Sample petition for waiver

CHAPTER 8  
SALE OF GOODS AND SERVICES

- 8.1(68B) Selling of goods or services by members of the board
- 8.2(68B) Conditions of consent for members

CHAPTER 9  
DECLARATORY ORDERS

9.1(17A)	Petition for declaratory order
9.2(17A)	Notice of petition
9.3(17A)	Intervention
9.4(17A)	Briefs
9.5(17A)	Inquiries
9.6(17A)	Service and filing of petitions and other papers
9.7(17A)	Consideration
9.8(17A)	Action on petition
9.9(17A)	Refusal to issue order
9.10(17A)	Contents of declaratory order—effective date
9.11(17A)	Copies of orders
9.12(17A)	Effect of a declaratory order

TITLE III  
*LICENSING*

CHAPTER 10  
GENERAL REQUIREMENTS

10.1(153)	Licensed or registered personnel
10.2(147,153)	Display of license, registration, permit, and renewal
10.3(153)	Authorized practice of a dental hygienist
10.4(153)	Unauthorized practice of a dental hygienist
10.5(153)	Public health supervision allowed
10.6(147,153,272C)	Other requirements

CHAPTER 11  
LICENSURE TO PRACTICE DENTISTRY OR DENTAL HYGIENE

11.1(147,153)	Applicant responsibilities
11.2(147,153)	Dental licensure by examination
11.3(153)	Dental licensure by credentials
11.4(153)	Graduates of foreign dental schools
11.5(147,153)	Dental hygiene licensure by examination
11.6(153)	Dental hygiene licensure by credentials
11.7(147,153)	Dental hygiene application for local anesthesia permit
11.8(147,153)	Review of applications
11.9(147,153)	Grounds for denial of application
11.10(147)	Denial of licensure—appeal procedure
11.11(252J,261)	Receipt of certificate of noncompliance

CHAPTER 12  
DENTAL AND DENTAL HYGIENE EXAMINATIONS

12.1(147,153)	Clinical examination procedure for dentistry
12.2(147,153)	System of retaking dental examinations
12.3(147,153)	Portfolio examination procedure for dentistry
12.4(147,153)	Clinical examination procedure for dental hygiene
12.5(147,153)	System of retaking dental hygiene examinations

CHAPTER 13  
SPECIAL LICENSES

13.1(153)	Resident license
13.2(153)	Dental college and dental hygiene program faculty permits

- 13.3(153) Temporary permit
- 13.4(153) Retired volunteer license

#### CHAPTER 14

##### RENEWAL AND REINSTATEMENT

- 14.1(147,153,272C) Renewal of license to practice dentistry or dental hygiene
- 14.2(153) Renewal of registration as a dental assistant
- 14.3(136C,153) Renewal of dental assistant radiography qualification
- 14.4(147,153,272C) Grounds for nonrenewal
- 14.5(147,153,272C) Late renewal
- 14.6(147,153,272C) Reinstatement of a lapsed license or registration
- 14.7(136C,153) Reinstatement of lapsed radiography qualification
- 14.8(153) Reactivation of an inactive license or registration

#### CHAPTER 15

##### FEES

- 15.1(147,153) Establishment of fees
- 15.2(147,153) Definitions
- 15.3(153) Examination fees
- 15.4(153) Application fees
- 15.5(153) Renewal fees
- 15.6(153) Late renewal fees
- 15.7(147,153) Reinstatement fees
- 15.8(153) Miscellaneous fees
- 15.9(153) Continuing education fees
- 15.10(153) Facility inspection fee
- 15.11(22,147,153) Public records
- 15.12(22,147,153) Purchase of a mailing list or data list
- 15.13(147,153) Returned checks
- 15.14(147,153,272C) Copies of the laws and rules
- 15.15(17A,147,153,272C) Waiver prohibited

#### CHAPTER 16

##### PRESCRIBING, ADMINISTERING, AND DISPENSING DRUGS

- 16.1(124,153,155A) Definitions
- 16.2(153) Scope of authority and prescribing requirements
- 16.3(153) Dispensing—requirements for containers and labeling
- 16.4(153) Prescription requirements
- 16.5(153) Required use of the PMP

#### CHAPTERS 17 to 19

##### Reserved

#### TITLE IV

##### AUXILIARY PERSONNEL

#### CHAPTER 20

##### DENTAL ASSISTANTS

- 20.1(153) Registration required
- 20.2(153) Definitions
- 20.3(153) Applicant responsibilities
- 20.4(153) Scope of practice
- 20.5(153) Categories of dental assistants: dental assistant trainee, registered dental assistant
- 20.6(153) Registration requirements

20.7(153)	Review of applications
20.8(153)	Registration denial
20.9(147,153)	Denial of registration—appeal procedure
20.10(153)	Examination requirements
20.11(153)	System of retaking dental assistant examinations
20.12(153)	Continuing education
20.13(252J,261)	Receipt of certificate of noncompliance
20.14(153)	Unlawful practice
20.15(153)	Advertising and soliciting of dental services prohibited
20.16(153)	Public health supervision allowed
20.17(153)	Students enrolled in dental assisting programs

## CHAPTER 21

## DENTAL LABORATORY TECHNICIAN

21.1(153)	Definition
21.2(153)	Unlawful practice by dental laboratory technician
21.3(153)	Advertising and soliciting dental services prohibited

## CHAPTER 22

## DENTAL ASSISTANT RADIOGRAPHY QUALIFICATION

22.1(136C,153)	Qualification required
22.2(136C,153)	Definitions
22.3(136C,153)	Exemptions
22.4(136C,153)	Application requirements for dental radiography qualification
22.5(136C,153)	Examination requirements
22.6(136C,153)	Penalties

## CHAPTER 23

## EXPANDED FUNCTIONS

23.1(153)	Definitions
23.2(153)	Expanded function requirements and eligibility
23.3(153)	Expanded function categories
23.4(153)	Level 1 expanded function procedures for dental assistants
23.5(153)	Level 1 expanded function procedures for dental hygienists
23.6(153)	Level 2 expanded function procedures for dental hygienists and dental assistants
23.7(153)	Expanded function training

## CHAPTER 24

## Reserved

## CHAPTER 25

## CONTINUING EDUCATION

25.1(153)	Definitions
25.2(153)	Continuing education administrative requirements
25.3(153)	Documentation of continuing education hours
25.4(153)	Required continuing education courses
25.5(153)	Acceptable programs and activities
25.6(153)	Unacceptable programs and activities
25.7(153)	Prior approval of activities
25.8(153)	Postapproval of activities
25.9(153)	Designation of continuing education hours
25.10(153)	Extensions and exemptions
25.11(153)	Exemptions for inactive practitioners

- 25.12(153) Approval of sponsors
- 25.13(153) Review of programs or sponsors
- 25.14(153) Noncompliance with continuing dental education requirements
- 25.15(153) Dental hygiene continuing education

#### CHAPTER 26 ADVERTISING

- 26.1(153) General
- 26.2(153) Requirements
- 26.3(153) Fees
- 26.4(153) Public representation
- 26.5(153) Responsibility
- 26.6(153) Advertisement records

#### CHAPTER 27 STANDARDS OF PRACTICE AND PRINCIPLES OF PROFESSIONAL ETHICS

- 27.1(153) General
- 27.2(153,272C) Patient acceptance
- 27.3(153) Emergency service
- 27.4(153) Consultation and referral
- 27.5(153) Use of personnel
- 27.6(153) Evidence of incompetent treatment
- 27.7(153) Representation of care and fees
- 27.8(153) General practitioner announcement of services
- 27.9(153) Unethical and unprofessional conduct
- 27.10(153) Retirement or discontinuance of practice
- 27.11(153,272C) Record keeping
- 27.12(17A,147,153,272C) Waiver prohibited

#### CHAPTER 28 Reserved

#### CHAPTER 29 SEDATION AND NITROUS OXIDE

- 29.1(153) Definitions
- 29.2(153) Advertising
- 29.3(153) Nitrous oxide inhalation analgesia
- 29.4(153) Minimal sedation standards
- 29.5(153) Shared standards for moderate sedation, deep sedation and general anesthesia
- 29.6(153) Moderate sedation standards
- 29.7(153) Deep sedation or general anesthesia standards
- 29.8(153) Facility and equipment requirements for moderate sedation, deep sedation or general anesthesia
- 29.9(153) Use of another licensed sedation provider or permit holder
- 29.10(153) Reporting of adverse occurrences related to sedation or nitrous oxide
- 29.11(153) Requirements for issuance of a moderate sedation or general anesthesia permit
- 29.12(153) ACC
- 29.13(153) Review of permit applications
- 29.14(153) Renewal
- 29.15(147,153,272C) Grounds for nonrenewal
- 29.16(153) Noncompliance

TITLE VI  
*PROFESSIONAL REGULATION*

CHAPTER 30  
DISCIPLINE

30.1(153)	General
30.2(153)	Methods of discipline
30.3(153)	Discretion of board
30.4(147,153,272C)	Grounds for discipline
30.5(153)	Impaired practitioner review committee

CHAPTER 31  
COMPLAINTS AND INVESTIGATIONS

31.1(272C)	Complaint review
31.2(153)	Form and content
31.3(153)	Address
31.4(153)	Investigation
31.5(153)	Issuance of investigatory subpoenas
31.6(153)	Board appearances
31.7(153)	Peer review
31.8(272C)	Duties of peer review committees
31.9(272C)	Board review
31.10(272C)	Confidentiality of investigative files
31.11(272C)	Reporting of judgments or settlements
31.12(272C)	Investigation of reports of judgments and settlements
31.13(272C)	Mandatory reporting
31.14	Reserved
31.15(272C)	Immunities

CHAPTER 32  
MEDIATION OF DISPUTES

32.1(153)	Definitions
32.2(153)	Mediation authorized
32.3(153)	Mediation process
32.4(153)	Assignment of mediator
32.5(153)	Cancellation
32.6(153)	Mediation meetings
32.7(153)	Mediation report
32.8(679)	Mediation agreement
32.9(679)	Mediation confidential
32.10(679)	Mediator immunity

TITLES VII TO X

CHAPTER 33  
CHILD SUPPORT NONCOMPLIANCE

33.1(252J,598)	Definitions
33.2(252J,598)	Issuance or renewal of a license or registration—denial
33.3(252J,598)	Suspension or revocation of a license or registration

CHAPTER 34  
STUDENT LOAN DEFAULT/NONCOMPLIANCE  
WITH AGREEMENT FOR PAYMENT OF OBLIGATION

- 34.1(261) Definitions  
34.2(261) Issuance or renewal of a license or registration—denial  
34.3(261) Suspension or revocation of a license or registration

CHAPTER 35  
IOWA PRACTITIONER REVIEW COMMITTEE

- 35.1(153,272C) Iowa practitioner review committee  
35.2(272C) Board referrals to the Iowa practitioner review committee

CHAPTER 36  
NONPAYMENT OF STATE DEBT

- 36.1(272D) Definitions  
36.2(272D) Issuance or renewal of a license—denial  
36.3(272D) Suspension or revocation of a license  
36.4(272D) Sharing of information

CHAPTERS 37 to 50  
Reserved

CHAPTER 51  
CONTESTED CASES

- 51.1(17A) Scope and applicability  
51.2(17A) Definitions  
51.3(17A) Probable cause  
51.4(17A) Legal review  
51.5(17A) Time requirements  
51.6(17A) Statement of charges and notice of hearing  
51.7(17A) Legal representation  
51.8(17A) Presiding officer in a disciplinary contested case  
51.9(17A) Presiding officer in a nondisciplinary contested case  
51.10(17A) Disqualification  
51.11(17A) Consolidation—severance  
51.12(17A) Pleadings  
51.13(17A) Service and filing  
51.14(17A) Discovery  
51.15(17A,272C) Issuance of subpoenas in a contested case  
51.16(17A) Motions  
51.17(17A) Prehearing conference  
51.18(17A) Continuances  
51.19(17A) Settlements  
51.20(17A) Hearing procedures  
51.21(17A) Evidence  
51.22(17A) Default  
51.23(17A) Ex parte communication  
51.24(17A) Recording costs  
51.25(17A) Interlocutory appeals  
51.26(17A) Proposed and final decision  
51.27(17A) Applications for rehearing  
51.28(17A) Stays of board actions  
51.29(17A) No factual dispute contested cases

- 51.30(17A) Emergency adjudicative proceedings
- 51.31(153) Judicial review
- 51.32(17A) Notification of decision
- 51.33(17A) Publicizing disciplinary action
- 51.34(153) Reinstatement
- 51.35(272C) Disciplinary hearings—fees and costs

CHAPTER 52

MILITARY SERVICE AND VETERAN RECIPROCITY

- 52.1(85GA,ch1116) Definitions
- 52.2(85GA,ch1116) Military education, training, and service credit
- 52.3(85GA,ch1116) Veteran reciprocity

TITLE III  
LICENSING

## CHAPTER 10

## GENERAL REQUIREMENTS

[Prior to 5/18/88, Dental Examiners, Board of[320]]

**650—10.1(153) Licensed or registered personnel.** Persons engaged in the practice of dentistry in Iowa must be licensed by the board as a dentist, and persons performing services under Iowa Code section 153.15 must be licensed by the board as a dental hygienist. Persons engaged in the practice of dental assisting must be registered by the board pursuant to 650—Chapter 20.

This rule is intended to implement Iowa Code sections 147.2 and 153.17.

**650—10.2(147,153) Display of license, registration, permit, and renewal.** The license to practice dentistry or dental hygiene or the registration as a dental assistant and the current renewal must be prominently displayed by the licensee or registrant at each permanent practice location. A dentist who holds a permit to administer deep sedation/general anesthesia or conscious sedation, or a dental hygienist who holds a permit to administer local anesthesia, shall also prominently display the permit and the current renewal at each permanent practice location.

**10.2(1)** Additional certificates shall be obtained from the board whenever a licensee or registrant practices at more than one address.

**10.2(2)** Duplicate licenses, certificates of registration, or permits shall be issued by the board upon satisfactory proof of loss or destruction of the original license, certificate of registration, or permit.

This rule is intended to implement Iowa Code sections 147.7, 147.10 and 147.80(17).

**650—10.3(153) Authorized practice of a dental hygienist.**

**10.3(1)** “Practice of dental hygiene” as defined in Iowa Code section 153.15 means the performance of the following educational, therapeutic, preventive and diagnostic dental hygiene services. Such services, except educational services, shall be delegated by and performed under the supervision of a dentist licensed pursuant to Iowa Code chapter 153.

*a.* Educational. Assessing the need for, planning, implementing, and evaluating oral health education programs for individual patients and community groups; conducting workshops and in-service training sessions on dental health for nurses, school personnel, institutional staff, community groups and other agencies providing consultation and technical assistance for promotional, preventive and educational services.

*b.* Therapeutic. Identifying and evaluating factors which indicate the need for and performing (1) oral prophylaxis, which includes supragingival and subgingival debridement of plaque, and detection and removal of calculus with instruments or any other devices; (2) periodontal scaling and root planing; (3) removing and polishing hardened excess restorative material; (4) administering local anesthesia with the proper permit; (5) administering nitrous oxide inhalation analgesia in accordance with 650—subrules 29.6(4) and 29.6(5); (6) applying or administering medicaments prescribed by a dentist, including chemotherapeutic agents and medicaments or therapies for the treatment of periodontal disease and caries; (7) removal of adhesives.

*c.* Preventive. Applying pit and fissure sealants and other medications or methods for caries and periodontal disease control; organizing and administering fluoride rinse or sealant programs.

*d.* Diagnostic. Reviewing medical and dental health histories; performing oral inspection; indexing dental and periodontal disease; preliminary charting of existing dental restorations and teeth; making occlusal registrations for mounting study casts; testing pulp vitality; testing glucose levels; analyzing dietary surveys.

*e.* The following services may only be delegated by a dentist to a dental hygienist: administration of local anesthesia, placement of sealants, and the removal of any plaque, stain, calculus, or hard natural or synthetic material except by toothbrush, floss, or rubber cup coronal polish.

*f.* Phlebotomy.

*g.* Expanded function procedures in accordance with 650—Chapter 23.

**10.3(2)** All authorized services provided by a dental hygienist, except educational services, shall be performed under the general, direct, or public health supervision of a dentist currently licensed in the state of Iowa in accordance with 650—1.1(153) and 650—10.5(153).

**10.3(3)** Under the general or public health supervision of a dentist, a dental hygienist may provide educational services, assessment, screening, or data collection for the preparation of preliminary written records for evaluation by a licensed dentist. A dentist is not required to examine a patient prior to the provision of these dental hygiene services.

**10.3(4)** The administration of local anesthesia or nitrous oxide inhalation analgesia shall only be provided under the direct supervision of a dentist.

**10.3(5)** All other authorized services provided by a dental hygienist to a new patient shall be provided under the direct or public health supervision of a dentist. An examination by the dentist must take place during an initial visit by a new patient, except when hygiene services are provided under public health supervision.

**10.3(6)** Subsequent examination and monitoring of the patient, including definitive diagnosis and treatment planning, is the responsibility of the dentist and shall be carried out in a reasonable period of time in accordance with the professional judgment of the dentist based upon the individual needs of the patient.

**10.3(7)** General supervision shall not preclude the use of direct supervision when in the professional judgment of the dentist such supervision is necessary to meet the individual needs of the patient.

This rule is intended to implement Iowa Code section 153.15.

[ARC 2141C, IAB 9/16/15, effective 10/21/15; ARC 3487C, IAB 12/6/17, effective 1/10/18; ARC 4676C, IAB 9/25/19, effective 10/30/19]

**650—10.4(153) Unauthorized practice of a dental hygienist.** A dental hygienist who renders hygiene services, except educational services, that have not been delegated by a licensed dentist or that are not performed under the supervision of a licensed dentist as provided by rule shall be deemed to be practicing illegally.

**10.4(1)** The unauthorized practice of dental hygiene means allowing a person not licensed in dentistry or dental hygiene to perform dental hygiene services authorized in Iowa Code section 153.15 and rule 650—10.3(153).

**10.4(2)** The unauthorized practice of dental hygiene also means the performance of services by a dental hygienist that exceeds the scope of practice granted in Iowa Code section 153.15.

**10.4(3)** Students enrolled in dental hygiene programs. Students enrolled in an accredited dental hygiene program are not considered to be engaged in the unlawful practice of dental hygiene provided that such practice is in connection with their regular course of instruction and meets the following:

*a.* The practice of clinical skills on peers enrolled in the same program must be under the direct supervision of a program instructor with an active Iowa dental hygiene license, Iowa faculty permit, or Iowa dental license;

*b.* The practice of clinical skills on members of the public must be under the general supervision of a dentist with an active Iowa dental license;

*c.* The practice of clinical skills involving the administration or monitoring of nitrous oxide or the administration of local anesthesia must be under the direct supervision of a dentist with an active Iowa dental license.

This rule is intended to implement Iowa Code sections 147.10, 147.57 and 153.15.

[ARC 2592C, IAB 6/22/16, effective 7/27/16; ARC 3487C, IAB 12/6/17, effective 1/10/18; ARC 3987C, IAB 8/29/18, effective 10/3/18]

**650—10.5(153) Public health supervision allowed.** A dentist who meets the requirements of this rule may provide public health supervision to a dental hygienist if the dentist has an active Iowa license and the services are provided in public health settings.

**10.5(1)** *Public health settings defined.* For the purposes of this rule, public health settings are limited to schools; Head Start programs; programs affiliated with the early childhood Iowa (ECI) initiative authorized by Iowa Code chapter 256I; child care centers (excluding home-based child care centers);

federally qualified health centers; public health dental vans; free clinics; nonprofit community health centers; nursing facilities; and federal, state, or local public health programs.

**10.5(2) Public health supervision defined.** “Public health supervision” means all of the following:

*a.* The dentist authorizes and delegates the services provided by a dental hygienist to a patient in a public health setting, with the exception that hygiene services may be rendered without the patient’s first being examined by a licensed dentist;

*b.* The dentist is not required to provide future dental treatment to patients served under public health supervision;

*c.* The dentist and the dental hygienist have entered into a written supervision agreement that details the responsibilities of each licensee, as specified in subrule 10.5(3); and

*d.* The dental hygienist has an active Iowa license with a minimum of one year of clinical practice experience.

**10.5(3) Licensee responsibilities.** When working together in a public health supervision relationship, a dentist and dental hygienist shall enter into a written agreement that specifies the following responsibilities.

*a.* The dentist providing public health supervision must:

(1) Be available to provide communication and consultation with the dental hygienist;

(2) Have age- and procedure-specific standing orders for the performance of dental hygiene services. Those standing orders must include consideration for medically compromised patients and medical conditions for which a dental evaluation must occur prior to the provision of dental hygiene services;

(3) Specify a period of time in which an examination by a dentist must occur prior to providing further hygiene services. However, this examination requirement does not apply to educational services, assessments, screenings, and fluoride if specified in the supervision agreement;

(4) Specify the location or locations where the hygiene services will be provided under public health supervision; and

(5) Complete board-approved training on silver diamine fluoride if the supervision agreement permits the use of silver diamine fluoride. The supervision agreement must specify guidelines for use of silver diamine fluoride and must follow board-approved protocols.

*b.* A dental hygienist providing services under public health supervision may provide assessments; screenings; data collection; and educational, therapeutic, preventive, and diagnostic services as defined in rule 650—10.3(153), except for the administration of local anesthesia or nitrous oxide inhalation analgesia, and must:

(1) Maintain contact and communication with the dentist providing public health supervision;

(2) Practice according to age- and procedure-specific standing orders as directed by the supervising dentist, unless otherwise directed by the dentist for a specific patient;

(3) Provide to the patient, parent, or guardian a written plan for referral to a dentist and assessment of further dental treatment needs;

(4) Have each patient sign a consent form that notifies the patient that the services that will be received do not take the place of regular dental checkups at a dental office and are meant for people who otherwise would not have access to services;

(5) Specify a procedure for creating and maintaining dental records for the patients that are treated by the dental hygienist, including where these records are to be located; and

(6) Complete board-approved training on silver diamine fluoride if the supervision agreement permits the use of silver diamine fluoride. The supervision agreement must specify guidelines for use of silver diamine fluoride and must follow board-approved protocols.

*c.* The written agreement for public health supervision must be maintained by the dentist and the dental hygienist and must be made available to the board upon request. The dentist and dental hygienist must review the agreement at least biennially.

*d.* A copy of the written agreement for public health supervision shall be filed with the Bureau of Oral and Health Delivery Systems, Iowa Department of Public Health, Lucas State Office Building, 321 E. 12th Street, Des Moines, Iowa 50319.

**10.5(4) Reporting requirements.** Each dental hygienist who has rendered services under public health supervision must complete a summary report at the completion of a program or, in the case of an ongoing program, at least annually. The report shall be filed with the bureau of oral and health delivery systems of the Iowa department of public health on forms provided by the department and shall include information related to the number of patients seen and services provided so that the department may assess the impact of the program. The department will provide summary reports to the board on an annual basis.

This rule is intended to implement Iowa Code section 153.15.

[ARC 7767B, IAB 5/20/09, effective 6/24/09; ARC 0629C, IAB 3/6/13, effective 4/10/13; ARC 2141C, IAB 9/16/15, effective 10/21/15; ARC 3987C, IAB 8/29/18, effective 10/3/18]

**650—10.6(147,153,272C) Other requirements.**

**10.6(1) Change of name.** Each person licensed or registered by the board must notify the board, by written correspondence, of a change of legal name within 60 days of such change. Proof of a legal name change, such as a copy of a notarized letter, marriage certificate, or other legal document establishing the change must accompany the request for a name change.

**10.6(2) Change of address.** Each person licensed or registered by the board must notify the board within 60 days, through the board's online system, of changes in email and mailing addresses. Address changes shall be submitted as follows:

*a. Primary mailing address.* Licensees or registrants shall designate a primary mailing address. The primary mailing address may be a designated work or home address.

*b. Practice locations.* Licensees or registrants shall report addresses for all practice locations. Practice locations include full-time and part-time practice locations.

*c. Email address.* Each licensee or registrant shall report, when available, an email address for the purpose of electronic communications from the board.

**10.6(3) Child and dependent adult abuse training.** Licensees or registrants who regularly examine, attend, counsel or treat children or adults in Iowa must obtain mandatory training in child and dependent adult abuse identification and reporting within six months of initial employment and subsequently every five years in accordance with 650—subrule 25.2(9).

**10.6(4) Reporting requirements.** Each licensee and registrant shall be responsible for reporting to the board, within 30 days, any of the following:

*a.* Every adverse judgment in a professional malpractice action to which the licensee or registrant was a party.

*b.* Every settlement of a claim against the licensee or registrant alleging malpractice.

*c.* Any license or registration revocation, suspension or other disciplinary action taken by a licensing authority of another state, territory or country within 30 days of the final action by the licensing authority.

This rule is intended to implement Iowa Code sections 147.9, 232.69, 235B.16 and 272C.9.

[ARC 0265C, IAB 8/8/12, effective 9/12/12; ARC 3987C, IAB 8/29/18, effective 10/3/18]

[Filed 8/23/78, Notice 6/28/78—published 9/20/78, effective 10/25/78]

[Filed emergency 12/16/83—published 1/4/84, effective 12/16/83]

[Filed emergency 2/24/84 after Notice 1/4/84—published 3/14/84, effective 2/24/84]

[Filed 12/14/84, Notice 10/10/84—published 1/2/85, effective 2/6/85]

[Filed 4/28/88, Notice 3/23/88—published 5/18/88, effective 6/22/88]

[Filed 7/28/95, Notice 5/10/95—published 8/16/95, effective 9/20/95]

[Filed 10/30/98, Notice 5/20/98—published 11/18/98, effective 12/23/98]

[Filed 1/22/99, Notice 11/18/98—published 2/10/99, effective 3/17/99]

[Filed 7/23/99, Notice 5/19/99—published 8/11/99, effective 9/15/99]

[Filed 1/21/00, Notice 12/15/99—published 2/9/00, effective 3/15/00]

[Filed 10/23/00, Notice 8/9/00—published 11/15/00, effective 1/1/01]

[Filed 1/19/01, Notice 11/15/00—published 2/7/01, effective 3/14/01]

[Filed 6/21/02, Notice 2/20/02—published 7/10/02, effective 8/14/02]

[Filed 12/4/03, Notice 9/17/03—published 12/24/03, effective 1/28/04]

[Filed 7/1/04, Notice 5/12/04—published 7/21/04, effective 8/25/04]  
[Filed 4/22/05, Notice 2/2/05—published 5/11/05, effective 6/15/05]  
[Filed 1/27/06, Notice 9/28/05—published 2/15/06, effective 3/22/06]  
[Nullified language editorially removed 5/24/06]†

[Filed emergency 4/23/07 after Notice 2/28/07—published 5/23/07, effective 4/23/07]  
[Filed ARC 7767B (Notice ARC 7555B, IAB 2/11/09), IAB 5/20/09, effective 6/24/09]  
[Filed ARC 0265C (Notice ARC 0128C, IAB 5/16/12), IAB 8/8/12, effective 9/12/12]  
[Filed ARC 0629C (Notice ARC 0471C, IAB 11/28/12), IAB 3/6/13, effective 4/10/13]  
[Filed ARC 2141C (Notice ARC 2043C, IAB 6/24/15), IAB 9/16/15, effective 10/21/15]  
[Filed ARC 2592C (Notice ARC 2432C, IAB 3/2/16), IAB 6/22/16, effective 7/27/16]  
[Filed ARC 3487C (Notice ARC 3253C, IAB 8/16/17), IAB 12/6/17, effective 1/10/18]  
[Filed ARC 3987C (Notice ARC 3849C, IAB 6/20/18), IAB 8/29/18, effective 10/3/18]  
[Filed ARC 4676C (Notice ARC 4424C, IAB 5/8/19), IAB 9/25/19, effective 10/30/19]

<sup>1</sup> Effective date of 10.3(1) delayed until the end of the 2000 Session of the General Assembly by the Administrative Rules Review Committee at its meeting held September 15, 1999.

†See HJR 2006 of 2006 Session of the Eighty-first General Assembly regarding nullification of subrule 10.6(4).



CHAPTER 15  
FEES

**650—15.1(147,153) Establishment of fees.** The board is self-supporting through the collection of fees and does not receive an appropriation from the general fund. Pursuant to Iowa Code section 147.80, the board is to establish fees by rule based on the costs of sustaining the board and the actual costs of the services performed by the board. Under Iowa law, the board is required to annually prepare an estimate of projected revenues generated by the fees received and review projected expenses to ensure that there are sufficient funds to cover projected expenses.

[ARC 0164C, IAB 6/13/12, effective 5/21/12; ARC 0265C, IAB 8/8/12, effective 9/12/12]

**650—15.2(147,153) Definitions.** The following definitions apply to this chapter:

“*Fee*” means the amount charged for the services described in this chapter. All fees are nonrefundable. Overpayment of the fee will result in return of the original request and payment, prior to processing, with a clarification of the total amount due.

“*Service charge*” means the amount charged for making a service available online and is in addition to the actual fee for a service itself. For example, a licensee who renews a license online will pay the license renewal fee and a service charge.

[ARC 0265C, IAB 8/8/12, effective 9/12/12; ARC 3490C, IAB 12/6/17, effective 1/10/18]

**650—15.3(153) Examination fees.** All fees are nonrefundable. In addition to the fees specified in this rule, an applicant will pay a service charge for filing online.

**15.3(1) Portfolio dental examination fee.** The fee for dental examination on the basis of portfolio is \$1500.

**15.3(2) Reserved.**

[ARC 3488C, IAB 12/6/17, effective 1/10/18]

**650—15.4(153) Application fees.** All fees are nonrefundable. In addition to the fees specified in this rule, an applicant will pay a service charge for filing online.

**15.4(1) Dental licensure on the basis of examination.** The fees for a dental license issued on the basis of examination include an application fee, a fee for evaluation of a fingerprint packet and criminal background check and, if the applicant is applying within three months or less of a biennial renewal due date, the renewal fee.

*a. Application fee.* The application fee for a license to practice dentistry is \$200.

*b. Initial licensure period and renewal period.* If an applicant applies within three months or less of a biennial renewal due date, the applicant shall pay the renewal fee along with the licensure application fee. A license shall not be issued for a period less than three months or longer than two years and three months. Thereafter, a licensee shall pay the renewal fee as specified in rule 650—15.5(153).

*c. Fingerprint packet and criminal history check.* The fee for evaluation of a fingerprint packet and criminal background check is as specified in subrule 15.8(4).

**15.4(2) Dental hygiene licensure on the basis of examination.** The fees for a dental hygiene license issued on the basis of examination include an application fee, an initial licensure fee, and a fee for evaluation of a fingerprint packet and criminal background check.

*a. Application fee.* The application fee for a license to practice dental hygiene is \$100.

*b. Initial licensure period and renewal period.* If an applicant applies within three months or less of a biennial renewal due date, the applicant shall pay the renewal fee along with the licensure application fee. A license shall not be issued for a period less than three months or longer than two years and three months. Thereafter, a licensee shall pay the renewal fee as specified in rule 650—15.5(153).

*c. Fingerprint packet and criminal history check.* The fee for evaluation of a fingerprint packet and criminal background check is as specified in subrule 15.8(4).

**15.4(3) Resident dental license.** The application fee for a resident dental license is \$120.

**15.4(4) Faculty permit.** The application fee for a faculty permit is \$200.

**15.4(5) Dental licensure on the basis of credentials.** The fees for a dental license issued on the basis of credentials include an application fee, an initial licensure fee, and a fee for evaluation of a fingerprint packet and criminal background check.

*a. Application fee.* The application fee for a license to practice dentistry issued on the basis of credentials is \$550.

*b. Initial licensure period and renewal period.* If an applicant applies within three months or less of a biennial renewal due date, the applicant shall pay the renewal fee along with the licensure application fee. A license shall not be issued for a period less than three months or longer than two years and three months. Thereafter, a licensee shall pay the renewal fee as specified in rule 650—15.5(153).

*c. Fingerprint packet and criminal history check.* The fee for evaluation of a fingerprint packet and criminal background check is as specified in subrule 15.8(4).

**15.4(6) Dental hygiene licensure on the basis of credentials.** The fees for a dental hygiene license issued on the basis of credentials include an application fee, an initial licensure fee, and a fee for evaluation of a fingerprint packet and criminal background check.

*a. Application fee.* The application fee for a license to practice dental hygiene issued on the basis of credentials is \$200.

*b. Initial licensure period and renewal period.* If an applicant applies within three months or less of a biennial renewal due date, the applicant shall pay the renewal fee along with the licensure application fee. A license shall not be issued for a period less than three months or longer than two years and three months. Thereafter, a licensee shall pay the renewal fee as specified in rule 650—15.5(153).

*c. Fingerprint packet and criminal history check.* The fee for evaluation of a fingerprint packet and criminal background check is as specified in subrule 15.8(4).

**15.4(7) Reactivation of an inactive license or registration.** The fee for a reactivation application for inactive practitioners is \$50.

**15.4(8) Reinstatement of an inactive license or registration.** The fee for a reinstatement application for a lapsed license or registration is \$150.

**15.4(9) General anesthesia permit application.** The application fee for a general anesthesia permit is \$500.

**15.4(10) Moderate sedation permit application.** The application fee for a moderate sedation permit is \$500.

**15.4(11) Local anesthesia permit—initial application and reinstatement.** The application or reinstatement fee for a permit to authorize a dental hygienist to administer local anesthesia is \$70.

**15.4(12) Dental assistant trainee application.** The fee for an application for registration as a dental assistant trainee is \$25.

**15.4(13) Dental assistant registration only application.**

*a. Application fee.* The application fee for dental assistant registration is \$40.

*b. Initial registration period and renewal period.* If an applicant applies within three months or less of a biennial renewal due date, the applicant shall pay the renewal fee along with the registration application fee. A dental assistant registration shall not be issued for a period less than three months or longer than two years and three months. Thereafter, a registrant shall pay the renewal fee as specified in rule 650—15.5(153).

**15.4(14) Combined application—dental assistant registration and qualification in radiography.**

*a. Application fee.* The application fee for a combined application for both registration as a registered dental assistant and radiography qualification is \$60.

*b. Initial combined registration and radiography qualification period and renewal period.* If an applicant applies within three months or less of a biennial renewal due date, the applicant shall pay the renewal fee along with the combined registration/radiography qualification application fee. A dental assistant registration and radiography qualification shall not be issued for a period less than three months or longer than two years and three months. Thereafter, the applicant shall pay the renewal fee as specified in rule 650—15.5(153).

**15.4(15) Dental assistant radiography qualification application fee.** The fee for an application for dental assistant radiography qualification is \$40.

**15.4(16) Temporary permit—urgent need or educational services.** The fee for an application for a temporary permit to serve an urgent need or provide educational services is \$100 if an application is submitted online or \$150 if submitted via paper application.

**15.4(17) Temporary permit—volunteer services.** Rescinded ARC 0984C, IAB 9/4/13, effective 10/9/13.

[ARC 0265C, IAB 8/8/12, effective 9/12/12; ARC 0618C, IAB 3/6/13, effective 4/10/13; ARC 0984C, IAB 9/4/13, effective 10/9/13; ARC 3490C, IAB 12/6/17, effective 1/10/18; ARC 3488C, IAB 12/6/17, effective 1/10/18]

**650—15.5(153) Renewal fees.** All fees are nonrefundable. Each two-year renewal period begins on September 1 and runs through August 31. Dental licenses, moderate sedation permits, and general anesthesia permits expire in even-numbered years. Dental hygiene licenses, local anesthesia permits, dental assistant registration and qualification in dental radiography expire in odd-numbered years. To avoid late fees, paper renewal applications must be postmarked on or received in the board office by August 31. To avoid late fees, online renewal applications must be time-stamped no later than 11:59 p.m. (CST) on August 31.

**15.5(1) Dental license renewal.** The fee for renewal of a license to practice dentistry for a biennial period is \$315 for an active practitioner and \$315 for an inactive practitioner.

**15.5(2) Dental hygiene license renewal.** The fee for renewal of a license to practice dental hygiene for a biennial period is \$150 for an active practitioner and \$150 for an inactive practitioner.

**15.5(3) General anesthesia permit renewal.** The fee for renewal of a general anesthesia permit is \$125.

**15.5(4) Moderate sedation permit renewal.** The fee for renewal of a moderate sedation permit is \$125.

**15.5(5) Local anesthesia permit renewal.** The fee for renewal of a permit to authorize a dental hygienist to administer local anesthesia is \$25.

**15.5(6) Dental assistant registration renewal.** The fee for renewal of registration as a registered dental assistant is \$75.

**15.5(7) Combined renewal application—dental assistant registration and qualification in radiography.** The fee for a combined application to renew both a registration as a registered dental assistant and a radiography qualification is \$115.

**15.5(8) Dental assistant qualification in radiography renewal.** The fee for renewal of a certificate of qualification in dental radiography is \$40.

**15.5(9) Faculty permit renewal.** The fee for renewal of a faculty permit is \$315.

**15.5(10) Resident license renewal.** The fee for renewal or extension of a resident license is \$40.  
[ARC 0265C, IAB 8/8/12, effective 9/12/12; ARC 3488C, IAB 12/6/17, effective 1/10/18]

**650—15.6(153) Late renewal fees.** All fees are nonrefundable. A licensee, registrant or permit holder who fails to renew a license, registration or permit following expiration is subject to late renewal fees as described in this rule.

**15.6(1) Failure to renew a license, registration or permit prior to September 1.** Failure by a licensee, registrant or permit holder to renew the license, registration or permit prior to September 1 following expiration shall result in the following late fees:

- a. *Dental license or permit.* A late fee of \$100 shall be assessed, in addition to the renewal fee.
- b. *Dental hygiene license.* A late fee of \$100 shall be assessed, in addition to the renewal fee.
- c. *Dental assistant registration.* A late fee of \$20 shall be assessed, in addition to the renewal fee.

**15.6(2) Failure to renew a license, registration or permit prior to October 1.** Failure by a licensee, registrant or permit holder to renew the license, registration or permit prior to October 1 following expiration shall result in the following late fees:

- a. *Dental license or permit.* A late fee of \$150 shall be assessed, in addition to the renewal fee.
- b. *Dental hygiene license.* A late fee of \$150 shall be assessed, in addition to the renewal fee.
- c. *Dental assistant registration.* A late fee of \$40 shall be assessed, in addition to the renewal fee.

**15.6(3) Failure to renew a license, registration or permit prior to November 1.** Failure by a licensee, registrant or permit holder to renew a license, registration or permit prior to November 1

following expiration shall cause the license, registration or permit to lapse and become invalid. A licensee, registrant or permit holder whose license, registration or permit has lapsed and become invalid is prohibited from the practice of dentistry, dental hygiene, or dental assisting until the license, registration or permit is reinstated.

[ARC 0265C, IAB 8/8/12, effective 9/12/12; ARC 3488C, IAB 12/6/17, effective 1/10/18]

**650—15.7(147,153) Reinstatement fees.** If a license, registration or permit lapses or is inactive, a licensee, registrant or permit holder may submit an application for reinstatement. Licensees, registrants or permit holders are subject to reinstatement fees as described in this rule.

**15.7(1) Reinstatement of a dental license.** In addition to the reinstatement application fee specified in subrule 15.4(8), the applicant must pay all back renewal fees (not to exceed \$750) and the fee for evaluation of a fingerprint packet and criminal background check as specified in subrule 15.8(4).

**15.7(2) Reinstatement of a dental hygiene license.** In addition to the reinstatement application fee specified in subrule 15.4(8), the applicant must pay all back renewal fees (not to exceed \$750) and the fee for evaluation of a fingerprint packet and criminal background check as specified in subrule 15.8(4).

**15.7(3) Reinstatement of a dental assistant registration.** In addition to the reinstatement application fee specified in subrule 15.4(8), the applicant must pay all back renewal fees (not to exceed \$115) to reinstate a registration as a registered dental assistant.

**15.7(4) Combined reinstatement application—dental assistant registration and qualification in radiography.** In addition to the reinstatement application fee specified in subrule 15.4(8), the applicant must pay all back renewal fees (not to exceed \$175) for a combined application to reinstate both a registration as a registered dental assistant and a radiography qualification.

**15.7(5) Reinstatement of qualification in radiography.** In addition to the reinstatement application fee of \$40, the applicant must pay all back renewal fees (not to exceed \$60) to reinstate a qualification in dental radiography without registration as a dental assistant.

[ARC 0265C, IAB 8/8/12, effective 9/12/12; ARC 3490C, IAB 12/6/17, effective 1/10/18; ARC 3488C, IAB 12/6/17, effective 1/10/18]

**650—15.8(153) Miscellaneous fees.** Payments made to the Iowa Dental Board, which shall be considered a repayment receipt as defined in Iowa Code section 8.2, shall be received in the board office prior to release of the requested document.

**15.8(1) Duplicates.** The fee for issuance of a hard-copy duplicate license, permit or registration certificate or current renewal is \$25. Electronic copies are provided at no cost.

**15.8(2) Certification or verification.** The fee for a written certification or written verification of an Iowa license, permit or registration is \$25.

**15.8(3) Trainee manual.** The fee for the dental assistant trainee manual is \$70.

**15.8(4) Fingerprint packet and criminal history background check.** The fee for evaluation of a fingerprint packet and the criminal history background checks is \$46.

**15.8(5) IPRC monitoring.** The fee for monitoring for compliance with an IPRC agreement is \$100 per quarter, unless otherwise stated in the Iowa practitioner program contract entered into pursuant to 650—Chapter 35.

**15.8(6) Monitoring for compliance with settlement agreements.** The fee for monitoring a licensee's, registrant's or permit holder's compliance with a settlement agreement entered into pursuant to 650—subrule 51.19(9) is \$300 per quarter, unless otherwise stated in the settlement agreement.

**15.8(7) Disciplinary hearings—fees and costs.**

*a.* Definitions. As used in this subrule in relation to fees related to a formal disciplinary action filed by the board against a licensee, registrant or permit holder:

“*Deposition*” means the testimony of a person pursuant to subpoena or at the request of the state of Iowa taken in a setting other than a hearing.

“*Expenses*” means costs incurred by persons appearing pursuant to subpoena or at the request of the state of Iowa for purposes of providing testimony on the part of the state of Iowa in a hearing or other official proceeding and shall include mileage reimbursement at the rate specified in Iowa Code section

70A.9 or, if commercial air or ground transportation is used, the actual cost of transportation to and from the proceeding. Also included are actual costs incurred for meals and necessary lodging.

“*Medical examination fees*” means actual costs incurred by the board in a physical, mental, chemical abuse, or other impairment-related examination or evaluation of a licensee when the examination or evaluation is conducted pursuant to an order of the board.

“*Transcript*” means a printed verbatim reproduction of everything said on the record during a hearing or other official proceeding.

“*Witness fees*” means compensation paid by the board to persons appearing pursuant to subpoena or at the request of the state of Iowa for purposes of providing testimony on the part of the state of Iowa. For the purposes of this rule, compensation shall be the same as outlined in Iowa Code section 622.69 or 622.72 as the case may be.

b. The board may charge a fee not to exceed \$75 for conducting a disciplinary hearing which results in disciplinary action taken against the licensee by the board. In addition to the fee, the board may recover from the licensee costs for the following procedures and personnel:

(1) Court reporter and transcript.

(2) Witness fees and expenses. The parties in a contested case shall be responsible for any witness fees and expenses incurred by witnesses appearing at the contested case hearing. In addition, the board may assess a licensee the witness fees and expenses incurred by witnesses called to testify on behalf of the state of Iowa.

(3) Depositions. Deposition costs for the purposes of allocating costs against a licensee include only those deposition costs incurred by the state of Iowa. The licensee is directly responsible for the payment of deposition costs incurred by the licensee.

(4) Medical examination fees incurred relating to a person licensed under Iowa Code chapter 147. All costs of physical or mental examinations or substance abuse evaluations or drug screening or clinical competency evaluations ordered by the board pursuant to Iowa Code section 272C.9(1) as part of an investigation or pending complaint or as a sanction following a contested case shall be paid directly by the licensee.

**15.8(8) Certification of reimbursable costs.** The executive director or designee shall certify any reimbursable costs incurred by the board. The executive director shall calculate the specific costs, certify the cost calculated, and file the certification as part of the record in the contested case. A copy of the certification shall be served on the party responsible for payment of the certified costs at the time of the filing.

**15.8(9) Assessment of fees and costs.** A final decision of the board imposing disciplinary action against a licensee shall include the amount of any disciplinary hearing fee assessed, which shall not exceed \$75. If the board also assesses reimbursable costs against the licensee, the board shall file a certification of reimbursable costs which includes a statement of costs delineating each category of costs and the amount assessed. Fees and costs that cannot be calculated at the time of the issuance of the board’s final disciplinary order may be invoiced to the licensee at a later time, provided the board’s final disciplinary order states that the fees and costs will be invoiced at a later date. The board shall specify the time period in which the fees and costs must be paid by the licensee.

**15.8(10) Board treatment of collected fees, costs.** Fees and costs collected by the board shall be considered repayment receipts as defined in Iowa Code section 8.2.

**15.8(11) Failure to pay assessed fees, costs.** Failure of a licensee to pay the fees and costs assessed herein within the time period specified in the board’s final disciplinary order shall constitute a violation of an order of the board and shall be grounds for disciplinary action.

[ARC 0265C, IAB 8/8/12, effective 9/12/12; ARC 3490C, IAB 12/6/17, effective 1/10/18; ARC 3488C, IAB 12/6/17, effective 1/10/18; ARC 4676C, IAB 9/25/19, effective 10/30/19]

## **650—15.9(153) Continuing education fees.**

**15.9(1) Application for prior approval of activities.** The fee for an application for prior approval of a continuing education activity is \$10.

**15.9(2)** *Application for postapproval of activities.* The fee for an application for postapproval of a continuing education activity is \$10.

**15.9(3)** *Application for approved sponsor status.* The fee for an application to become an approved sponsor for a continuing education activity is \$100. The biennial renewal fee is \$100.  
[ARC 0265C, IAB 8/8/12, effective 9/12/12; ARC 3488C, IAB 12/6/17, effective 1/10/18]

**650—15.10(153) Facility inspection fee.** The actual costs for an on-site evaluation of a facility at which deep sedation/general anesthesia or moderate sedation is authorized pursuant to 650—Chapter 29 shall not exceed \$500 per facility per inspection.

[ARC 0265C, IAB 12/6/17, effective 9/12/12; ARC 3488C, IAB 12/6/17, effective 1/10/18]

**650—15.11(22,147,153) Public records.** Public records are available according to 650—Chapter 6, “Public Records and Fair Information Practices.” Payment made to the Iowa Dental Board, which shall be considered a repayment receipt as defined in Iowa Code section 8.2, shall be received in the board office prior to the release of the records.

**15.11(1)** Copies of public records shall be calculated at \$.25 per page plus labor. A \$16 per-hour fee shall be charged for labor in excess of one-half hour for searching and copying documents or retrieving and copying information stored electronically. No additional fee shall be charged for delivery of the records by mail or fax. A fax is an option if the requested records are fewer than 30 pages. The board office shall not require payment when the fees for the request would be less than \$5 total.

**15.11(2)** Electronic copies of public records delivered by email shall be calculated at \$.10 per page; the minimum charge shall be \$5. A \$16 per-hour fee shall be charged for labor in excess of one-half hour for searching and copying documents or retrieving and copying information stored electronically. The board office shall not require payment when the fee for the request would be less than \$5 total.

**15.11(3)** Electronic files of statements of charges, final orders and consent agreements from each board meeting may be delivered via email, upon written request, at no cost.

**15.11(4)** Printed copies of statements of charges, final orders and consent agreements from each board meeting shall be available for an annual subscription fee of \$120.

[ARC 0265C, IAB 8/8/12, effective 9/12/12; ARC 3490C, IAB 12/6/17, effective 1/10/18; ARC 3488C, IAB 12/6/17, effective 1/10/18]

**650—15.12(22,147,153) Purchase of a mailing list or data list.** Payment made to the Iowa Dental Board, which shall be considered a repayment receipt as defined in Iowa Code section 8.2, shall be received in the board office prior to the release of a list.

**15.12(1)** *Mailing list for dentists, hygienists or assistants.* The standard mailing list for all active licensees and registrants includes the full name, address, city, state, ZIP code, and Iowa county. The standard mailing list of dentists or dental hygienists includes resident licensees and faculty permit holders.

- a. Printed mailing list, \$65 per profession requested.
- b. Mailing list on disc or DVD, \$45 per profession requested.
- c. Mailing list in an electronic file, \$35 per profession requested.

**15.12(2)** *Data list for dentists, hygienists, or assistants.* The standard data list for active licensees or registrants includes full name, address, Iowa county (if applicable), original issue date, expiration date, license or registration number, license or registration status, specialty (if applicable), and whether public disciplinary action has been taken. The standard data list includes resident licensees and faculty permit holders. Additional data elements, programming or sorting increases the following fees by \$25.

- a. Printed standard data list, \$75 per profession requested.
- b. Standard data list on disc or DVD, \$55 per profession requested.
- c. Standard data list in an electronic file, \$45 per profession requested.

[ARC 0265C, IAB 8/8/12, effective 9/12/12; ARC 3490C, IAB 12/6/17, effective 1/10/18; ARC 3488C, IAB 12/6/17, effective 1/10/18]

**650—15.13(147,153) Returned checks.** The board shall charge a fee of \$39 for a check returned for any reason. If a license or registration had been issued by the board office based on a check that is later

returned by the bank, the board shall request payment by certified check or money order. If the fees are not paid within two weeks of notification of the returned check by certified mail, the licensee or registrant shall be subject to disciplinary action for noncompliance with board rules.

[ARC 0265C, IAB 8/8/12, effective 9/12/12; ARC 3488C, IAB 12/6/17, effective 1/10/18]

**650—15.14(147,153,272C) Copies of the laws and rules.** Copies of laws and rules pertaining to the practice of dentistry, dental hygiene, or dental assisting are available from the board office for the following fees.

1. Iowa Code and Iowa Administrative Code access, no fee, available at [www.state.ia.us/dentalboard](http://www.state.ia.us/dentalboard).

2. Printed copies of the Iowa Code chapters that pertain to the practice of dentistry, \$10.

3. Printed copies of dental board rules in the Iowa Administrative Code, \$15.

[ARC 0265C, IAB 8/8/12, effective 9/12/12; ARC 3488C, IAB 12/6/17, effective 1/10/18]

**650—15.15(17A,147,153,272C) Waiver prohibited.** Rules in this chapter are not subject to waiver pursuant to 650—Chapter 7 or any other provision of law.

[ARC 0265C, IAB 8/8/12, effective 9/12/12; ARC 3488C, IAB 12/6/17, effective 1/10/18]

These rules are intended to implement Iowa Code sections 147.10, 147.80 and 153.22.

[Filed 8/23/78, Notice 6/28/78—published 9/20/78, effective 10/25/78]

[Filed 3/18/82, Notice 2/3/82—published 4/14/82, effective 5/19/82]

[Filed emergency 12/16/83—published 1/4/84, effective 12/16/83]

[Filed emergency 2/24/84 after Notice 1/4/84—published 3/14/84, effective 2/24/84]

[Filed 10/3/86, Notice 8/13/86—published 10/22/86, effective 11/26/86]

[Filed emergency 2/19/88—published 3/9/88, effective 2/19/88]

[Filed 4/28/88, Notice 3/23/88—published 5/18/88, effective 6/22/88]

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

[Filed 1/29/92, Notice 11/13/91—published 2/19/92, effective 3/25/92]

[Filed 10/30/98, Notice 5/20/98—published 11/18/98, effective 12/23/98]

[Filed 1/22/99, Notice 11/18/98—published 2/10/99, effective 3/17/99]

[Filed 10/23/00, Notice 8/9/00—published 11/15/00, effective 1/1/01]

[Filed 1/19/01, Notice 11/15/00—published 2/7/01, effective 3/14/01]

[Filed 6/21/02, Notice 2/20/02—published 7/10/02, effective 8/14/02]

[Filed 8/29/02, Notice 7/10/02—published 9/18/02, effective 10/23/02]

[Filed 8/29/03, Notice 5/14/03—published 9/17/03, effective 10/22/03]<sup>◇</sup>

[Filed 7/1/04, Notice 5/12/04—published 7/21/04, effective 8/25/04]

[Filed 8/31/04, Notice 7/21/04—published 9/29/04, effective 11/3/04]

[Filed 4/22/05, Notice 2/2/05—published 5/11/05, effective 6/15/05]

[Filed 9/9/05, Notice 7/20/05—published 9/28/05, effective 11/2/05]

[Filed 2/5/07, Notice 11/22/06—published 2/28/07, effective 4/4/07]

[Filed Emergency ARC 0164C, IAB 6/13/12, effective 5/21/12]

[Filed ARC 0265C (Notice ARC 0128C, IAB 5/16/12), IAB 8/8/12, effective 9/12/12]

[Filed ARC 0618C (Notice ARC 0473C, IAB 11/28/12), IAB 3/6/13, effective 4/10/13]

[Filed ARC 0984C (Notice ARC 0724C, IAB 5/1/13), IAB 9/4/13, effective 10/9/13]

[Filed ARC 3488C (Notice ARC 3252C, IAB 8/16/17), IAB 12/6/17, effective 1/10/18]

[Filed ARC 3490C (Notice ARC 3156C, IAB 7/5/17), IAB 12/6/17, effective 1/10/18]

[Filed ARC 4676C (Notice ARC 4424C, IAB 5/8/19), IAB 9/25/19, effective 10/30/19]

<sup>◇</sup> Two or more ARCs



TITLE IV  
AUXILIARY PERSONNEL

## CHAPTER 20

## DENTAL ASSISTANTS

[Prior to 5/18/88, Dental Examiners, Board of[320]]

**650—20.1(153) Registration required.** A person shall not practice on or after July 1, 2001, as a dental assistant unless the person has registered with the board and received a certificate of registration pursuant to this chapter.

**650—20.2(153) Definitions.** As used in this chapter:

*“Dental assistant”* means any person who, under the supervision of a dentist, performs any extraoral services including infection control or the use of hazardous materials or performs any intraoral services on patients. The term “dental assistant” does not include persons otherwise actively licensed in Iowa to practice dental hygiene or nursing who are engaged in the practice of said profession.

*“Dental assistant trainee”* means any person who is engaging in on-the-job training to meet the requirements for registration and who is learning the necessary skills under the personal supervision of a licensed dentist. Trainees may also engage in on-the-job training in dental radiography pursuant to 650—22.3(136C,153).

*“Direct supervision”* means that the dentist is present in the treatment facility, but it is not required that the dentist be physically present in the treatment room while the registered dental assistant is performing acts assigned by the dentist.

*“General supervision”* means that a dentist has examined the patient and has delegated the services to be provided by a registered dental assistant, which are limited to all extraoral duties, dental radiography, intraoral suctioning, and use of a curing light, intraoral digital imaging and intraoral camera. The dentist need not be present in the facility while these services are being provided.

*“Personal supervision”* for intraoral procedures means the dentist is physically present in the treatment room to oversee and direct all intraoral or chairside services of the dental assistant trainee. “Personal supervision” for extraoral procedures means a licensee or registrant is physically present in the treatment room to oversee and direct all extraoral services of the dental assistant trainee.

*“Public health supervision”* means all of the following:

1. The dentist authorizes and delegates the services provided by a registered dental assistant to a patient in a public health setting, with the exception that services may be rendered without the patient’s first being examined by a licensed dentist;
2. The dentist is not required to provide future dental treatment to patients served under public health supervision;
3. The dentist and the registered dental assistant have entered into a written supervision agreement that details the responsibilities of each licensee/registrant, as specified in subrule 20.16(2); and
4. The registered dental assistant has an active Iowa registration and a minimum of one year of clinical practice experience.

*“Registered dental assistant”* means any person who has met the requirements for registration and has been issued a certificate of registration.

*“Trainee status expiration date”* means 12 months from the date of issuance.

[ARC 8369B, IAB 12/16/09, effective 1/20/10; ARC 0465C, IAB 11/28/12, effective 1/2/13; ARC 2028C, IAB 6/10/15, effective 7/15/15; ARC 3489C, IAB 12/6/17, effective 1/10/18]

**650—20.3(153) Applicant responsibilities.** An applicant for dental assistant trainee status or dental assistant registration bears full responsibility for each of the following:

**20.3(1)** Providing accurate, up-to-date, and truthful information on the application including, but not limited to, prior professional experiences, education, training, examination scores, and disciplinary history.

**20.3(2)** Submitting complete application materials. An application for trainee status will be considered active for 90 days from the date the application is received. An application for dental

assistant registration, reactivation, or reinstatement will be considered valid for 180 days 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 trainee status, dental assistant registration, or reinstatement, the application shall be considered incomplete and the applicant must submit a new application and application fee.

[ARC 3489C, IAB 12/6/17, effective 1/10/18]

**650—20.4(153) Scope of practice.**

**20.4(1)** In all instances, a dentist assumes responsibility for determining, on the basis of diagnosis, the specific treatment patients will receive and which aspects of treatment may be delegated to qualified personnel as authorized in these rules.

**20.4(2)** A licensed dentist may delegate to a dental assistant those procedures for which the dental assistant has received training. This delegation shall be based on the best interests of the patient. Such services shall be delegated by and performed under the supervision of a licensed dentist and may include:

- a. Placement and removal of dry socket medication;
- b. Placement of periodontal dressings;
- c. Testing pulp vitality;
- d. Preliminary charting of existing dental restorations and teeth;
- e. Glucose testing;
- f. Phlebotomy; and
- g. Expanded function procedures in accordance with 650—Chapter 23.

**20.4(3)** The dentist shall exercise supervision and shall be fully responsible for all acts performed by a dental assistant. A dentist may not delegate to a dental assistant any of the following, unless allowed pursuant to 650—Chapter 23:

- a. Diagnosis, examination, treatment planning, or prescription, including prescription for drugs and medicaments or authorization for restorative, prosthodontic or orthodontic appliances.
- b. Surgical procedures on hard and soft tissues within the oral cavity and any other intraoral procedure that contributes to or results in an irreversible alteration to the oral anatomy.
- c. Administration of local anesthesia.
- d. Placement of sealants.
- e. Removal of any plaque, stain, or hard natural or synthetic material except by toothbrush, floss, or rubber cup coronal polish, or removal of any calculus.
- f. Dental radiography, unless the assistant is qualified pursuant to 650—Chapter 22.
- g. Those procedures that require the professional judgment and skill of a dentist.

**20.4(4)** A dental assistant may perform duties consistent with these rules under the supervision of a licensed dentist. The specific duties dental assistants may perform are based upon:

- a. The education of the dental assistant.
- b. The experience of the dental assistant.

[ARC 2028C, IAB 6/10/15, effective 7/15/15; ARC 3489C, IAB 12/6/17, effective 1/10/18; ARC 4676C, IAB 9/25/19, effective 10/30/19]

**650—20.5(153) Categories of dental assistants: dental assistant trainee, registered dental assistant.** There are two categories of dental assistants. Both the supervising dentist and the registered dental assistant or dental assistant trainee are responsible for maintaining documentation of training. Such documentation must be maintained in the office of practice and shall be provided to the board upon request.

**20.5(1) Registered dental assistant.** Registered dental assistants are individuals who have met the requirements for registration and have been issued a certificate of registration. A registered dental assistant may, under general supervision, perform dental radiography, intraoral suctioning, use of a curing light and intraoral camera, and all extraoral duties that are assigned by the dentist and are consistent with these rules. During intraoral procedures, the registered dental assistant may, under direct supervision, assist the dentist in performing duties assigned by the dentist that are consistent with these rules. The registered dental assistant may take radiographs if qualified pursuant to 650—Chapter 22.

**20.5(2) Dental assistant trainee.** Dental assistant trainees are all individuals who are engaging in on-the-job training to meet the requirements for registration and who are learning the necessary skills under the personal supervision of a licensed dentist. Trainees may also engage in on-the-job training in dental radiography pursuant to rule 650—22.3(136C,153).

*a. General requirements.* The dental assistant trainee shall meet the following requirements:

(1) Successfully complete a course of study and examination in the areas of infection control, hazardous materials, and jurisprudence. The course of study shall be prior approved by the board and sponsored by a board-approved postsecondary school.

(2) If a trainee fails to become registered by the trainee status expiration date, the trainee must stop work as a dental assistant trainee. If the trainee has not yet met the requirements for registration, the trainee may reapply for trainee status but may not work until a new dental assistant trainee status certificate has been issued by the board.

*b. Trainee restart.*

(1) Reapplying for trainee status. A trainee may “start over” as a dental assistant trainee provided the trainee submits an application in compliance with subrule 20.6(1).

(2) Examination scores valid for three years. A “repeat” trainee is not required to retake an examination (jurisprudence, infection control/hazardous materials, radiography) if the trainee has successfully passed the examination within three years of the date of application. If a trainee has failed two or more examinations, the trainee must satisfy the remedial education requirements in subrule 20.11(1). The trainee status application will not be approved until the trainee successfully completes any required remedial education.

(3) New trainee status expiration date issued. If the repeat trainee application is approved, the board office will establish a new trainee status expiration date by which registration must be completed.

(4) Maximum of two “start over” periods allowed. In addition to the initial 12-month trainee status period, a dental assistant is permitted up to two start over periods as a trainee. If a trainee seeks an additional start over period beyond two, the trainee shall submit a petition for rule waiver under 650—Chapter 7.

*c. Trainees enrolled in cooperative education or work study programs.* The requirements stated in this subrule apply to all dental assistant trainees, including a person enrolled in a cooperative education or work-study program through an Iowa high school. In addition, a trainee under 18 years of age shall not participate in dental radiography.

[ARC 0465C, IAB 11/28/12, effective 1/2/13; ARC 2028C, IAB 6/10/15, effective 7/15/15; ARC 3489C, IAB 12/6/17, effective 1/10/18; ARC 4676C, IAB 9/25/19, effective 10/30/19]

**650—20.6(153) Registration requirements.** Effective July 2, 2001, dental assistants must meet the following requirements for registration:

**20.6(1) Dental assistant trainee.**

*a.* On or after May 1, 2013, a dentist supervising a person performing dental assistant duties must ensure that the person has been issued a trainee status certificate from the board office prior to the person’s first date of employment as a dental assistant. A dentist who has been granted a temporary permit to provide volunteer services for a qualifying event of limited duration pursuant to 650—subrule 13.3(3), or an Iowa-licensed dentist who is volunteering at such qualifying event, is exempt from this requirement for a dental assistant who is working under the dentist’s supervision at the qualifying event.

*b.* Applications for registration as a dental assistant trainee must be filed on official board forms and include the following:

(1) The fee as specified in 650—Chapter 15.

(2) Evidence of high school graduation or equivalent.

(3) Evidence the applicant is 17 years of age or older.

(4) Any additional information required by the board relating to the character and experience of the applicant as may be necessary to evaluate the applicant’s qualifications.

(5) If the applicant does not meet the requirements of (2) and (3) above, evidence that the applicant is enrolled in a cooperative education or work-study program through an Iowa high school.

*c.* Prior to the trainee status expiration date, the dental assistant trainee is required to successfully complete a board-approved course of study and examination in the areas of infection control, hazardous materials, and jurisprudence. The course of study may be taken at a board-approved postsecondary school or on the job using curriculum approved by the board for such purpose. Evidence of meeting this requirement prior to the trainee status expiration date shall be submitted by the employer dentist.

*d.* Prior to the trainee status expiration date, the dental assistant trainee's supervising dentist must ensure that the trainee has received a certificate of registration or has been issued start-over trainee status in accordance with rule 650—20.5(153) before performing any further dental assisting duties.

**20.6(2)** Registered dental assistant.

*a.* To meet this qualification, a person must:

- (1) Work in a dental office for six months as a dental assistant trainee; or
- (2) If licensed out of state, have had at least six months of prior dental assisting experience under a licensed dentist within the past two years; or
- (3) Be a graduate of an accredited dental assisting program approved by the board; and
- (4) Be a high school graduate or equivalent; and
- (5) Be 17 years of age or older.

*b.* Applications for registration as a registered dental assistant must be filed on official board forms and include the following:

- (1) The fee as specified in 650—Chapter 15.
- (2) Evidence of meeting the requirements specified in 20.6(2) “*a.*”
- (3) Evidence of successful completion of a course of study approved by the board and sponsored by a board-approved, accredited dental assisting program in the areas of infection control, hazardous materials, and jurisprudence. The course of study may be taken at a board-approved, accredited dental assisting program or on the job using curriculum approved by the board for such purpose.
- (4) Evidence of successful completion of a board-approved examination in the areas of infection control, hazardous materials, and jurisprudence.
- (5) Evidence of high school graduation or the equivalent.
- (6) Evidence the applicant is 17 years of age or older.
- (7) Evidence of meeting the qualifications of 650—Chapter 22 if engaging in dental radiography.
- (8) A statement:
  1. Confirming that the applicant possesses a valid certificate from a nationally recognized course in cardiopulmonary resuscitation (CPR) that included a “hands-on” clinical component;
  2. Providing the expiration date of the CPR certificate; and
  3. Acknowledging that the CPR certificate will be retained and made available to board office staff as part of routine auditing and monitoring.
- (9) Any additional information required by the board relating to the character, education and experience of the applicant as may be necessary to evaluate the applicant's qualifications.

**20.6(3)** All applications must be signed and verified by the applicant as to the truth of the documents and statements contained therein.

[ARC 8369B, IAB 12/16/09, effective 1/20/10; ARC 0265C, IAB 8/8/12, effective 9/12/12; ARC 0465C, IAB 11/28/12, effective 1/2/13; ARC 2028C, IAB 6/10/15, effective 7/15/15; ARC 3489C, IAB 12/6/17, effective 1/10/18; ARC 4187C, IAB 12/19/18, effective 1/23/19; ARC 4676C, IAB 9/25/19, effective 10/30/19]

**650—20.7(153) Review of applications.** The board shall follow the procedures specified in rule 650—11.8(147,153) in reviewing applications for registration and qualification.

[ARC 4676C, IAB 9/25/19, effective 10/30/19]

**650—20.8(153) Registration denial.** The board may deny an application for registration as a dental assistant for any of the following reasons:

1. Failure to meet the requirements for registration as specified in these rules.
2. Pursuant to Iowa Code section 147.4, upon any of the grounds for which registration may be revoked or suspended as specified in 650—Chapter 30.

[ARC 2028C, IAB 6/10/15, effective 7/15/15]

**650—20.9(147,153) Denial of registration—appeal procedure.** The board shall follow the procedures specified in 650—11.10(147) if the board proposes to deny registration to a dental assistant applicant.

This rule is intended to implement Iowa Code sections 147.3, 147.4 and 147.29.  
[ARC 7789B, IAB 5/20/09, effective 6/24/09; ARC 2028C, IAB 6/10/15, effective 7/15/15]

**650—20.10(153) Examination requirements.** Beginning July 2, 2001, applicants for registration must successfully pass an examination approved by the board on infection control, hazardous waste, and jurisprudence.

**20.10(1)** Examinations approved by the board are those administered by the board or board's approved testing centers or the Dental Assisting National Board Infection Control Examination, if taken after June 1, 1991, in conjunction with the board-approved jurisprudence examination. In lieu of the board's infection control examination, the board may approve an infection control examination given by another state licensing board if the board determines that the examination is substantially equivalent to the examination administered by the board.

**20.10(2)** Information on taking the examination may be obtained by contacting the board office at 400 S.W. 8th Street, Suite D, Des Moines, Iowa 50309-4687.

**20.10(3)** An examinee must meet such other requirements as may be imposed by the board's approved dental assistant testing centers.

**20.10(4)** A dental assistant trainee must successfully pass the examination within 12 months of the first date of employment. A dental assistant trainee who does not successfully pass the examination within 12 months shall be prohibited from working as a dental assistant until the dental assistant trainee passes the examination in accordance with these rules.

**20.10(5)** A score of 75 or better on the board infection control/hazardous material exam and a score of 75 or better on the board jurisprudence exam shall be considered successful completion of the examination. The board accepts the passing standard established by the Dental Assisting National Board for applicants who take the Dental Assisting National Board Infection Control Examination.

**20.10(6)** The written examination may be waived by the board, in accordance with the board's waiver rules at 650—Chapter 7, in practice situations where the written examination is deemed to be unnecessary or detrimental to the dentist's practice.  
[ARC 2028C, IAB 6/10/15, effective 7/15/15]

**650—20.11(153) System of retaking dental assistant examinations.**

**20.11(1)** *Second examination.*

*a.* On the second examination attempt, a dental assistant shall be required to obtain a score of 75 percent or better on each section of the examination.

*b.* A dental assistant who fails the second examination will be required to complete the remedial education requirements set forth in subrule 20.11(2).

**20.11(2)** *Third and subsequent examinations.*

*a.* Prior to the third examination attempt, a dental assistant must submit proof of additional formal education in the area of the examination failure in a program approved by the board or sponsored by a school accredited by the Commission on Dental Accreditation of the American Dental Association.

*b.* A dental assistant who fails the examination on the third attempt may not practice as a dental assistant in a dental office or clinic until additional remedial education approved by the board has been obtained.

*c.* For the purposes of additional study prior to retakes, the fourth or subsequent examination failure shall be considered the same as the third.

[ARC 2028C, IAB 6/10/15, effective 7/15/15]

**650—20.12(153) Continuing education.** Each person registered as a dental assistant shall complete continuing education requirements as specified in 650—Chapter 25.

[ARC 0265C, IAB 8/8/12, effective 9/12/12; ARC 2028C, IAB 6/10/15, effective 7/15/15; ARC 3489C, IAB 12/6/17, effective 1/10/18]

**650—20.13(252J,261) Receipt of certificate of noncompliance.** The board shall consider the receipt of a certificate of noncompliance from the college student aid commission pursuant to Iowa Code sections 261.121 to 261.127 and 650—Chapter 34 or receipt of a certificate of noncompliance of a support order from the child support recovery unit pursuant to Iowa Code chapter 252J and 650—Chapter 33. Registration denial or denial of renewal of registration shall follow the procedures in the statutes and board rules as set forth in this rule.

This rule is intended to implement Iowa Code chapter 252J and sections 261.121 to 261.127.  
[ARC 0265C, IAB 8/8/12, effective 9/12/12; ARC 2028C, IAB 6/10/15, effective 7/15/15]

**650—20.14(153) Unlawful practice.** A dental assistant who assists a dentist in practicing dentistry in any capacity other than as a person supervised by a dentist in a dental office, or who directly or indirectly procures a licensed dentist to act as nominal owner, proprietor or director of a dental office as a guise or subterfuge to enable such dental assistant to engage directly or indirectly in the practice of dentistry, or who performs dental service directly or indirectly on or for members of the public other than as a person working for a dentist shall be deemed to be practicing dentistry without a license.

[ARC 0265C, IAB 8/8/12, effective 9/12/12; ARC 2028C, IAB 6/10/15, effective 7/15/15]

**650—20.15(153) Advertising and soliciting of dental services prohibited.** Dental assistants shall not advertise, solicit, represent or hold themselves out in any manner to the general public that they will furnish, construct, repair or alter prosthetic, orthodontic or other appliances, with or without consideration, to be used as substitutes for or as part of natural teeth or associated structures or for the correction of malocclusions or deformities, or that they will perform any other dental service.

[ARC 0265C, IAB 8/8/12, effective 9/12/12; ARC 2028C, IAB 6/10/15, effective 7/15/15]

**650—20.16(153) Public health supervision allowed.** A dentist may provide public health supervision to a registered dental assistant if the dentist has an active Iowa license and the services are provided in a public or private school, public health agencies, hospitals, or the armed forces.

**20.16(1) Public health agencies defined.** For the purposes of this rule, public health agencies include programs operated by federal, state, or local public health departments.

**20.16(2) Responsibilities.** When working together in a public health supervision relationship, a dentist and registered dental assistant shall enter into a written agreement that specifies the following responsibilities.

*a.* The dentist providing public health supervision must:

- (1) Be available to provide communication and consultation with the registered dental assistant;
- (2) Have age- and procedure-specific standing orders for the performance of services. Those standing orders must include consideration for medically compromised patients and medical conditions for which a dental evaluation must occur prior to the provision of services;
- (3) Specify a period of time in which an examination by a dentist must occur prior to providing further services;
- (4) Specify the location or locations where the services will be provided under public health supervision.

*b.* A registered dental assistant providing services under public health supervision may only provide services which are limited to all extraoral duties, dental radiography, intraoral suctioning, and use of a curing light and intraoral camera and must:

- (1) Maintain contact and communication with the dentist providing public health supervision;
- (2) Practice according to age- and procedure-specific standing orders as directed by the supervising dentist, unless otherwise directed by the dentist for a specific patient;
- (3) Ensure that the patient, parent, or guardian receives a written plan for referral to a dentist;
- (4) Ensure that each patient, parent, or guardian signs a consent form that notifies the patient that the services that will be received do not take the place of regular dental checkups at a dental office and are meant for people who otherwise would not have access to services; and
- (5) Ensure that a procedure is in place for creating and maintaining dental records for the patients who are treated, including where these records are to be located.

c. The written agreement for public health supervision must be maintained by the dentist and the registered dental assistant and a copy filed with the board office within 30 days of the date on which the dentist and the registered dental assistant entered into the agreement. The dentist and registered dental assistant must review the agreement at least biennially.

d. The registered dental assistant shall file annually with the supervising dentist and the bureau of oral and health delivery systems a report detailing the number of patients seen, the services provided to patients and the infection control protocols followed at each practice location.

e. A copy of the written agreement for public health supervision shall be filed with the Bureau of Oral and Health Delivery Systems, Iowa Department of Public Health, Lucas State Office Building, 321 E. 12th Street, Des Moines, Iowa 50319.

**20.16(3) Reporting requirements.** Each registered dental assistant who has rendered services under public health supervision must complete a summary report at the completion of a program or, in the case of an ongoing program, at least annually. The report shall be filed with the bureau of oral and health delivery systems of the Iowa department of public health on forms provided by the department and shall include information related to the number of patients seen and services provided so that the department may assess the impact of the program. The department will provide summary reports to the board on an annual basis.

[ARC 2028C, IAB 6/10/15, effective 7/15/15]

**650—20.17(153) Students enrolled in dental assisting programs.** Students enrolled in an accredited dental assisting program are not considered to be engaged in the unlawful practice of dental assisting provided that such practice is in connection with their regular course of instruction and meets the following:

1. The practice of clinical skills on peers enrolled in the same program must be under the direct supervision of a program instructor with an active Iowa dental assistant registration, Iowa dental hygiene license, Iowa faculty permit, or Iowa dental license;

2. The practice of clinical skills on members of the public must be under the direct supervision of a dentist with an active Iowa dental license.

[ARC 2593C, IAB 6/22/16, effective 7/27/16]

These rules are intended to implement Iowa Code chapter 153.

[Filed 4/9/79, Notice 10/4/78—published 5/2/79, effective 6/6/79]<sup>1</sup>

[Filed 8/3/79, Notice 6/27/79—published 8/22/79, effective 9/26/79]

[Filed 3/20/86, Notice 9/11/85—published 4/9/86, effective 5/14/86]

[Filed 4/28/88, Notice 3/23/88—published 5/18/88, effective 6/22/88]

[Filed 11/19/93, Notices 6/9/93, 8/18/93—published 12/8/93, effective 1/12/94]

[Filed 11/2/95, Notice 8/16/95—published 11/22/95, effective 12/27/95]

[Filed 10/23/00, Notice 8/9/00—published 11/15/00, effective 1/1/01]

[Filed 7/27/01, Notice 5/30/01—published 8/22/01, effective 9/26/01]

[Filed emergency 6/21/02—published 7/10/02, effective 7/1/02]

[Filed 1/30/03, Notice 11/13/02—published 2/19/03, effective 3/26/03]

[Filed 8/29/03, Notice 5/14/03—published 9/17/03, effective 10/22/03]

[Filed 7/1/04, Notice 5/12/04—published 7/21/04, effective 8/25/04]

[Filed 4/22/05, Notice 2/2/05—published 5/11/05, effective 6/15/05]

[Filed emergency 6/30/05—published 7/20/05, effective 7/1/05]

[Filed 2/5/07, Notice 11/22/06—published 2/28/07, effective 4/4/07]

[Filed 1/10/08, Notice 11/7/07—published 1/30/08, effective 3/5/08]

[Filed ARC 7789B (Notice ARC 7575B, IAB 2/11/09), IAB 5/20/09, effective 6/24/09]

[Filed ARC 8369B (Notice ARC 8044B, IAB 8/12/09), IAB 12/16/09, effective 1/20/10]

[Filed ARC 0265C (Notice ARC 0128C, IAB 5/16/12), IAB 8/8/12, effective 9/12/12]

[Filed ARC 0465C (Notice ARC 0170C, IAB 6/13/12), IAB 11/28/12, effective 1/2/13]

[Filed ARC 0985C (Notice ARC 0723C, IAB 5/1/13), IAB 9/4/13, effective 10/9/13]

[Filed ARC 2028C (Notice ARC 1940C, IAB 4/1/15), IAB 6/10/15, effective 7/15/15]

[Filed ARC 2593C (Notice ARC 2431C, IAB 3/2/16), IAB 6/22/16, effective 7/27/16]  
[Filed ARC 3489C (Notice ARC 3157C, IAB 7/5/17), IAB 12/6/17, effective 1/10/18]  
[Filed ARC 4187C (Notice ARC 4005C, IAB 9/26/18), IAB 12/19/18, effective 1/23/19]  
[Filed ARC 4676C (Notice ARC 4424C, IAB 5/8/19), IAB 9/25/19, effective 10/30/19]

<sup>1</sup> The Administrative Rules Review Committee at their May 21, 1979, meeting delayed the effective date of Chapters 20 and 21 70 days.

CHAPTER 23  
EXPANDED FUNCTIONS

**650—23.1(153) Definitions.** As used in this chapter:

“*Accredited school*” means a dental, dental hygiene, or dental assisting education program accredited by the Commission on Dental Accreditation (CODA).

“*Clinical training*” means training which includes patient experiences.

“*Didactic training*” means educational instruction.

“*Direct supervision*” means that the dentist is present in the treatment facility, but it is not required that the dentist be physically present in the treatment room.

“*Fabrication*” means the construction or creation of an impression, occlusal registration, provisional restoration or denture, as defined in this chapter.

“*General supervision of a dental assistant*” means that a dentist has examined the patient and has delegated the services to be provided by a registered dental assistant, which are limited to all extraoral duties, dental radiography, intraoral suctioning, use of a curing light, intraoral camera, and recementation of a provisional restoration. The dentist need not be present in the facility while these services are being provided.

“*General supervision of a dental hygienist*” means that a dentist has examined the patient and has prescribed authorized services to be provided by a dental hygienist. The dentist need not be present in the facility while these services are being provided. If a dentist will not be present, the following requirements shall be met:

1. Patients or their legal guardians must be informed prior to the appointment that no dentist will be present and therefore no examination will be conducted at that appointment.
2. The hygienist must consent to the arrangement.
3. Basic emergency procedures must be established and in place, and the hygienist must be capable of implementing these procedures.
4. The treatment to be provided must be prior prescribed by a licensed dentist and must be entered in writing in the patient record.

“*Laboratory training*” means training that is hands-on, that may include simulation, and that prepares a dental hygienist or dental assistant for patient experiences. Laboratory training can be done as part of an approved course, or obtained through a supervising dentist.

“*Observational supervision,*” for expanded functions, is for training purposes only and means the dentist is physically present in the treatment room to oversee and direct all services being provided as part of clinical training.

“*Patient experiences*” are procedures that are performed on a patient, during the course of clinical training, under the observational supervision of a dentist.

“*Prosthetic*” means any provisional or permanent restoration intended to replace a tooth or teeth.

“*Provisional restoration*” means a crown or bridge placed with the intention of being replaced with a permanent crown or bridge at a later date, or a permanent crown provisionally recemented to be replaced or recemented at a later date.

[ARC 4676C, IAB 9/25/19, effective 10/30/19]

**650—23.2(153) Expanded function requirements and eligibility.**

**23.2(1)** Dental hygienists or dental assistants may only perform expanded function procedures upon successful completion of a board-approved course of training and certification by the board. All expanded function procedures must be delegated by and performed under the direct supervision of a dentist licensed pursuant to Iowa Code chapter 153 unless otherwise specified in this rule. A dental assistant trainee is not eligible to perform or receive training in expanded function procedures. This shall not preclude dental hygienists or dental assistants from practicing expanded function procedures for training purposes while enrolled in a board-approved course of training.

**23.2(2)** To be eligible to train in Level 1 expanded function procedures, dental hygienists or dental assistants must comply with one of the following:

- a. Hold an active dental hygiene license in Iowa; or
- b. Hold an active dental assistant registration, and comply with at least one of the following:
  - (1) Be a graduate of an accredited school; or
  - (2) Be currently certified by the Dental Assisting National Board (DANB); or
  - (3) Have at least one year of clinical practice as a registered dental assistant; or
  - (4) Have at least one year of clinical practice as a dental assistant in a state that does not require registration.

**23.2(3)** A dentist who delegates Level 1 or Level 2 expanded function procedures to dental hygienists or dental assistants under direct supervision must examine the patient to review the quality of work prior to the conclusion of the dental appointment. The following expanded function procedures are exempt from this requirement and may be performed under general supervision:

- a. Recementation of a provisional restoration.
- b. Taking occlusal registrations for purposes other than mounting study casts by Level 1 or Level 2 dental hygienists only.

[ARC 4676C, IAB 9/25/19, effective 10/30/19]

**650—23.3(153) Expanded function categories.**

**23.3(1) Basic Level 1.** Dental hygienists or dental assistants who train in some, but not all, Level 1 expanded function procedures are deemed to be basic expanded function dental hygienists or dental assistants. Dental hygienists and dental assistants must be issued a certificate of completion for the corresponding function by a board-approved training program before performing a specific expanded function procedure. A dentist may delegate to dental hygienists or dental assistants only those Level 1 expanded function procedures for which training has been successfully completed.

**23.3(2) Certified Level 1.** Expanded function dental hygienists or dental assistants who have successfully completed training for all Level 1 expanded function procedures and have been issued a certificate of completion by a board-approved training program are deemed to be certified Level 1 dental hygienists or dental assistants.

**23.3(3) Certified Level 2.** Before beginning Level 2 training to become certified in Level 2, expanded function dental hygienists or dental assistants must have a minimum of one year of clinical practice as a certified Level 1 dental hygienist or dental assistant and pass an entrance examination administered by the Level 2 training program.

- a. Dental hygienists or dental assistants who have successfully completed training in Level 2 expanded function procedures and have been issued a certificate of completion by a board-approved training program are deemed to be certified Level 2 dental hygienists or dental assistants.

- b. A dentist may delegate any Level 1 or Level 2 expanded function procedures to dental hygienists or dental assistants who are certified Level 2.

[ARC 4676C, IAB 9/25/19, effective 10/30/19]

**650—23.4(153) Level 1 expanded function procedures for dental assistants.** Level 1 expanded function procedures for dental assistants include:

- 23.4(1)** Taking occlusal registrations;
- 23.4(2)** Placement and removal of gingival retraction material;
- 23.4(3)** Fabrication, temporary cementation, and removal of provisional restorations;
- 23.4(4)** Applying cavity liners and bases; desensitizing agents; and bonding systems, to include the placement of orthodontic brackets, following the determination of location by the supervising dentist;
- 23.4(5)** Monitoring of patients receiving nitrous oxide inhalation analgesia, which may include increasing oxygen levels as needed, pursuant to the following:
  - a. A dentist shall induce a patient and establish the maintenance level;
  - b. A dental assistant may make adjustments that decrease the nitrous oxide concentration during the administration of nitrous oxide;
  - c. A dental assistant may turn off the oxygen delivery at the completion of the dental procedure;
- 23.4(6)** Taking final impressions;
- 23.4(7)** Removal of adhesives using nonmotorized hand instrumentation;

**23.4(8)** Placement of Class 1 temporary filling materials; and

**23.4(9)** Recementation of provisional restorations.

[ARC 4676C, IAB 9/25/19, effective 10/30/19]

**650—23.5(153) Level 1 expanded function procedures for dental hygienists.** Level 1 expanded function procedures for dental hygienists include:

**23.5(1)** Taking occlusal registrations;

**23.5(2)** Placement and removal of gingival retraction material;

**23.5(3)** Fabrication, temporary cementation, and removal of provisional restorations;

**23.5(4)** Applying cavity liners and bases and applying bonding systems for restorative purposes, including the placement of orthodontic brackets, following the determination of location by the supervising dentist;

**23.5(5)** Taking final impressions;

**23.5(6)** Placement of Class 1 temporary filling materials; and

**23.5(7)** Recementation of provisional restorations.

[ARC 4676C, IAB 9/25/19, effective 10/30/19]

**650—23.6(153) Level 2 expanded function procedures for dental hygienists and dental assistants.**

**23.6(1)** Level 2 expanded function procedures for dental hygienists and dental assistants include:

*a.* Placement and shaping of amalgam following preparation of a tooth by a dentist;

*b.* Placement and shaping of adhesive restorative materials following preparation of a tooth by a dentist;

*c.* Polishing of adhesive restorative material using a slow-speed handpiece;

*d.* Fitting of stainless steel crowns on primary posterior teeth, and cementation after fit verification by the dentist;

*e.* Tissue conditioning (soft reline only);

*f.* Extraoral adjustment to acrylic dentures without making any adjustments to the prosthetic teeth; and

*g.* Placement of intracoronal temporary fillings following preparation of a tooth by a dentist.

**23.6(2)** These Level 2 expanded function procedures refer to both primary and permanent teeth except as otherwise noted.

[ARC 4676C, IAB 9/25/19, effective 10/30/19]

**650—23.7(153) Expanded function training.**

**23.7(1)** *Approved expanded function training programs.* Training programs for Level 1 and Level 2 expanded function procedures must be board-approved. Training programs for Level 2 expanded function procedures shall be eligible for board approval if the training is offered through the University of Iowa College of Dentistry or another accredited school.

**23.7(2)** *Certificates of completion.* All board-approved training programs are authorized and required to issue certificates to dental hygienists and dental assistants who successfully complete expanded function training. A certificate shall be issued for one or more of the listed expanded function procedures completed as Basic Level 1, or a certificate shall be issued for Certified Level 1 or Certified Level 2. Dental hygienists and dental assistants shall prominently display the expanded functions certificate in each dental facility where services are provided.

**23.7(3)** *Training requirements.* Training may be completed in one or more of the listed expanded function procedures. Clinical training in expanded function procedures must be completed under observational supervision. Beginning January 1, 2020, Level 1 expanded function training must consist of the following:

*a.* An initial assessment to determine the base entry level of all participants in the program;

*b.* Completion of a training program that meets the following minimum standards for each function:

(1) Taking occlusal registrations:

Goal: To reproduce the patient's jaw relationship accurately.

Standard: Demonstrate an accurate occlusal registration confirmed by a supervising dentist.

Minimum training requirement: One hour of didactic training, and clinical training that includes a minimum of five patient experiences under observational supervision.

(2) Placement and removal of gingival retraction material:

Goal: To expose the margins of a crown by displacing tissue from the tooth.

Standard: Perform the procedural steps to place and remove retraction material and recognize oral conditions and techniques that may compromise tissue displacement or patient health.

Minimum training requirement: Two hours of didactic training, the equivalent of one hour of laboratory training that includes a minimum of three experiences, and clinical training that includes a minimum of five patient experiences under observational supervision.

(3) Fabrication, temporary cementation and removal of provisional restorations:

Goal: To replicate the anatomy and function of the natural tooth, prior to the final restoration.

Standard: Use various methods to fabricate and temporarily cement single-unit and multiunit provisional restorations.

Minimum training requirement: Four hours of didactic training, the equivalent of four hours of laboratory training that includes a minimum of five experiences, and clinical training that includes a minimum of ten patient experiences under observational supervision.

(4) Applying cavity liners and bases; desensitizing agents; and bonding systems, to include the placement of orthodontic brackets, following the determination of location by the supervising dentist:

Goal: To apply appropriate material that protects existing tooth structure and adheres existing tooth structure to restorative materials.

Standard: Manipulate and apply appropriate material to meet clinical competency.

Minimum training requirement: Two hours of didactic training, the equivalent of one hour of laboratory training that includes a minimum of two experiences, and clinical training that includes a minimum of 5 patient experiences in each one of these areas (for a total of 15 patient experiences under observational supervision).

(5) Monitoring of patients receiving nitrous oxide inhalation analgesia, pursuant to subrule 23.4(5):

Goal: Understand the equipment, recognize the signs of patient distress or adverse reaction, and know when to call for help.

Standard: Exercise the ability to maintain patient safety while nitrous oxide is used.

Minimum training requirement: Two hours of didactic training, one hour of laboratory training in the office where the dental hygienist or dental assistant is employed, and five patient experiences under observational supervision.

(6) Taking final impressions:

Goal: Reproduce soft and hard oral tissues, digitally or with impression materials.

Standard: Complete the procedural steps to obtain a clinically acceptable final impression.

Minimum training requirement: Three hours of didactic training, and the equivalent of clinical training that includes a minimum of six patient experiences under observational supervision.

(7) Removal of adhesives using nonmotorized hand instrumentation:

Goal: Remove excess adhesives and bonding materials to eliminate soft tissue irritation.

Standard: Identify how, when and where to remove excessive bonding or adhesive material.

Minimum training requirement: One hour of didactic training, and clinical training that includes a minimum of five patient experiences under observational supervision.

(8) Placement of Class 1 temporary filling materials:

Goal: Place Class 1 temporary filling materials following preparation of a tooth by a dentist.

Standard: Identify how, when and where to place Class 1 temporary filling materials.

Minimum training requirement: One hour of didactic training, and clinical training that includes a minimum of five patient experiences under observational supervision.

(9) Recementation of provisional restorations:

Goal: Secure the provisional restoration to a previously prepared tooth after the provisional restoration has become loose or dislodged.

Standard: Use various methods to fabricate and temporarily cement single-unit and multiunit provisional restorations.

Minimum training requirement: If this training is completed in conjunction with training in fabrication, temporary cementation and removal of provisional crown and bridge restorations, the training requirements may be combined since the procedures are related. If this training is being completed separately, the same training requirements for fabrication, temporary cementation and removal of provisional restorations applies.

c. A postcourse written examination at the conclusion of the training program, with a minimum of ten questions per function, must be administered. Participants must obtain a score of 75 percent or higher on each examination administered.

**23.7(4) Grandfathering.** Any dental hygienist or dental assistant who has completed expanded function training prior to January 1, 2020, can continue to perform expanded function procedures for which training has been completed. For any expanded function procedures that are new, in whole or in part, additional training to satisfy the standard and minimum training requirement is required of the dental hygienist or dental assistant prior to performing the new expanded function procedure.

[ARC 4676C, IAB 9/25/19, effective 10/30/19]

These rules are intended to implement Iowa Code chapter 153.

[Filed ARC 4676C (Notice ARC 4424C, IAB 5/8/19), IAB 9/25/19, effective 10/30/19]



CHAPTER 24  
Reserved



CHAPTER 25  
CONTINUING EDUCATION  
[Prior to 5/18/88, Dental Examiners, Board of[320]]

**650—25.1(153) Definitions.** For the purpose of this chapter, these definitions shall apply:

*“Advisory committee”* means a committee on continuing education formed to review and advise the board with respect to applications for approval of sponsors or activities. The committee’s members shall be appointed by the board and consist of at least one member of the board, two licensed dentists with expertise in the area of professional continuing education, two licensed dental hygienists with expertise in the area of professional continuing education, and two registered dental assistants with expertise in the area of professional continuing education. The advisory committee on continuing education may recommend approval or denial of applications or requests submitted to it pending final approval or disapproval of the board at its next meeting.

*“Board”* means the dental board.

*“Continuing dental education”* consists of education activities designed to review existing concepts and techniques and to update knowledge on advances in dental and medical sciences. The objective of continuing dental education is to improve the knowledge, skills, and ability of the individual to deliver the highest quality of service to the public and professions.

Continuing dental education should favorably enrich past dental education experiences. Programs should make it possible for practitioners to attune dental practice to new knowledge as it becomes available. All continuing dental education should strengthen the skills of critical inquiry, balanced judgment and professional technique.

*“Dental public health”* is the science and art of preventing and controlling dental diseases and promoting dental health through organized community efforts. It is that form of dental practice in which the community serves as the patient rather than the individual. It is concerned with the dental health education of the public, with applied dental research, with the administration of group dental care programs, and with the prevention and control of dental diseases on a community basis.

*“Hour of continuing education”* means one unit of credit which shall be granted for each hour of contact instruction and shall be designated as a “clock hour.” This credit shall apply to either academic or clinical instruction.

*“Licensee”* means any person who has been issued a certificate to practice dentistry or dental hygiene in the state of Iowa.

*“Opioid”* means a drug that produces an agonist effect on opioid receptors and is indicated or used for the treatment of pain.

*“Registrant”* means any person registered to practice as a dental assistant in the state of Iowa.

*“Self-study activities”* means the study of something by oneself, without direct supervision or attendance in a class. “Self-study activities” may include Internet-based coursework, television viewing, video programs, correspondence work or research, or computer programs that are interactive and require branching, navigation, participation and decision making on the part of the viewer. Internet-based webinars which include the involvement of an instructor and participants in real time and which allow for communication with the instructor through messaging, telephone or other means shall not be construed to be self-study activities.

*“Sponsor”* means a person, educational institution, or organization sponsoring continuing education activities which has been approved by the board as a sponsor pursuant to these rules. During the time a person, educational institution, or organization is an approved sponsor, all continuing education activities of such person or organization may be deemed automatically approved provided the continuing education activities meet the continuing education guidelines of the board.

[ARC 3489C, IAB 12/6/17, effective 1/10/18; ARC 4409C, IAB 4/24/19, effective 5/29/19]

**650—25.2(153) Continuing education administrative requirements.**

**25.2(1)** Each person licensed to practice dentistry or dental hygiene in this state shall complete during the biennium renewal period a minimum of 30 hours of continuing education approved by the board.

**25.2(2)** Each person registered to practice dental assisting in this state shall complete during the biennium renewal period a minimum of 20 hours of continuing education approved by the board.

**25.2(3)** Each person who holds a qualification in dental radiography in this state shall complete during the biennium renewal period a minimum of two hours of continuing education in the area of dental radiography.

**25.2(4)** The continuing education compliance period shall be the 24-month period commencing September 1 and ending on August 31 of the renewal cycle.

**25.2(5)** Hours of continuing education credit may be obtained by attending and participating in a continuing education activity either previously approved by the board or which otherwise meets the requirements herein and is approved by the board pursuant to rule 650—25.5(153).

**25.2(6)** It is the responsibility of each licensee or registrant to finance the costs of continuing education.

[ARC 3489C, IAB 12/6/17, effective 1/10/18]

#### **650—25.3(153) Documentation of continuing education hours.**

**25.3(1)** Every licensee or registrant shall maintain a record of all courses attended by keeping the certificates of attendance for four years. The board reserves the right to require any licensee or registrant to submit the certificates of attendance for the continuing education courses attended. If selected for continuing education audit, the licensee or registrant shall file a signed continuing education form and submit certificates or other evidence of attendance.

**25.3(2)** Licensees and registrants are responsible for obtaining proof of attendance forms when attending courses. Clock hours must be verified by the sponsor with the issuance of proof of attendance forms to the licensee or registrant.

**25.3(3)** Each licensee or registrant shall report the number of continuing education credit hours completed during the current renewal cycle in compliance with this chapter. Such report shall be filed with the board at the time of application for renewal of a dental or dental hygiene license or renewal of dental assistant registration.

**25.3(4)** No carryover of credits from one biennial period to the next will be allowed.

[ARC 3489C, IAB 12/6/17, effective 1/10/18]

#### **650—25.4(153) Required continuing education courses.**

**25.4(1)** The following courses are required for all licensees and registrants:

- a. Mandatory reporter training for child abuse and dependent adult abuse.
- b. Cardiopulmonary resuscitation.
- c. Infection control.
- d. Jurisprudence.

**25.4(2)** Mandatory reporter training for child abuse and dependent adult abuse.

a. Licensees or registrants who regularly examine, attend, counsel or treat 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 conditions for exemptions as identified in paragraph 25.4(2) “f,” pursuant to Iowa Code chapter 232. Completion of training in this course shall result in two hours of continuing education credit.

b. Licensees or registrants who regularly examine, attend, counsel or treat 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 conditions for exemptions as identified in paragraph 25.4(2) “f,” pursuant to Iowa Code chapter 235B.

c. Licensees or registrants who regularly examine, attend, counsel or treat both children and adults in Iowa shall indicate on the renewal application completion of at least two hours of training on the identification and reporting of abuse in children and dependent adults in the previous five years or conditions for exemptions as identified in paragraph 25.4(2) “f,” pursuant to Iowa Code chapters 232 and 235B. Training may be completed through separate courses or in one combined course that includes curricula for identifying and reporting child abuse and dependent adult abuse. Completion of training in this combined course shall result in three hours of continuing education credit.

*d.* The licensee or registrant shall maintain written documentation for five years after completion of the mandatory training, including program date(s), content, duration, and proof of participation. The board may audit this information at any time within the five-year period.

*e.* Training programs in child and dependent adult abuse identification and reporting that are approved by the board are those that use a curriculum approved by the abuse education review panel of the department of public health or a training program offered by the department of human services, the department of education, an area education agency, a school district, the Iowa law enforcement academy, an Iowa college or university, or a similar state agency.

*f.* Exemptions. Licensees and registrants shall be exempt from the requirement for mandatory training for identifying and reporting child and dependent adult abuse if the board determines that it is in the public interest or that at the time of the renewal the licensee or registrant is issued an extension or exemption pursuant to rule 650—25.10(153).

**25.4(3)** Cardiopulmonary resuscitation (CPR). Licensees and registrants shall furnish evidence of valid certification for CPR, which shall be credited toward the continuing education requirement for renewal of the license, faculty permit or registration. Such evidence shall be filed at the time of renewal of the license, faculty permit or registration. Valid certification means certification by an organization on an annual basis or, if that certifying organization requires certification on a less frequent basis, evidence that the licensee or registrant has been properly certified for each year covered by the renewal period. In addition, the course must include a clinical component. Credit hours awarded for certification in CPR shall not exceed three hours of required continuing education hours per biennium. Credit hours awarded for certification in pediatric advanced life support (PALS) or advanced cardiac life support (ACLS) may be claimed hour for hour.

**25.4(4)** Infection control. Beginning September 1, 2018, licensees and registrants shall complete continuing education in the area of infection control. Licensees and registrants shall furnish evidence of continuing education completed within the previous biennium in the area of infection control standards, as required by the Centers for Disease Control and Prevention of the United States Department of Health and Human Services. Completion of continuing education in the area of infection control shall be credited toward the required continuing education requirement in the renewal period during which it was completed. A minimum of one hour shall be submitted.

**25.4(5)** Jurisprudence. Beginning September 1, 2018, licensees and registrants shall complete continuing education in the area of Iowa jurisprudence related to the practice of dentistry, dental hygiene and dental assisting. Licensees and registrants shall furnish evidence of continuing education completed within the previous biennium in the area of Iowa jurisprudence. Completion of continuing education in the area of Iowa jurisprudence shall be credited toward the required continuing education requirement in the renewal period during which it was completed. A minimum of one hour shall be submitted.

**25.4(6)** The following is required for dentists only.

*a.* As a condition of license renewal, a licensed dentist who has prescribed opioids to a patient during the biennium renewal period shall obtain a minimum of one hour of continuing education credit on opioids. This training shall include guidelines for prescribing opioids, including recommendations on limitations of dosages and the length of prescriptions, risk factors for abuse, and nonopioid and nonpharmacological therapy options. This hour may count toward the 30 hours of continuing education required for license renewal. The licensee shall maintain documentation of this hour, which may be subject to audit. If the continuing education did not cover the U.S. Centers for Disease Control and Prevention guideline for prescribing opioids for chronic pain, the licensee shall read the guideline prior to license renewal.

*b.* A licensed dentist who did not prescribe opioids during the biennium renewal period may attest that the dentist is not subject to this requirement due to the fact that the dentist did not prescribe opioids during the time period.

[ARC 3489C, IAB 12/6/17, effective 1/10/18; ARC 4409C, IAB 4/24/19, effective 5/29/19]

**650—25.5(153) Acceptable programs and activities.**

**25.5(1)** A continuing education activity shall be acceptable and not require board approval if it meets the following criteria:

*a.* It constitutes an organized program of learning (including a workshop or symposium) which contributes directly to the professional competency of the licensee or registrant and is of value to dentistry and applicable to oral health care; and

*b.* It pertains to common subjects or other subject matters which relate to the practice of dentistry, dental hygiene, or dental assisting which are intended to refresh and review, or update knowledge of new or existing concepts and techniques, and enhance the dental health of the public; and

*c.* It is conducted by individuals who have sufficient special education, training and experience to be considered experts concerning the subject matter of the program. The program must include a written outline or manual that substantively pertains to the subject matter of the program.

**25.5(2)** Types of activities acceptable for continuing dental education credit may include:

*a.* A dental science course that includes topics which address the clinical practice of dentistry, dental hygiene, dental assisting and dental public health.

*b.* Courses in record keeping, medical conditions which may have an effect on oral health, ergonomics related to clinical practice, HIPAA, risk management, sexual boundaries, communication with patients, OSHA regulations, and the discontinuation of practice related to the transition of patient care and patient records.

*c.* Sessions attended at a multiday convention-type meeting. A multiday convention-type meeting is held at a national, state, or regional level and involves a variety of concurrent educational experiences directly related to the practice of dentistry.

*d.* Postgraduate study relating to health sciences.

*e.* Successful completion of a recognized specialty examination or the Dental Assisting National Board (DANB) examination.

*f.* Self-study activities.

*g.* Original presentation of continuing dental education courses.

*h.* Publication of scientific articles in professional journals related to dentistry, dental hygiene, or dental assisting.

**25.5(3)** Credit may be given for other continuing education activities upon request and approval by the board.

[ARC 3489C, IAB 12/6/17, effective 1/10/18]

#### **650—25.6(153) Unacceptable programs and activities.**

**25.6(1)** Unacceptable subject matter and activity types include, but are not limited to, personal development, business aspects of practice, business strategy, financial management, marketing, sales, practice growth, personnel management, insurance, collective bargaining, and events where volunteer services are provided. While desirable, those subjects and activities are not applicable to dental skills, knowledge, and competence. Therefore, such courses will receive no credit toward renewal. The board may deny credit for any course.

**25.6(2)** Inquiries relating to acceptability of continuing dental education activities, approval of sponsors, or exemptions should be directed to Advisory Committee on Continuing Dental Education, Iowa Dental Board, 400 S.W. 8th Street, Suite D, Des Moines, Iowa 50309-4687.

[ARC 3489C, IAB 12/6/17, effective 1/10/18]

**650—25.7(153) Prior approval of activities.** A person or organization, other than an approved sponsor, that desires prior approval for a course, program or other continuing education activity or that desires to establish approval of the activity prior to attendance may apply for approval to the board, using board-approved forms, at least 90 days in advance of the commencement of the activity. Within 90 days after receipt of such application, the board shall advise the licensee or registrant in writing whether the activity is approved and the number of hours allowed. All requests may be reviewed by the advisory committee on continuing education prior to final approval or denial by the board. An application fee as specified in 650—Chapter 15 is required. Continuing education course approval shall be valid for a period of five years following the date of board approval. Thereafter, courses may be resubmitted for

approval. Courses which clearly meet the criteria listed under acceptable programs and activities are not required to be submitted for approval.

[ARC 3489C, IAB 12/6/17, effective 1/10/18]

**650—25.8(153) Postapproval of activities.** A licensee or registrant seeking credit for attendance and participation in an educational activity which was not conducted by an approved sponsor or otherwise approved and which does not clearly meet the acceptable programs and activities listed in rule 650—25.5(153) may apply for approval to the board using board-approved forms. Within 90 days after receipt of such application, the board shall advise the licensee or registrant in writing whether the activity is approved and the number of hours allowed. All requests may be reviewed by the advisory committee on continuing education prior to final approval or denial by the board. An application fee as specified in 650—Chapter 15 is required.

[ARC 3489C, IAB 12/6/17, effective 1/10/18]

**650—25.9(153) Designation of continuing education hours.** Continuing education hours shall be determined by the length of a continuing education course in clock hours. For the purpose of calculating continuing education hours for renewal of a license or registration, the following rules shall apply:

**25.9(1)** Attendance at a multiday convention.

*a.* Attendees at a multiday convention may receive a maximum of 1.5 hours of credit per day with the maximum of six hours of credit allowed per biennium.

*b.* Sponsors of multiday conventions shall submit to the board for review and prior approval guidelines for awarding credit for convention attendance.

**25.9(2)** Presenters or attendees of table clinics at a meeting.

*a.* Four hours of credit shall be allowed for presentation of an original table clinic at a meeting as verified by the sponsor when the subject matter conforms with rule 650—25.5(153).

*b.* Attendees at the table clinic session of a dental, dental hygiene, or dental assisting meeting shall receive two hours of credit as verified by the sponsor when the subject matter conforms with rule 650—25.5(153).

**25.9(3)** Postgraduate study relating to health sciences shall receive 15 credits per semester.

**25.9(4)** Successful completion of a specialty examination or the Dental Assisting National Board (DANB) shall result in 15 hours of credit.

**25.9(5)** Self-study activities shall result in a maximum of 12 hours of continuing education credit per biennium.

**25.9(6)** An original presentation of continuing dental education shall result in credit double that which the participants receive. Additional credit will not be granted for the repeating of presentations within the biennium. Credit is not given for teaching that represents part of the licensee's or registrant's normal academic duties as a full-time or part-time faculty member or consultant.

**25.9(7)** Publication of scientific articles in professional journals related to dentistry, dental hygiene, or dental assisting shall result in 5 hours of credit per article with the maximum of 20 hours allowed per biennium.

[ARC 3489C, IAB 12/6/17, effective 1/10/18]

**650—25.10(153) Extensions and exemptions.**

**25.10(1) *Illness or disability.*** The board may, in individual cases involving physical disability or illness, grant an exemption of the continuing education requirements or an extension of time within which to fulfill the same or make the required reports. No exemption or extension of time shall be granted unless written application is made on forms provided by the board and signed by the licensee or registrant and a licensed health care professional. Extensions or exemptions of the continuing education requirements may be granted by the board for any period of time not to exceed one calendar year. In the event that the physical disability or illness upon which an exemption has been granted continues beyond the period granted, the licensee or registrant must apply for an extension of the exemption. The board may, as a condition of the exemption, require the applicant to make up a certain portion or all of the continuing education requirements.

**25.10(2) Other extensions or exemptions.** Extensions or exemptions of continuing education requirements will be considered by the board on an individual basis. Licensees or registrants will be exempt from the continuing education requirements for:

- a. Periods that the person serves honorably on active duty in the military services;
- b. Periods that the person practices the person's profession in another state or district having a continuing education requirement and the licensee or registrant meets all requirements of that state or district for practice therein;
- c. Periods that the person is a government employee working in the person's licensed or registered specialty and assigned to duty outside the United States;
- d. Other periods of active practice and absence from the state approved by the board;
- e. The current biennium renewal period, or portion thereof, following original issuance of the license;
- f. For dental assistants registered pursuant to rule 650—20.6(153), the current biennium renewal period, or portion thereof, following original issuance of the registration.

[ARC 3489C, IAB 12/6/17, effective 1/10/18; ARC 4676C, IAB 9/25/19, effective 10/30/19]

**650—25.11(153) Exemptions for inactive practitioners.** No continuing education hours are required to renew a license or registration on inactive status until application for reactivation is made. A licensee or registrant with a license or registration on inactive status is prohibited from practicing unless and until the license or registration is restored to active status.

[ARC 3489C, IAB 12/6/17, effective 1/10/18]

**650—25.12(153) Approval of sponsors.**

**25.12(1)** An organization or person which desires approval as a sponsor of courses, programs, or other continuing education activities shall apply for approval to the board stating its education history, including approximate dates, subjects offered, total hours of instruction presented, and names and qualifications of instructors. All applications shall be reviewed by the advisory committee on continuing education prior to final approval or denial by the board.

**25.12(2)** Prospective sponsors must apply to the board using approved forms in order to obtain approved sponsor status. An application fee as specified in 650—Chapter 15 is required. Sponsors must pay the biennial renewal fee as specified in 650—Chapter 15 and file a sponsor recertification record report biennially.

**25.12(3)** The person or organization sponsoring continuing education activities shall make a written record of the Iowa licensees or registrants in attendance, maintain the written record for a minimum of five years, and submit the record upon the request of the board. The sponsor of the continuing education activity shall also provide proof of attendance and the number of credit hours awarded to the licensee or registrant who participates in the continuing education activity.

**25.12(4)** Sponsors must be formally organized and adhere to board rules for planning and providing continuing dental education activities. Programs sponsored by individuals or institutions for commercial or proprietary purposes, especially programs in which the speaker advertises or urges the use of any particular dental product or appliance, may be recognized for credit on a prior-approval basis only. When courses are promoted as approved continuing education courses which do not meet the requirements as defined by the board, the sponsor will be required to refund the registration fee to the participants. Approved sponsors may offer noncredit courses provided the participants have been informed that no credit will be given. Failure to meet this requirement may result in loss of approved sponsor status.

[ARC 3489C, IAB 12/6/17, effective 1/10/18]

**650—25.13(153) Review of programs or sponsors.** The board on its own motion or at the recommendation of the advisory committee on continuing education may monitor or review any continuing education program or sponsors already approved by the board. Upon evidence of a failure to meet the requirements of rule 650—25.12(153), the board may revoke the approval status of the sponsor. Upon evidence of significant variation in the program presented from the program approved, the board may deny all or any part of the approved hours granted to the program. A provider that

wishes to appeal the board's decision regarding revocation of approval status or denial of continuing education credit shall file an appeal within 30 days of the board's decision. A timely appeal shall initiate a contested case proceeding. The contested case shall be conducted pursuant to Iowa Code chapter 17A and 650—Chapter 51. The written decision issued at the conclusion of a contested case hearing shall be considered final agency action.  
[ARC 3489C, IAB 12/6/17, effective 1/10/18]

**650—25.14(153) Noncompliance with continuing dental education requirements.** It is the licensee's or registrant's personal responsibility to comply with these rules. The license or registration of individuals not complying with the continuing dental education rules may be subject to disciplinary action by the board or nonrenewal of the license or registration.  
[ARC 3489C, IAB 12/6/17, effective 1/10/18]

**650—25.15(153) Dental hygiene continuing education.** The dental hygiene committee, in its discretion, shall make recommendations to the board for approval or denial of requests pertaining to dental hygiene education. The dental hygiene committee may utilize the continuing education advisory committee as needed. The board's review of the dental hygiene committee recommendation is subject to 650—Chapter 1. The following items pertaining to dental hygiene shall be forwarded to the dental hygiene committee for review.

1. Dental hygiene continuing education requirements and requests for approval of programs, activities and sponsors.
2. Requests by dental hygienists for waivers, extensions and exemptions of the continuing education requirements.
3. Requests for exemptions from inactive dental hygiene practitioners.
4. Requests for reinstatement from inactive dental hygiene practitioners.
5. Appeals of denial of dental hygiene continuing education and conduct of hearings as necessary.

[ARC 3489C, IAB 12/6/17, effective 1/10/18]

These rules are intended to implement Iowa Code sections 147.10, 153.15A, and 153.39 and chapter 272C.

[Filed 8/23/78, Notice 6/28/78—published 9/20/78, effective 10/25/78]

[Filed emergency 12/16/83—published 1/4/84, effective 12/16/83]

[Filed emergency 2/24/84 after Notice 1/4/84—published 3/14/84, effective 2/24/84]

[Filed 12/12/85, Notice 9/11/85—published 1/1/86, effective 2/5/86]

[Filed 4/28/88, Notice 3/23/88—published 5/18/88, effective 6/22/88]

[Filed 3/16/90, Notice 12/27/89—published 4/4/90, effective 5/9/90]

[Filed 4/3/91, Notice 2/20/91—published 5/1/91, effective 6/5/91]

[Filed 1/29/93, Notice 11/25/92—published 2/17/93, effective 3/24/93]

[Filed 5/1/97, Notice 2/26/97—published 5/21/97, effective 6/25/97]

[Filed 10/17/97, Notice 8/13/97—published 11/5/97, effective 12/10/97]

[Filed 1/22/99, Notice 11/18/98—published 2/10/99, effective 3/17/99]

[Filed 4/29/99, Notice 3/24/99—published 5/19/99, effective 6/23/99]

[Filed 11/12/99, Notice 8/11/99—published 12/1/99, effective 1/5/00]

[Filed emergency 1/21/00—published 2/9/00, effective 1/21/00]

[Filed 10/23/00, Notice 8/9/00—published 11/15/00, effective 1/1/01]

[Filed 1/18/02, Notice 11/14/01—published 2/6/02, effective 3/13/02]

[Filed 1/18/02, Notice 11/14/01—published 2/6/02, effective 10/1/02]

[Filed emergency 6/21/02—published 7/10/02, effective 7/1/02]

[Filed without Notice 10/24/02—published 11/13/02, effective 12/18/02]

[Filed 7/1/04, Notice 5/12/04—published 7/21/04, effective 8/25/04]

[Filed 9/9/05, Notice 7/20/05—published 9/28/05, effective 11/2/05]

[Filed 4/6/06, Notice 2/15/06—published 4/26/06, effective 7/1/06]

[Filed 2/5/07, Notice 9/27/06—published 2/28/07, effective 4/4/07]

[Filed 2/5/07, Notice 11/22/06—published 2/28/07, effective 4/4/07]

[Filed ARC 8369B (Notice ARC 8044B, IAB 8/12/09), IAB 12/16/09, effective 1/20/10]  
[Filed ARC 9218B (Notice ARC 8846B, IAB 6/16/10), IAB 11/3/10, effective 12/8/10]  
[Filed ARC 0265C (Notice ARC 0128C, IAB 5/16/12), IAB 8/8/12, effective 9/12/12]  
[Filed ARC 3489C (Notice ARC 3157C, IAB 7/5/17), IAB 12/6/17, effective 1/10/18]  
[Filed ARC 4409C (Notice ARC 4305C, IAB 2/13/19), IAB 4/24/19, effective 5/29/19]  
[Filed ARC 4676C (Notice ARC 4424C, IAB 5/8/19), IAB 9/25/19, effective 10/30/19]

**REVENUE DEPARTMENT[701]**

Created by 1986 Iowa Acts, chapter 1245.

## CHAPTERS 1 and 2

Reserved

## CHAPTER 3

## VOLUNTARY DISCLOSURE PROGRAM

3.1(421,422,423) Voluntary disclosure program

## CHAPTER 4

## MULTILEVEL MARKETER AGREEMENTS

4.1(421) Multilevel marketers—in general

## CHAPTER 5

## PUBLIC RECORDS AND FAIR INFORMATION PRACTICES

(Uniform Rules)

5.1(17A,22) Definitions  
 5.3(17A,22) Requests for access to records  
 5.6(17A,22) Procedure by which additions, dissents, or objections may be entered into certain records  
 5.9(17A,22) Disclosures without the consent of the subject  
 5.10(17A,22) Routine use  
 5.11(17A,22) Consensual disclosure of confidential records  
 5.12(17A,22) Release to subject  
 5.13(17A,22) Availability of records  
 5.14(17A,22) Personally identifiable information  
 5.15(17A,22) Other groups of records  
 5.16(17A,22) Applicability

## TITLE I

*ADMINISTRATION*

## CHAPTER 6

## ORGANIZATION, PUBLIC INSPECTION

6.1(17A) Establishment, organization, general course and method of operations, methods by which and location where the public may obtain information or make submissions or requests  
 6.2(17A) Public inspection  
 6.3(17A) Examination of records  
 6.4(17A) Copies of proposed rules  
 6.5(17A) Regulatory analysis procedures  
 6.6(422) Retention of records and returns by the department  
 6.7(68B) Consent to sell  
 6.8(421) Tax return extension in disaster areas

## CHAPTER 7

## PRACTICE AND PROCEDURE BEFORE THE DEPARTMENT OF REVENUE

7.1(421,17A) Applicability and scope of rules  
 7.2(421,17A) Definitions  
 7.3(17A) Business hours  
 7.4(17A) Computation of time, filing of documents  
 7.5(17A) Form and style of papers  
 7.6(17A) Persons authorized to represent themselves or others

7.7(17A)	Resolution of tax liability
7.8(17A)	Protest
7.9(17A)	Identifying details
7.10(17A)	Docket
7.11(17A)	Informal procedures and dismissals of protests
7.12(17A)	Answer
7.13(17A)	Subpoenas
7.14(17A)	Commencement of contested case proceedings
7.15(17A)	Discovery
7.16(17A)	Prehearing conference
7.17(17A)	Contested case proceedings
7.18(17A)	Interventions
7.19(17A)	Record and transcript
7.20(17A)	Application for rehearing
7.21(17A)	Service
7.22(17A)	Ex parte communications and disqualification
7.23(17A)	Licenses
7.24(17A)	Declaratory order—in general
7.25(17A)	Department procedure for rule making
7.26(17A)	Public inquiries on rule making and the rule-making records
7.27(17A)	Criticism of rules
7.28(17A)	Waiver or variance of certain department rules
7.29(17A)	Petition for rule making
7.30(9C,91C)	Procedure for nonlocal business entity bond forfeitures
7.31(421)	Abatement of unpaid tax
7.32(421)	Time and place of taxpayer interviews
7.33(421)	Mailing to the last-known address
7.34(421)	Power of attorney
7.35(421)	Taxpayer designation of tax type and period to which voluntary payments are to be applied

## CHAPTER 8

### FORMS AND COMMUNICATIONS

8.1(17A,421)	Definitions
8.2(17A,421)	Department forms
8.3(17A,421)	Substitute forms
8.4(17A)	Description of forms
8.5(422)	Electronic filing of Iowa income tax returns

## CHAPTER 9

### FILING AND EXTENSION OF TAX LIENS AND CHARGING OFF UNCOLLECTIBLE TAX ACCOUNTS

9.1(422,423)	Definitions
9.2(422,423)	Lien attaches
9.3(422,423)	Purpose of filing
9.4(422,423)	Place of filing
9.5(422,423)	Time of filing
9.6(422,423)	Period of lien
9.7(422,423)	Fees

## CHAPTER 10

## INTEREST, PENALTY, EXCEPTIONS TO PENALTY, AND JEOPARDY ASSESSMENTS

10.1(421)	Definitions	
10.2(421)	Interest	
10.3(422,423,450,452A)	Interest on refunds and unpaid tax	
10.4(421)	Frivolous return penalty	
10.5(421)	Improper receipt of credit or refund	
		PENALTY FOR TAX PERIOD BEGINNING AFTER JANUARY 1, 1991
10.6(421)	Penalties	
10.7(421)	Waiver of penalty—definitions	
10.8(421)	Penalty exceptions	
10.9(421)	Notice of penalty exception for one late return in a three-year period	
10.10 to 10.19	Reserved	
		RETAIL SALES
10.20 to 10.29	Reserved	
		USE
10.30 to 10.39	Reserved	
		INDIVIDUAL INCOME
10.40 to 10.49	Reserved	
		WITHHOLDING
10.50 to 10.55	Reserved	
		CORPORATE
10.56 to 10.65	Reserved	
		FINANCIAL INSTITUTIONS
10.66 to 10.70	Reserved	
		MOTOR FUEL
10.71(452A)	Penalty and enforcement provisions	
10.72(452A)	Interest	
10.73 to 10.75	Reserved	
		CIGARETTES AND TOBACCO
10.76(453A)	Penalties	
10.77(453A)	Interest	
10.78	Reserved	
10.79(453A)	Request for statutory exception to penalty	
10.80 to 10.84	Reserved	
		INHERITANCE
10.85 to 10.89	Reserved	
		IOWA ESTATE
10.90 to 10.95	Reserved	
		GENERATION SKIPPING
10.96 to 10.100	Reserved	
		FIDUCIARY INCOME
10.101 to 10.109	Reserved	
		HOTEL AND MOTEL
10.110 to 10.114	Reserved	

## ALL TAXES

- 10.115(421) Application of payments to penalty, interest, and then tax due for payments made on or after January 1, 1995, unless otherwise designated by the taxpayer

## JEOPARDY ASSESSMENTS

- 10.116(422,453B) Jeopardy assessments  
 10.117(422,453B) Procedure for posting bond  
 10.118(422,453B) Time limits  
 10.119(422,453B) Amount of bond  
 10.120(422,453B) Posting of bond  
 10.121(422,453B) Order  
 10.122(422,453B) Director's order  
 10.123(422,453B) Type of bond  
 10.124(422,453B) Form of surety bond  
 10.125(422,453B) Duration of the bond  
 10.126(422,453B) Exoneration of the bond

TITLE II  
EXCISECHAPTER 11  
ADMINISTRATION

- 11.1(422,423) Definitions  
 11.2(422,423) Statute of limitations  
 11.3(422,423) Credentials and receipts  
 11.4(422,423) Retailers required to keep records  
 11.5(422,423) Audit of records  
 11.6(422,423) Billings  
 11.7(422,423) Collections  
 11.8(422,423) No property exempt from distress and sale  
 11.9(422,423) Information confidential  
 11.10(423) Bonding procedure

## CHAPTER 12

## FILING RETURNS, PAYMENT OF TAX, PENALTY AND INTEREST

- 12.1(422) Returns and payment of tax  
 12.2(422,423) Remittances  
 12.3(422) Permits and negotiated rate agreements  
 12.4(422) Nonpermit holders  
 12.5(422,423) Regular permit holders responsible for collection of tax  
 12.6(422,423) Sale of business  
 12.7(422) Bankruptcy, insolvency or assignment for benefit of creditors  
 12.8(422) Vending machines and other coin-operated devices  
 12.9(422) Claim for refund of tax  
 12.10(423) Audit limitation for certain services  
 12.11 Reserved  
 12.12(422) Extension of time for filing  
 12.13(422) Determination of filing status  
 12.14(422,423) Immediate successor liability for unpaid tax  
 12.15(422,423) Officers and partners—personal liability for unpaid tax  
 12.16(422) Show sponsor liability  
 12.17(423) Purchaser liability for unpaid sales tax  
 12.18(423) Biodiesel production refund

- 12.19(15) Sales and use tax refund for eligible businesses  
 12.20(423) Collection, permit, and tax return exemption for certain out-of-state businesses

## CHAPTER 13

## PERMITS

- 13.1(422) Retail sales tax permit required  
 13.2(422) Application for permit  
 13.3(422) Permit not transferable—sale of business  
 13.4(422) Permit—consolidated return optional  
 13.5(422) Retailers operating a temporary business  
 13.6(422) Reinstatement of canceled permit  
 13.7(422) Reinstatement of revoked permit  
 13.8(422) Withdrawal of permit  
 13.9(422) Loss or destruction of permit  
 13.10(422) Change of location  
 13.11(422) Change of ownership  
 13.12(422) Permit posting  
 13.13(422) Trustees, receivers, executors and administrators  
 13.14(422) Vending machines and other coin-operated devices  
 13.15(422) Other amusements  
 13.16(422) Substantially delinquent tax—denial of permit  
 13.17(422) Substantially delinquent tax—revocation of permit

## CHAPTER 14

## COMPUTATION OF TAX

- 14.1(422) Tax not to be included in price  
 14.2(422,423,77GA, ch1130) Retail bracket system for state sales and local option sales and service tax  
 14.3(422,423) Taxation of transactions due to rate change

## CHAPTER 15

## DETERMINATION OF A SALE AND SALE PRICE

- 15.1(422) Conditional sales to be included in gross sales  
 15.2(422,423) Repossessed goods  
 15.3(422,423) Exemption certificates, direct pay permits, fuel used in processing, and beer and wine wholesalers  
 15.4(422,423) Bad debts  
 15.5(422,423) Recovery of bad debts by collection agency or attorney  
 15.6(422,423) Discounts, rebates and coupons  
 15.7 Reserved  
 15.8(422,423) Returned merchandise  
 15.9(422) Goods damaged in transit  
 15.10(422) Consignment sales  
 15.11(422,423) Leased departments  
 15.12(422,423) Excise tax included in and excluded from gross receipts  
 15.13(422,423) Freight, other transportation charges, and exclusions from the exemption applicable to these services  
 15.14(422,423) Installation charges when tangible personal property is sold at retail  
 15.15(422) Premiums and gifts  
 15.16(422) Gift certificates  
 15.17(422,423) Finance charge  
 15.18(422,423) Coins and other currency exchanged at greater than face value

- 15.19(422,423) Trade-ins
- 15.20(422,423) Corporate mergers which do not involve taxable sales of tangible personal property or services

CHAPTER 16  
TAXABLE SALES

- 16.1(422) Tax imposed
- 16.2(422) Used or secondhand tangible personal property
- 16.3(422,423) Tangible personal property used or consumed by the manufacturer thereof
- 16.4(422,423) Patterns, dies, jigs, tools, and manufacturing or printing aids
- 16.5(422,423) Explosives used in mines, quarries and elsewhere
- 16.6(422,423) Electrotypes, types, zinc etchings, halftones, stereotypes, color process plates and wood mounts
- 16.7 Reserved
- 16.8(422,423) Wholesalers and jobbers selling at retail
- 16.9(422,423) Materials and supplies sold to retail stores
- 16.10(422,423) Sales to certain corporations organized under federal statutes
- 16.11(422,423) Paper plates, paper cups, paper dishes, paper napkins, paper, wooden or plastic spoons and forks and straws
- 16.12(422) Tangible personal property purchased for resale but incidentally consumed by the purchaser
- 16.13(422) Property furnished without charge by employers to employees
- 16.14(422) Sales in interstate commerce—goods delivered into this state
- 16.15(422) Owners or operators of buildings
- 16.16(422,423) Tangible personal property made to order
- 16.17(422,423) Blacksmith and machine shops
- 16.18(422,423) Sales of signs at retail
- 16.19(422,423) Products sold by cooperatives to members or patrons
- 16.20(422,423) Municipal utilities, investor-owned utilities, or municipal or rural electrification cooperatives or associations
- 16.21(422,423) Sale of pets
- 16.22(422,423) Sales on layaway
- 16.23(422) Meal tickets, coupon books, and merchandise cards
- 16.24(422,423) Truckers engaged in retail business
- 16.25(422,423) Foreign truckers selling at retail in Iowa
- 16.26(422) Admissions to amusements, athletic events, commercial amusement enterprises, fairs, and games
- 16.27 and 16.28 Reserved
- 16.29(422) Rental of personal property in connection with the operation of amusements
- 16.30(422) Commercial amusement enterprises—companies or persons which contract to furnish show for fixed fee
- 16.31 Reserved
- 16.32(422) River steamboats
- 16.33(422) Pawnbrokers
- 16.34(422,423) Druggists and pharmacists
- 16.35(422,423) Memorial stones
- 16.36(422) Communication services furnished by hotel to its guests
- 16.37(422) Private clubs
- 16.38 Reserved
- 16.39(422) Athletic events
- 16.40(422,423) Iowa dental laboratories
- 16.41(422,423) Dental supply houses

16.42(422)	News distributors and magazine distributors
16.43(422,423)	Magazine subscriptions by independent dealers
16.44(422,423)	Sales by finance companies
16.45(422,423)	Sale of baling wire and baling twine
16.46(422,423)	Snowmobiles and motorboats
16.47(422)	Conditional sales contracts
16.48(422,423)	Carpeting and other floor coverings
16.49(422,423)	Bowling
16.50(422,423)	Various special problems relating to public utilities
16.51(423)	Sales of services treated as sales of tangible personal property

#### CHAPTER 17 EXEMPT SALES

17.1(422,423)	Gross receipts expended for educational, religious, and charitable purposes
17.2(422)	Fuel used in processing—when exempt
17.3(422,423)	Processing exemptions
17.4	Reserved
17.5(422,423)	Sales to the American Red Cross, the Coast Guard Auxiliary, Navy-Marine Corps Relief Society, and U.S.O
17.6(422,423)	Sales of vehicles subject to registration—new and used—by dealers
17.7(422,423)	Sales to certain federal corporations
17.8(422)	Sales in interstate commerce—goods transported or shipped from this state
17.9(422,423)	Sales of breeding livestock, fowl and certain other property used in agricultural production
17.10(422,423)	Materials used for seed inoculations
17.11(422,423)	Educational institution
17.12(422)	Coat or hat checkrooms
17.13(422,423)	Railroad rolling stock
17.14(422,423)	Chemicals, solvents, sorbents, or reagents used in processing
17.15(422,423)	Demurrage charges
17.16(422,423)	Sale of a draft horse
17.17(422,423)	Beverage container deposits
17.18(422,423)	Films, video tapes and other media, exempt rental and sale
17.19(422,423)	Gross receipts from the sale or rental of tangible personal property or from services performed, rendered, or furnished to certain nonprofit corporations exempt from tax
17.20(422)	Raffles
17.21(422)	Exempt sales of prizes
17.22(422,423)	Modular homes
17.23(422,423)	Sales to other states and their political subdivisions
17.24(422)	Nonprofit private museums
17.25(422,423)	Exempt sales by excursion boat licensees
17.26(422,423)	Bedding for agricultural livestock or fowl
17.27(422,423)	Statewide notification center service exemption
17.28(422,423)	State fair and fair societies
17.29(422,423)	Reciprocal shipment of wines
17.30(422,423)	Nonprofit organ procurement organizations
17.31(422,423)	Sale of electricity to water companies
17.32(422)	Food and beverages sold by certain organizations are exempt
17.33(422,423)	Sales of building materials, supplies and equipment to not-for-profit rural water districts
17.34(422,423)	Sales to hospices

17.35(422,423)	Sales of livestock ear tags
17.36(422,423)	Sale or rental of information services
17.37(422,423)	Temporary exemption from sales tax on certain utilities
17.38(422,423)	State sales tax phase-out on energies
17.39(422,423)	Art centers
17.40(422,423)	Community action agencies
17.41(422,423)	Legislative service bureau

## CHAPTER 18

TAXABLE AND EXEMPT SALES DETERMINED BY METHOD  
OF TRANSACTION OR USAGE

18.1(422,423)	Tangible personal property purchased from the United States government
18.2(422,423)	Sales of butane, propane and other like gases in cylinder drums, etc.
18.3(422,423)	Chemical compounds used to treat water
18.4(422)	Mortgages and trustees
18.5(422,423)	Sales to agencies or instrumentalities of federal, state, county and municipal government
18.6(422,423)	Relief agencies
18.7(422,423)	Containers, including packing cases, shipping cases, wrapping material and similar items
18.8(422)	Auctioneers
18.9(422)	Sales by farmers
18.10(422,423)	Florists
18.11(422,423)	Landscaping materials
18.12(422,423)	Hatcheries
18.13(422,423)	Sales by the state of Iowa, its agencies and instrumentalities
18.14(422,423)	Sales of livestock and poultry feeds
18.15(422,423)	Student fraternities and sororities
18.16(422,423)	Photographers and photostaters
18.17(422,423)	Gravel and stone
18.18(422,423)	Sale of ice
18.19(422,423)	Antiques, curios, old coins or collector's postage stamps
18.20(422,423)	Communication services
18.21(422,423)	Morticians or funeral directors
18.22(422,423)	Physicians, dentists, surgeons, ophthalmologists, oculists, optometrists, and opticians
18.23(422)	Veterinarians
18.24(422,423)	Hospitals, infirmaries and sanitariums
18.25(422,423)	Warranties and maintenance contracts
18.26(422)	Service charge and gratuity
18.27(422)	Advertising agencies, commercial artists, and designers
18.28(422,423)	Casual sales
18.29(422,423)	Processing, a definition of the word, its beginning and completion characterized with specific examples of processing
18.30(422)	Taxation of American Indians
18.31(422,423)	Tangible personal property purchased by one who is engaged in the performance of a service
18.32(422,423)	Sale, transfer or exchange of tangible personal property or taxable enumerated services between affiliated corporations
18.33(422,423)	Printers' and publishers' supplies exemption with retroactive effective date
18.34(422,423)	Automatic data processing
18.35(422,423)	Drainage tile

18.36(422,423)	True leases and purchases of tangible personal property by lessors
18.37(422,423)	Motor fuel, special fuel, aviation fuels and gasoline
18.38(422,423)	Urban transit systems
18.39(422,423)	Sales or services rendered, furnished, or performed by a county or city
18.40(422,423)	Renting of rooms
18.41(422,423)	Envelopes for advertising
18.42(422,423)	Newspapers, free newspapers and shoppers' guides
18.43(422,423)	Written contract
18.44(422,423)	Sale or rental of farm machinery and equipment
18.45(422,423)	Sale or rental of computers, industrial machinery and equipment; refund of and exemption from tax paid for periods prior to July 1, 1997
18.46(422,423)	Automotive fluids
18.47(422,423)	Maintenance or repair of fabric or clothing
18.48(422,423)	Sale or rental of farm machinery, equipment, replacement parts, and repairs used in livestock, dairy, or plant production
18.49(422,423)	Aircraft sales, rental, component parts, and services exemptions prior to, on, and after July 1, 1999
18.50(422,423)	Property used by a lending organization
18.51(422,423)	Sales to nonprofit legal aid organizations
18.52(422,423)	Irrigation equipment used in farming operations
18.53(422,423)	Sales to persons engaged in the consumer rental purchase business
18.54(422,423)	Sales of advertising material
18.55(422,423)	Drop shipment sales
18.56(422,423)	Wind energy conversion property
18.57(422,423)	Exemptions applicable to the production of flowering, ornamental, and vegetable plants
18.58(422,423)	Exempt sales or rentals of computers, industrial machinery and equipment, and exempt sales of fuel and electricity on and after July 1, 1997, but before July 1, 2016
18.59(422,423)	Exempt sales to nonprofit hospitals
18.60(422,423)	Exempt sales of gases used in the manufacturing process
18.61(422,423)	Exclusion from tax for property delivered by certain media

## CHAPTER 19

### SALES AND USE TAX ON CONSTRUCTION ACTIVITIES

19.1(422,423)	General information
19.2(422,423)	Contractors are consumers of building materials, supplies, and equipment by statute
19.3(422,423)	Sales of building materials, supplies, and equipment to contractors, subcontractors, builders or owners
19.4(422,423)	Contractors, subcontractors or builders who are retailers
19.5(422,423)	Building materials, supplies, and equipment used in the performance of construction contracts within and outside Iowa
19.6(422,423)	Prefabricated structures
19.7(422,423)	Types of construction contracts
19.8(422,423)	Machinery and equipment sales contracts with installation
19.9(422,423)	Construction contracts with equipment sales (mixed contracts)
19.10(422,423)	Distinguishing machinery and equipment from real property
19.11(422,423)	Tangible personal property which becomes structures
19.12(422,423)	Construction contracts with tax exempt entities
19.13(422,423)	Tax on enumerated services
19.14(422,423)	Transportation cost
19.15(422,423)	Start-up charges

19.16(422,423)	Liability of subcontractors
19.17(422,423)	Liability of sponsors
19.18(422,423)	Withholding
19.19(422,423)	Resale certificates
19.20(423)	Reporting for use tax

## CHAPTER 20

FOODS FOR HUMAN CONSUMPTION, PRESCRIPTION DRUGS, INSULIN,  
HYPODERMIC SYRINGES, DIABETIC TESTING MATERIALS, PROSTHETIC,  
ORTHOTIC OR ORTHOPEDIC DEVICES

20.1(422,423)	Foods for human consumption
20.2(422,423)	Food coupon rules
20.3(422,423)	Nonparticipating retailer in the food coupon program
20.4(422,423)	Determination of eligible foods
20.5(422,423)	Meals and prepared food
20.6(422,423)	Vending machines
20.7(422,423)	Prescription drugs and devices
20.8(422,423)	Exempt sales of nonprescription medical devices, other than prosthetic devices
20.9(422,423)	Prosthetic, orthotic and orthopedic devices
20.10(422,423)	Sales and rentals covered by Medicaid and Medicare
20.11(422,423)	Reporting
20.12(422,423)	Exempt sales of clothing and footwear during two-day period in August

## CHAPTERS 21 to 25

Reserved

## TITLE III

## SALES TAX ON SERVICES

## CHAPTER 26

## SALES AND USE TAX ON SERVICES

26.1(422)	Definition and scope
26.2(422)	Enumerated services exempt
26.3(422)	Alteration and garment repair
26.4(422)	Armored car
26.5(422)	Vehicle repair
26.6(422)	Battery, tire and allied
26.7(422)	Investment counseling
26.8(422)	Bank and financial institution service charges
26.9(422)	Barber and beauty
26.10(422)	Boat repair
26.11(422)	Car and vehicle wash and wax
26.12(422)	Carpentry
26.13(422)	Roof, shingle and glass repair
26.14(422)	Dance schools and dance studios
26.15(422)	Dry cleaning, pressing, dyeing and laundering
26.16(422)	Electrical and electronic repair and installation
26.17(423)	Photography and retouching
26.18(422,423)	Equipment and tangible personal property rental
26.19(422)	Excavating and grading
26.20(422)	Farm implement repair of all kinds
26.21(422)	Flying service
26.22(422)	Furniture, rug, upholstery, repair and cleaning
26.23(422)	Fur storage and repair

26.24(422)	Golf and country clubs and all commercial recreation
26.25(422)	House and building moving
26.26(422)	Household appliance, television and radio repair
26.27(422)	Jewelry and watch repair
26.28(422)	Machine operators
26.29(422)	Machine repair of all kinds
26.30(422)	Motor repair
26.31(422)	Motorcycle, scooter and bicycle repair
26.32(422)	Oilers and lubricators
26.33(422)	Office and business machine repair
26.34(422)	Painting, papering and interior decorating
26.35(422)	Parking facilities
26.36(422)	Pipe fitting and plumbing
26.37(422)	Wood preparation
26.38(422)	Private employment agency, executive search agency
26.39(422)	Printing and binding
26.40(422)	Sewing and stitching
26.41(422)	Shoe repair and shoeshine
26.42(422)	Storage warehousing, storage locker, and storage warehousing of raw agricultural products and household goods
26.43(422,423)	Telephone answering service
26.44(422)	Test laboratories
26.45(422)	Termite, bug, roach, and pest eradicators
26.46(422)	Tin and sheet metal repair
26.47(422)	Turkish baths, massage, and reducing salons
26.48(422)	Vulcanizing, recapping or retreading
26.49	Reserved
26.50(422)	Weighing
26.51(422)	Welding
26.52(422)	Well drilling
26.53(422)	Wrapping, packing and packaging of merchandise other than processed meat, fish, fowl and vegetables
26.54(422)	Wrecking service
26.55(422)	Wrecker and towing
26.56(422)	Cable and pay television
26.57(422)	Camera repair
26.58(422)	Campgrounds
26.59(422)	Gun repair
26.60(422)	Janitorial and building maintenance or cleaning
26.61(422)	Lawn care
26.62(422)	Landscaping
26.63(422)	Pet grooming
26.64(422)	Reflexology
26.65(422)	Tanning beds and tanning salons
26.66(422)	Tree trimming and removal
26.67(422)	Water conditioning and softening
26.68(422)	Motor vehicle, recreational vehicle and recreational boat rental
26.69(422)	Security and detective services
26.70	Reserved
26.71(422,423)	Solid waste collection and disposal services
26.72(422,423)	Sewage services
26.73	Reserved

26.74(422,423)	Aircraft rental
26.75(422,423)	Sign construction and installation
26.76(422,423)	Swimming pool cleaning and maintenance
26.77(422,423)	Taxidermy
26.78(422,423)	Mini-storage
26.79(422,423)	Dating services
26.80(422,423)	Personal transportation service
26.81(422)	Sales of bundled services contracts

## CHAPTER 27

## AUTOMOBILE RENTAL EXCISE TAX

27.1(423C)	Definitions and characterizations
27.2(423C)	Tax imposed upon rental of automobiles
27.3(423C)	Lessor's obligation to collect tax
27.4(423C)	Administration of tax

TITLE IV  
USECHAPTER 28  
DEFINITIONS

28.1(423)	Taxable use defined
28.2(423)	Processing of property defined
28.3(423)	Purchase price defined
28.4(423)	Retailer maintaining a place of business in this state defined

CHAPTER 29  
CERTIFICATES

29.1(423)	Certificate of registration
29.2(423)	Cancellation of certificate of registration
29.3(423)	Certificates of resale, direct pay permits, or processing

CHAPTER 30  
FILING RETURNS, PAYMENT OF TAX, PENALTY AND INTEREST

30.1(423)	Liability for use tax and denial and revocation of permit
30.2(423)	Measure of use tax
30.3(421,423)	Consumer's use tax return
30.4(423)	Retailer's use tax return
30.5(423)	Collection requirements of registered retailers
30.6(423)	Bracket system to be used by registered vendors
30.7(423)	Sales tax or use tax paid to another state
30.8(423)	Registered retailers selling tangible personal property on a conditional sale contract basis
30.9(423)	Registered vendors repossessing goods sold on a conditional sale contract basis
30.10(423)	Penalties for late filing of a monthly tax deposit or use tax returns
30.11(423)	Claim for refund of use tax
30.12(423)	Extension of time for filing

CHAPTER 31  
RECEIPTS SUBJECT TO USE TAX

31.1(423)	Transactions consummated outside this state
31.2(423)	Goods coming into this state
31.3(423)	Sales by federal government or agencies to consumers
31.4(423)	Sales for lease of vehicles subject to registration—taxation and exemptions

- 31.5(423) Motor vehicle use tax on long-term leases
- 31.6(423) Sales of aircraft subject to registration
- 31.7(423) Communication services

#### CHAPTER 32

##### RECEIPTS EXEMPT FROM USE TAX

- 32.1(423) Tangible personal property and taxable services subject to sales tax
- 32.2(423) Sales tax exemptions applicable to use tax
- 32.3(423) Mobile homes and manufactured housing
- 32.4(423) Exemption for vehicles used in interstate commerce
- 32.5(423) Exemption for transactions if sales tax paid
- 32.6(423) Exemption for ships, barges, and other waterborne vessels
- 32.7(423) Exemption for containers
- 32.8(423) Exemption for building materials used outside this state
- 32.9(423) Exemption for vehicles subject to registration
- 32.10(423) Exemption for vehicles operated under Iowa Code chapter 326
- 32.11(423) Exemption for vehicles purchased for rental or lease
- 32.12(423) Exemption for vehicles previously purchased for rental
- 32.13(423) Exempt use of aircraft on and after July 1, 1999
- 32.14(423) Exemption for tangible personal property brought into Iowa under Iowa Code section 29C.24

#### CHAPTER 33

##### RECEIPTS SUBJECT TO USE TAX DEPENDING ON METHOD OF TRANSACTION

- 33.1 Reserved
- 33.2(423) Federal manufacturer's or retailer's excise tax
- 33.3(423) Fuel consumed in creating power, heat or steam for processing or generating electric current
- 33.4(423) Repair of tangible personal property outside the state of Iowa
- 33.5(423) Taxation of American Indians
- 33.6(422,423) Exemption for property used in Iowa only in interstate commerce
- 33.7(423) Property used to manufacture certain vehicles to be leased
- 33.8(423) Out-of-state rental of vehicles subject to registration subsequently used in Iowa
- 33.9(423) Sales of mobile homes, manufactured housing, and related property and services
- 33.10(423) Tax imposed on the use of manufactured housing as tangible personal property and as real estate

#### CHAPTER 34

##### VEHICLES SUBJECT TO REGISTRATION

- 34.1(422,423) Definitions
- 34.2(423) County treasurer shall collect tax
- 34.3(423) Returned vehicles and tax refunded by manufacturers
- 34.4(423) Use tax collections required
- 34.5(423) Exemptions
- 34.6(423) Vehicles subject to registration received as gifts or prizes
- 34.7(423) Titling of used foreign vehicles by dealers
- 34.8(423) Dealer's retail sales tax returns
- 34.9(423) Affidavit forms
- 34.10(423) Exempt and taxable purchases of vehicles for taxable rental
- 34.11(423) Manufacturer's refund of use tax to a consumer, lessor, or lessee of a defective motor vehicle

- 34.12(423) Government payments for a motor vehicle which do not involve government purchases of the same
- 34.13(423) Transfers of vehicles resulting from corporate mergers and other types of corporate transfers
- 34.14(423) Refund of use tax paid on the purchase of a motor vehicle
- 34.15(423) Registration by manufacturers
- 34.16(423) Rebates
- 34.17(321,423) Repossession of a vehicle
- 34.18(423) Federal excise tax
- 34.19(423) Claiming an exemption from Iowa tax
- 34.20(423) Affidavit forms
- 34.21(423) Insurance companies

#### CHAPTERS 35 and 36

Reserved

#### CHAPTER 37

#### UNDERGROUND STORAGE TANK RULES

#### INCORPORATED BY REFERENCE

- 37.1(424) Rules incorporated

#### TITLE V INDIVIDUAL

#### CHAPTER 38 ADMINISTRATION

- 38.1(422) Definitions
- 38.2(422) Statute of limitations
- 38.3(422) Retention of records
- 38.4(422) Authority for deductions
- 38.5(422) Jeopardy assessments
- 38.6(422) Information deemed confidential
- 38.7(422) Power of attorney
- 38.8(422) Delegations to audit and examine
- 38.9(422) Bonding procedure
- 38.10(422) Indexation
- 38.11(422) Appeals of notices of assessment and notices of denial of taxpayer's refund claims
- 38.12(422) Indexation of the optional standard deduction for inflation
- 38.13(422) Reciprocal tax agreements
- 38.14(422) Information returns for reporting income payments to the department of revenue
- 38.15(422) Relief of innocent spouse for substantial understatement of tax attributable to other spouse
- 38.16(422) Preparation of taxpayers' returns by department employees
- 38.17(422) Resident determination
- 38.18(422) Tax treatment of income repaid in current tax year which had been reported on prior Iowa individual income tax return

#### CHAPTER 39

#### FILING RETURN AND PAYMENT OF TAX

- 39.1(422) Who must file
- 39.2(422) Time and place for filing
- 39.3(422) Form for filing
- 39.4(422) Filing status
- 39.5(422) Payment of tax

39.6(422)	Minimum tax
39.7(422)	Tax on lump-sum distributions
39.8(422)	State income tax limited to taxpayer's net worth immediately before the distressed sale
39.9(422)	Special tax computation for all low-income taxpayers except single taxpayers
39.10(422)	Election to report excess income from sale or exchange of livestock due to drought in the next tax year
39.11(422)	Forgiveness of tax for an individual whose federal income tax was forgiven because the individual was killed outside the United States due to military or terroristic action
39.12(422)	Tax benefits for persons in the armed forces deployed outside the United States and for certain other persons serving in support of those forces
39.13	Reserved
39.14(422)	Tax benefits for persons serving in support of the Bosnia-Herzegovina hazardous duty area
39.15(422)	Special tax computation for taxpayers who are 65 years of age or older

## CHAPTER 40

## DETERMINATION OF NET INCOME

40.1(422)	Net income defined
40.2(422)	Interest and dividends from federal securities
40.3(422)	Interest and dividends from foreign securities and securities of state and other political subdivisions
40.4	Reserved
40.5(422)	Military pay
40.6(422)	Interest and dividend income
40.7(422)	Current year capital gains and losses
40.8(422)	Gains and losses on property acquired before January 1, 1934
40.9(422)	Work opportunity tax credit and alcohol and cellulosic biofuel fuels credit
40.10 and 40.11	Reserved
40.12(422)	Income from partnerships or limited liability companies
40.13(422)	Subchapter "S" income
40.14(422)	Contract sales
40.15(422)	Reporting of incomes by married taxpayers who file a joint federal return but elect to file separately for Iowa income tax purposes
40.16(422)	Income of nonresidents
40.17(422)	Income of part-year residents
40.18(422)	Net operating loss carrybacks and carryovers
40.19(422)	Casualty losses
40.20(422)	Adjustments to prior years
40.21(422)	Additional deduction for wages paid or accrued for work done in Iowa by certain individuals
40.22(422)	Disability income exclusion
40.23(422)	Social security benefits
40.24(99E)	Lottery prizes
40.25 and 40.26	Reserved
40.27(422)	Incomes from distressed sales of qualifying taxpayers
40.28	Reserved
40.29(422)	Intangible drilling costs
40.30(422)	Percentage depletion
40.31(422)	Away-from-home expenses of state legislators

40.32(422)	Interest and dividends from regulated investment companies which are exempt from federal income tax
40.33	Reserved
40.34(422)	Exemption of restitution payments for persons of Japanese ancestry
40.35(422)	Exemption of Agent Orange settlement proceeds received by disabled veterans or beneficiaries of disabled veterans
40.36(422)	Exemption of interest earned on bonds issued to finance beginning farmer loan program
40.37(422)	Exemption of interest from bonds issued by the Iowa comprehensive petroleum underground storage tank fund board
40.38(422)	Capital gain deduction or exclusion for certain types of net capital gains
40.39(422)	Exemption of interest from bonds or notes issued to fund the 911 emergency telephone system
40.40(422)	Exemption of active-duty military pay of national guard personnel and armed forces reserve personnel received for services related to operation desert shield
40.41	Reserved
40.42(422)	Depreciation of speculative shell buildings
40.43(422)	Retroactive exemption for payments received for providing unskilled in-home health care services to a relative
40.44(422,541A)	Individual development accounts
40.45(422)	Exemption for distributions from pensions, annuities, individual retirement accounts, or deferred compensation plans received by nonresidents of Iowa
40.46(422)	Taxation of compensation of nonresident members of professional athletic teams
40.47(422)	Partial exclusion of pensions and other retirement benefits for disabled individuals, individuals who are 55 years of age or older, surviving spouses, and survivors
40.48(422)	Health insurance premiums deduction
40.49(422)	Employer social security credit for tips
40.50(422)	Computing state taxable amounts of pension benefits from state pension plans
40.51(422)	Exemption of active-duty military pay of national guard personnel and armed forces military reserve personnel for overseas services pursuant to military orders for peacekeeping in the Bosnia-Herzegovina area
40.52(422)	Mutual funds
40.53(422)	Deduction for contributions by taxpayers to the Iowa educational savings plan trust and addition to income for refunds of contributions previously deducted
40.54(422)	Roth individual retirement accounts
40.55(422)	Exemption of income payments for victims of the Holocaust and heirs of victims
40.56(422)	Taxation of income from the sale of obligations of the state of Iowa and its political subdivisions
40.57(422)	Installment sales by taxpayers using the accrual method of accounting
40.58(422)	Exclusion of distributions from retirement plans by national guard members and members of military reserve forces of the United States
40.59	Reserved
40.60(422)	Additional first-year depreciation allowance
40.61(422)	Exclusion of active duty pay of national guard members and armed forces military reserve members for service under orders for Operation Iraqi Freedom, Operation Noble Eagle, Operation Enduring Freedom or Operation New Dawn
40.62(422)	Deduction for overnight expenses not reimbursed for travel away from home of more than 100 miles for performance of service as a member of the national guard or armed forces military reserve
40.63(422)	Exclusion of income from military student loan repayments

40.64(422)	Exclusion of death gratuity payable to an eligible survivor of a member of the armed forces, including a member of a reserve component of the armed forces who has died while on active duty
40.65(422)	Section 179 expensing
40.66(422)	Deduction for certain unreimbursed expenses relating to a human organ transplant
40.67(422)	Deduction for alternative motor vehicles
40.68(422)	Injured veterans grant program
40.69(422)	Exclusion of ordinary or capital gain income realized as a result of involuntary conversion of property due to eminent domain
40.70(422)	Exclusion of income from sale, rental or furnishing of tangible personal property or services directly related to production of film, television or video projects
40.71(422)	Exclusion for certain victim compensation payments
40.72(422)	Exclusion of Vietnam Conflict veterans bonus
40.73(422)	Exclusion for health care benefits of nonqualified tax dependents
40.74(422)	Exclusion for AmeriCorps Segal Education Award
40.75(422)	Exclusion of certain amounts received from Iowa veterans trust fund
40.76(422)	Exemption of active duty pay for armed forces, armed forces military reserve, or the national guard
40.77(422)	Exclusion of biodiesel production refund
40.78(422)	Allowance of certain deductions for 2008 tax year
40.79(422)	Special filing provisions related to 2010 tax changes
40.80(422)	Exemption for military retirement pay
40.81(422)	Iowa ABLE savings plan trust
40.82(422,541B)	First-time homebuyer savings accounts
40.83(422)	Like-kind exchanges of personal property completed after December 31, 2017, but before tax periods beginning on or after January 1, 2020

## CHAPTER 41

## DETERMINATION OF TAXABLE INCOME

41.1(422)	Verification of deductions required
41.2(422)	Federal rulings and regulations
41.3(422)	Federal income tax deduction and federal refund
41.4(422)	Optional standard deduction
41.5(422)	Itemized deductions
41.6(422)	Itemized deductions—separate returns by spouses
41.7(422)	Itemized deductions—part-year residents
41.8(422)	Itemized deductions—nonresidents
41.9(422)	Annualizing income
41.10(422)	Income tax averaging
41.11(422)	Reduction in state itemized deductions for certain high-income taxpayers
41.12(422)	Deduction for home mortgage interest for taxpayers with mortgage interest credit
41.13(422)	Iowa income taxes and Iowa tax refund

## CHAPTER 42

## ADJUSTMENTS TO COMPUTED TAX AND TAX CREDITS

42.1(257,422)	School district surtax
42.2(422D)	Emergency medical services income surtax
42.3(422)	Exemption credits
42.4(422)	Tuition and textbook credit for expenses incurred for dependents attending grades kindergarten through 12 in Iowa
42.5(422)	Nonresident and part-year resident credit
42.6(422)	Out-of-state tax credits

42.7(422)	Out-of-state tax credit for minimum tax
42.8(422)	Withholding and estimated tax credits
42.9(422)	Motor fuel credit
42.10(422)	Alternative minimum tax credit for minimum tax paid in a prior tax year
42.11(15,422)	Research activities credit
42.12(422)	New jobs credit
42.13(422)	Earned income credit
42.14(15)	Investment tax credit—new jobs and income program and enterprise zone program
42.15(422)	Child and dependent care credit
42.16(422)	Franchise tax credit
42.17(15E)	Eligible housing business tax credit
42.18(422)	Assistive device tax credit
42.19(404A,422)	Historic preservation and cultural and entertainment district tax credit for projects with Part 2 applications approved and tax credits reserved prior to July 1, 2014
42.20(422)	Ethanol blended gasoline tax credit
42.21(15E)	Eligible development business investment tax credit
42.22(15E,422)	Venture capital credits
42.23(15)	New capital investment program tax credits
42.24(15E,422)	Endow Iowa tax credit
42.25(422)	Soy-based cutting tool oil tax credit
42.26(15I,422)	Wage-benefits tax credit
42.27(422,476B)	Wind energy production tax credit
42.28(422,476C)	Renewable energy tax credit
42.29(15)	High quality job creation program
42.30(15E,422)	Economic development region revolving fund tax credit
42.31(422)	Early childhood development tax credit
42.32(422)	School tuition organization tax credit
42.33(422)	E-85 gasoline promotion tax credit
42.34(422)	Biodiesel blended fuel tax credit
42.35(422)	Soy-based transformer fluid tax credit
42.36(16,422)	Agricultural assets transfer tax credit and custom farming contract tax credit
42.37(15,422)	Film qualified expenditure tax credit
42.38(15,422)	Film investment tax credit
42.39(422)	Ethanol promotion tax credit
42.40(422)	Charitable conservation contribution tax credit
42.41(15,422)	Redevelopment tax credit
42.42(15)	High quality jobs program
42.43(16,422)	Disaster recovery housing project tax credit
42.44(422)	Deduction of credits
42.45(15)	Aggregate tax credit limit for certain economic development programs
42.46(422)	E-15 plus gasoline promotion tax credit
42.47(422)	Geothermal tax credits
42.48(422)	Solar energy system tax credit
42.49(422)	Volunteer fire fighter, volunteer emergency medical services personnel and reserve peace officer tax credit
42.50(422)	Taxpayers trust fund tax credit
42.51(422,85GA,SF452)	From farm to food donation tax credit
42.52(422)	Adoption tax credit
42.53(15)	Workforce housing tax incentives program
42.54(404A,422)	Historic preservation and cultural and entertainment district tax credit for projects registered on or after July 1, 2014, and before August 15, 2016

- 42.55(404A,422) Historic preservation and cultural and entertainment district tax credit for projects registered on or after August 15, 2016
- 42.56(15,422) Renewable chemical production tax credit program

CHAPTER 43  
ASSESSMENTS AND REFUNDS

- 43.1(422) Notice of discrepancies
- 43.2(422) Notice of assessment, supplemental assessments and refund adjustments
- 43.3(422) Overpayments of tax
- 43.4(68A,422,456A) Optional designations of funds by taxpayer
- 43.5(422) Abatement of tax
- 43.6 and 43.7 Reserved
- 43.8(422) Livestock production credit refunds for corporate taxpayers and individual taxpayers

CHAPTER 44  
PENALTY AND INTEREST

- 44.1(422) Penalty
- 44.2(422) Computation of interest on unpaid tax
- 44.3(422) Computation of interest on refunds resulting from net operating losses
- 44.4(422) Computation of interest on overpayments

CHAPTER 45  
PARTNERSHIPS

- 45.1(422) General rule
- 45.2(422) Partnership returns
- 45.3(422) Contents of partnership return
- 45.4(422) Distribution and taxation of partnership income

CHAPTER 46  
WITHHOLDING

- 46.1(422) Who must withhold
- 46.2(422) Computation of amount withheld
- 46.3(422) Forms, returns and reports
- 46.4(422) Withholding on nonresidents
- 46.5(422) Penalty and interest
- 46.6(422) Withholding tax credit to workforce development fund
- 46.7(422) ACE training program credits from withholding
- 46.8(260E) New job tax credit from withholding
- 46.9(15) Supplemental new jobs credit from withholding and alternative credit for housing assistance programs
- 46.10(403) Targeted jobs withholding tax credit

CHAPTER 47  
Reserved

CHAPTER 48  
COMPOSITE RETURNS

- 48.1(422) Composite returns
- 48.2(422) Definitions
- 48.3(422) Filing requirements
- 48.4 Reserved
- 48.5(422) Composite return required by director
- 48.6(422) Determination of composite Iowa income

- 48.7(422) Determination of composite Iowa tax
- 48.8(422) Estimated tax
- 48.9(422) Time and place for filing

#### CHAPTER 49

##### ESTIMATED INCOME TAX FOR INDIVIDUALS

- 49.1(422) Who must pay estimated income tax
- 49.2(422) Time for filing and payment of tax
- 49.3(422) Estimated tax for nonresidents
- 49.4(422) Special estimated tax periods
- 49.5(422) Reporting forms
- 49.6(422) Penalty—underpayment of estimated tax
- 49.7(422) Estimated tax carryforwards and how the carryforward amounts are affected under different circumstances

#### CHAPTER 50

##### APPORTIONMENT OF INCOME FOR RESIDENT SHAREHOLDERS OF S CORPORATIONS

- 50.1(422) Apportionment of income for resident shareholders of S corporations
- 50.2 Reserved
- 50.3(422) Distributions
- 50.4(422) Computation of net S corporation income
- 50.5(422) Computation of federal tax on S corporation income
- 50.6(422) Income allocable to Iowa
- 50.7(422) Credit for taxes paid to another state
- 50.8 and 50.9 Reserved
- 50.10(422) Example for tax periods beginning on or after January 1, 2002

#### TITLE VI *CORPORATION*

#### CHAPTER 51 ADMINISTRATION

- 51.1(422) Definitions
- 51.2(422) Statutes of limitation
- 51.3(422) Retention of records
- 51.4(422) Cancellation of authority to do business
- 51.5(422) Authority for deductions
- 51.6(422) Jeopardy assessments
- 51.7(422) Information confidential
- 51.8(422) Power of attorney
- 51.9(422) Delegation of authority to audit and examine

#### CHAPTER 52

##### FILING RETURNS, PAYMENT OF TAX, PENALTY AND INTEREST, AND TAX CREDITS

- 52.1(422) Who must file
- 52.2(422) Time and place for filing return
- 52.3(422) Form for filing
- 52.4(422) Payment of tax
- 52.5(422) Minimum tax
- 52.6(422) Motor fuel credit
- 52.7(422) Research activities credit
- 52.8(422) New jobs credit

52.9	Reserved
52.10(15)	New jobs and income program tax credits
52.11(422)	Refunds and overpayments
52.12(422)	Deduction of credits
52.13(422)	Livestock production credits
52.14(15E)	Enterprise zone tax credits
52.15(15E)	Eligible housing business tax credit
52.16(422)	Franchise tax credit
52.17(422)	Assistive device tax credit
52.18(404A,422)	Historic preservation and cultural and entertainment district tax credit for projects with Part 2 applications approved and tax credits reserved prior to July 1, 2014
52.19(422)	Ethanol blended gasoline tax credit
52.20(15E)	Eligible development business investment tax credit
52.21(15E,422)	Venture capital credits
52.22(15)	New capital investment program tax credits
52.23(15E,422)	Endow Iowa tax credit
52.24(422)	Soy-based cutting tool oil tax credit
52.25(15I,422)	Wage-benefits tax credit
52.26(422,476B)	Wind energy production tax credit
52.27(422,476C)	Renewable energy tax credit
52.28(15)	High quality job creation program
52.29(15E,422)	Economic development region revolving fund tax credit
52.30(422)	E-85 gasoline promotion tax credit
52.31(422)	Biodiesel blended fuel tax credit
52.32(422)	Soy-based transformer fluid tax credit
52.33(16,422)	Agricultural assets transfer tax credit and custom farming contract tax credit
52.34(15,422)	Film qualified expenditure tax credit
52.35(15,422)	Film investment tax credit
52.36(422)	Ethanol promotion tax credit
52.37(422)	Charitable conservation contribution tax credit
52.38(422)	School tuition organization tax credit
52.39(15,422)	Redevelopment tax credit
52.40(15)	High quality jobs program
52.41(15)	Aggregate tax credit limit for certain economic development programs
52.42(16,422)	Disaster recovery housing project tax credit
52.43(422)	E-15 plus gasoline promotion tax credit
52.44(422)	Solar energy system tax credit
52.45(422,85GA,SF452)	From farm to food donation tax credit
52.46(15)	Workforce housing tax incentives program
52.47(404A,422)	Historic preservation and cultural and entertainment district tax credit for projects registered on or after July 1, 2014, and before August 15, 2016
52.48(404A,422)	Historic preservation and cultural and entertainment district tax credit for projects registered on or after August 15, 2016
52.49(15,422)	Renewable chemical production tax credit program

## CHAPTER 53

## DETERMINATION OF NET INCOME

53.1(422)	Computation of net income for corporations
53.2(422)	Net operating loss carrybacks and carryovers
53.3(422)	Capital loss carryback
53.4(422)	Net operating and capital loss carrybacks and carryovers
53.5(422)	Interest and dividends from federal securities

- 53.6(422) Interest and dividends from foreign securities, and securities of state and their political subdivisions
- 53.7(422) Safe harbor leases
- 53.8(422) Additions to federal taxable income
- 53.9(422) Gains and losses on property acquired before January 1, 1934
- 53.10(422) Work opportunity tax credit and alcohol and cellulosic biofuel fuels credit
- 53.11(422) Additional deduction for wages paid or accrued for work done in Iowa by certain individuals
- 53.12(422) Federal income tax deduction
- 53.13(422) Iowa income taxes and Iowa tax refund
- 53.14(422) Method of accounting, accounting period
- 53.15(422) Consolidated returns
- 53.16(422) Federal rulings and regulations
- 53.17(422) Depreciation of speculative shell buildings
- 53.18(422) Deduction of multipurpose vehicle registration fee
- 53.19(422) Deduction of foreign dividends
- 53.20(422) Employer social security credit for tips
- 53.21(422) Deductions related to the Iowa educational savings plan trust
- 53.22(422) Additional first-year depreciation allowance
- 53.23(422) Section 179 expensing
- 53.24(422) Exclusion of ordinary or capital gain income realized as a result of involuntary conversion of property due to eminent domain
- 53.25(422) Exclusion of income from sale, rental or furnishing of tangible personal property or services directly related to production of film, television, or video projects
- 53.26(422) Exclusion of biodiesel production refund
- 53.27(422) Like-kind exchanges of personal property completed after December 31, 2017, but before tax periods beginning on or after January 1, 2020

#### CHAPTER 54

##### ALLOCATION AND APPORTIONMENT

- 54.1(422) Basis of corporate tax
- 54.2(422) Allocation or apportionment of investment income
- 54.3(422) Application of related expense to allocable interest, dividends, rents and royalties—tax periods beginning on or after January 1, 1978
- 54.4(422) Net gains and losses from the sale of assets
- 54.5(422) Where income is derived from the manufacture or sale of tangible personal property
- 54.6(422) Apportionment of income derived from business other than the manufacture or sale of tangible personal property
- 54.7(422) Apportionment of income of transportation, communications, and certain public utilities corporations
- 54.8(422) Apportionment of income derived from more than one business activity carried on within a single corporate structure
- 54.9(422) Allocation and apportionment of income in special cases

#### CHAPTER 55

##### ASSESSMENTS, REFUNDS, APPEALS

- 55.1(422) Notice of discrepancies
- 55.2(422) Notice of assessment
- 55.3(422) Refund of overpaid tax
- 55.4(421) Abatement of tax
- 55.5(422) Protests

CHAPTER 56  
ESTIMATED TAX FOR CORPORATIONS

56.1(422)	Who must pay estimated tax
56.2(422)	Time for filing and payment of tax
56.3(422)	Special estimate periods
56.4(422)	Reporting forms
56.5(422)	Penalties
56.6(422)	Overpayment of estimated tax

TITLE VII  
*FRANCHISE*

CHAPTER 57  
ADMINISTRATION

57.1(422)	Definitions
57.2(422)	Statutes of limitation
57.3(422)	Retention of records
57.4(422)	Authority for deductions
57.5(422)	Jeopardy assessments
57.6(422)	Information deemed confidential
57.7(422)	Power of attorney
57.8(422)	Delegation to audit and examine

CHAPTER 58  
FILING RETURNS, PAYMENT OF TAX, PENALTY AND INTEREST,  
AND TAX CREDITS

58.1(422)	Who must file
58.2(422)	Time and place for filing return
58.3(422)	Form for filing
58.4(422)	Payment of tax
58.5(422)	Minimum tax
58.6(422)	Refunds and overpayments
58.7(422)	Allocation of franchise tax revenues
58.8(15E)	Eligible housing business tax credit
58.9(15E)	Eligible development business investment tax credit
58.10(404A,422)	Historic preservation and cultural and entertainment district tax credit
58.11(15E,422)	Venture capital credits
58.12(15)	New capital investment program tax credits
58.13(15E,422)	Endow Iowa tax credit
58.14(15I,422)	Wage-benefits tax credit
58.15(422,476B)	Wind energy production tax credit
58.16(422,476C)	Renewable energy tax credit
58.17(15)	High quality job creation program
58.18(15E,422)	Economic development region revolving fund tax credit
58.19(15,422)	Film qualified expenditure tax credit
58.20(15,422)	Film investment tax credit
58.21(15)	High quality jobs program
58.22(422)	Solar energy system tax credit
58.23(15)	Workforce housing tax incentives program

CHAPTER 59  
DETERMINATION OF NET INCOME

59.1(422)	Computation of net income for financial institutions
59.2(422)	Net operating loss carrybacks and carryovers

59.3(422)	Capital loss carryback
59.4(422)	Net operating and capital loss carrybacks and carryovers
59.5(422)	Interest and dividends from federal securities
59.6(422)	Interest and dividends from foreign securities and securities of states and other political subdivisions
59.7(422)	Safe harbor leases
59.8(422)	Additional deduction for wages paid or accrued for work done in Iowa by certain individuals
59.9(422)	Work opportunity tax credit
59.10(422)	Like-kind exchanges of personal property completed after December 31, 2017, but before tax periods beginning on or after January 1, 2020
59.11(422)	Gains and losses on property acquired before January 1, 1934
59.12(422)	Federal income tax deduction
59.13(422)	Iowa franchise taxes
59.14(422)	Method of accounting, accounting period
59.15(422)	Consolidated returns
59.16(422)	Federal rulings and regulations
59.17(15E,422)	Charitable contributions relating to the endow Iowa tax credit
59.18(422)	Depreciation of speculative shell buildings
59.19(422)	Deduction of multipurpose vehicle registration fee
59.20(422)	Disallowance of expenses to carry an investment subsidiary for tax years which begin on or after January 1, 1995
59.21(422)	S corporation and limited liability company financial institutions
59.22(422)	Deduction for contributions made to the endowment fund of the Iowa educational savings plan trust
59.23(422)	Additional first-year depreciation allowance
59.24(422)	Section 179 expensing

#### ALLOCATION AND APPORTIONMENT

59.25(422)	Basis of franchise tax
59.26(422)	Allocation and apportionment
59.27(422)	Net gains and losses from the sale of assets
59.28(422)	Apportionment factor
59.29(422)	Allocation and apportionment of income in special cases

### CHAPTER 60

#### ASSESSMENTS, REFUNDS, APPEALS

60.1(422)	Notice of discrepancies
60.2(422)	Notice of assessment
60.3(422)	Refund of overpaid tax
60.4(421)	Abatement of tax
60.5(422)	Protests

### CHAPTER 61

#### ESTIMATED TAX FOR FINANCIAL INSTITUTIONS

61.1(422)	Who must pay estimated tax
61.2(422)	Time for filing and payment of tax
61.3(422)	Special estimate periods
61.4(422)	Reporting forms
61.5(422)	Penalties
61.6(422)	Overpayment of estimated tax

## CHAPTERS 62 to 66

## Reserved

TITLE VIII  
*MOTOR FUEL*

## CHAPTER 67

## ADMINISTRATION

67.1(452A)	Definitions
67.2(452A)	Statute of limitations, supplemental assessments and refund adjustments
67.3(452A)	Taxpayers required to keep records
67.4(452A)	Audit—costs
67.5(452A)	Estimate gallonage
67.6(452A)	Timely filing of returns, reports, remittances, applications, or requests
67.7(452A)	Extension of time to file
67.8(452A)	Penalty and interest
67.9(452A)	Penalty and enforcement provisions
67.10(452A)	Application of remittance
67.11(452A)	Reports, returns, records—variations
67.12(452A)	Form of invoice
67.13(452A)	Credit card invoices
67.14(452A)	Original invoice retained by purchaser—certified copy if lost
67.15(452A)	Taxes erroneously or illegally collected
67.16(452A)	Credentials and receipts
67.17(452A)	Information confidential
67.18(452A)	Delegation to audit and examine
67.19(452A)	Practice and procedure before the department of revenue
67.20(452A)	Time for filing protest
67.21(452A)	Bonding procedure
67.22(452A)	Tax refund offset
67.23(452A)	Supplier, restrictive supplier, importer, exporter, blender, dealer, or user licenses
67.24(452A)	Reinstatement of license canceled for cause
67.25(452A)	Fuel used in implements of husbandry
67.26(452A)	Excess tax collected
67.27(452A)	Retailer gallons report

## CHAPTER 68

## MOTOR FUEL AND UNDYED SPECIAL FUEL

68.1(452A)	Definitions
68.2(452A)	Tax rates—time tax attaches—responsible party
68.3(452A)	Exemption
68.4(452A)	Blended fuel taxation—nonterminal location
68.5(452A)	Tax returns—computations
68.6(452A)	Distribution allowance
68.7(452A)	Supplier credit—uncollectible account
68.8(452A)	Refunds
68.9(452A)	Claim for refund—payment of claim
68.10(452A)	Refund permit
68.11(452A)	Revocation of refund permit
68.12(452A)	Income tax credit in lieu of refund
68.13(452A)	Reduction of refund—sales and use tax
68.14(452A)	Terminal withdrawals—meters
68.15(452A)	Terminal and nonterminal storage facility reports and records

- 68.16(452A) Method of reporting taxable gallonage
- 68.17(452A) Transportation reports
- 68.18(452A) Bill of lading or manifest requirements
- 68.19(452A) Right of distributors and dealers to blend conventional blendstock for oxygenate blending, gasoline, or diesel fuel using a biofuel

## CHAPTER 69

## LIQUEFIED PETROLEUM GAS—

## COMPRESSED NATURAL GAS—LIQUEFIED NATURAL GAS

- 69.1(452A) Definitions
- 69.2(452A) Tax rates—time tax attaches—responsible party—payment of the tax
- 69.3(452A) Penalty and interest
- 69.4(452A) Bonding procedure
- 69.5(452A) Persons authorized to place L.P.G., L.N.G., or C.N.G. in the fuel supply tank of a motor vehicle
- 69.6(452A) Requirements to be licensed
- 69.7(452A) Licensed metered pumps
- 69.8(452A) Single license for each location
- 69.9(452A) Dealer's and user's license nonassignable
- 69.10(452A) Separate storage—bulk sales—highway use
- 69.11(452A) Combined storage—bulk sales—highway sales or use
- 69.12(452A) Exemption certificates
- 69.13(452A) L.P.G. sold to the state of Iowa, its political subdivisions, contract carriers under contract with public schools to transport pupils or regional transit systems
- 69.14(452A) Refunds
- 69.15(452A) Notice of meter seal breakage
- 69.16(452A) Location of records—L.P.G. or C.N.G. users and dealers

TITLE IX  
PROPERTY

## CHAPTER 70

## REPLACEMENT TAX AND STATEWIDE PROPERTY TAX

DIVISION I  
REPLACEMENT TAX

- 70.1(437A) Who must file return
- 70.2(437A) Time and place for filing return
- 70.3(437A) Form for filing
- 70.4(437A) Payment of tax
- 70.5(437A) Statute of limitations
- 70.6(437A) Billings
- 70.7(437A) Refunds
- 70.8(437A) Abatement of tax
- 70.9(437A) Taxpayers required to keep records
- 70.10(437A) Credentials
- 70.11(437A) Audit of records
- 70.12(437A) Collections/reimbursements
- 70.13(437A) Information confidential

DIVISION II  
STATEWIDE PROPERTY TAX

- 70.14(437A) Who must file return
- 70.15(437A) Time and place for filing return
- 70.16(437A) Form for filing

70.17(437A)	Payment of tax
70.18(437A)	Statute of limitations
70.19(437A)	Billings
70.20(437A)	Refunds
70.21(437A)	Abatement of tax
70.22(437A)	Taxpayers required to keep records
70.23(437A)	Credentials
70.24(437A)	Audit of records

## CHAPTER 71

### ASSESSMENT PRACTICES AND EQUALIZATION

71.1(405,427A,428,441,499B)	Classification of real estate
71.2(421,428,441)	Assessment and valuation of real estate
71.3(421,428,441)	Valuation of agricultural real estate
71.4(421,428,441)	Valuation of residential real estate
71.5(421,428,441)	Valuation of commercial real estate
71.6(421,428,441)	Valuation of industrial land and buildings
71.7(421,427A,428,441)	Valuation of industrial machinery
71.8(428,441)	Abstract of assessment
71.9(428,441)	Reconciliation report
71.10(421)	Assessment/sales ratio study
71.11(441)	Equalization of assessments by class of property
71.12(441)	Determination of aggregate actual values
71.13(441)	Tentative equalization notices
71.14(441)	Hearings before the department
71.15(441)	Final equalization order and appeals
71.16(441)	Alternative method of implementing equalization orders
71.17(441)	Special session of boards of review
71.18(441)	Judgment of assessors and local boards of review
71.19(441)	Conference boards
71.20(441)	Board of review
71.21(421,17A)	Property assessment appeal board
71.22(428,441)	Assessors
71.23(421,428,441)	Valuation of multiresidential real estate
71.24(421,428,441)	Valuation of dual classification property
71.25(441,443)	Omitted assessments
71.26(441)	Assessor compliance

## CHAPTER 72

### EXAMINATION AND CERTIFICATION OF ASSESSORS AND DEPUTY ASSESSORS

72.1(441)	Application for examination
72.2(441)	Examinations
72.3(441)	Eligibility requirements to take the examination
72.4(441)	Appraisal-related experience
72.5(441)	Regular certification
72.6(441)	Temporary certification
72.7	Reserved
72.8(441)	Deputy assessors—regular certification
72.9	Reserved
72.10(441)	Appointment of deputy assessors
72.11(441)	Special examinations
72.12(441)	Register of eligible candidates

- 72.13(441) Course of study for provisional appointees
- 72.14(441) Examining board
- 72.15(441) Appointment of assessor
- 72.16(441) Reappointment of assessor
- 72.17(441) Removal of assessor
- 72.18(421,441) Courses offered by the department of revenue

## CHAPTER 73

## PROPERTY TAX CREDIT AND RENT REIMBURSEMENT

- 73.1(425) Eligible claimants
- 73.2(425) Separate homesteads—husband and wife property tax credit
- 73.3(425) Dual claims
- 73.4(425) Multipurpose building
- 73.5(425) Multidwelling
- 73.6(425) Income
- 73.7(425) Joint tenancy
- 73.8(425) Amended claim
- 73.9(425) Simultaneous homesteads
- 73.10(425) Confidential information
- 73.11(425) Mobile, modular, and manufactured homes
- 73.12(425) Totally disabled
- 73.13(425) Nursing homes
- 73.14(425) Household
- 73.15(425) Homestead
- 73.16(425) Household income
- 73.17(425) Timely filing of claims
- 73.18(425) Separate homestead—husband and wife rent reimbursements
- 73.19(425) Gross rent/rent constituting property taxes paid
- 73.20(425) Leased land
- 73.21(425) Property: taxable status
- 73.22(425) Special assessments
- 73.23(425) Suspended, delinquent, or canceled taxes
- 73.24(425) Income: spouse
- 73.25(425) Common law marriage
- 73.26 Reserved
- 73.27(425) Special assessment credit
- 73.28(425) Credit applied
- 73.29(425) Deceased claimant
- 73.30(425) Audit of claim
- 73.31(425) Extension of time for filing a claim
- 73.32(425) Annual adjustment factor
- 73.33(425) Proration of claims
- 73.34(425) Unreasonable hardship

## CHAPTER 74

## MOBILE, MODULAR, AND MANUFACTURED HOME TAX

- 74.1(435) Definitions
- 74.2(435) Movement of home to another county
- 74.3(435) Sale of home
- 74.4(435) Reduced tax rate
- 74.5(435) Taxation—real estate
- 74.6(435) Taxation—square footage

- 74.7(435) Audit by department of revenue
- 74.8(435) Collection of tax

## CHAPTER 75

## PROPERTY TAX ADMINISTRATION

- 75.1(441) Tax year
- 75.2(445) Partial payment of tax
- 75.3(445) When delinquent
- 75.4(446) Payment of subsequent year taxes by purchaser
- 75.5(428,433,434,437,437A,438,85GA,SF451) Central assessment confidentiality
- 75.6(446) Tax sale
- 75.7(445) Refund of tax
- 75.8(614) Delinquent property taxes

## CHAPTER 76

## DETERMINATION OF VALUE OF RAILROAD COMPANIES

- 76.1(434) Definitions of terms
- 76.2(434) Filing of annual reports
- 76.3(434) Comparable sales
- 76.4(434) Stock and debt approach to unit value
- 76.5(434) Income capitalization approach to unit value
- 76.6(434) Cost approach to unit value
- 76.7(434) Correlation
- 76.8(434) Allocation of unit value to state
- 76.9(434) Exclusions

## CHAPTER 77

## DETERMINATION OF VALUE OF UTILITY COMPANIES

- 77.1(428,433,437,438) Definition of terms
- 77.2(428,433,437,438) Filing of annual reports
- 77.3(428,433,437,438) Comparable sales
- 77.4(428,433,437,438) Stock and debt approach to unit value
- 77.5(428,433,437,438) Income capitalization approach to unit value
- 77.6(428,433,437,438) Cost approach to unit value
- 77.7(428,433,437,438) Correlation
- 77.8(428,433,437,438) Allocation of unit value to state

## CHAPTER 78

REPLACEMENT TAX AND STATEWIDE PROPERTY  
TAX ON RATE-REGULATED WATER UTILITIES

## REPLACEMENT TAX

- 78.1(437B) Who must file return
- 78.2(437B) Time and place for filing return
- 78.3(437B) Form for filing
- 78.4(437B) Payment of tax
- 78.5(437B) Statute of limitations
- 78.6(437B) Billings
- 78.7(437B) Refunds
- 78.8(437B) Abatement of tax
- 78.9(437B) Taxpayers required to keep records
- 78.10(437B) Credentials
- 78.11(437B) Audit of records
- 78.12(437B) Information confidential

## STATEWIDE PROPERTY TAX

78.13(437B)	Who must file return
78.14(437B)	Time and place for filing return
78.15(437B)	Form for filing
78.16(437B)	Payment of tax
78.17(437B)	Statute of limitations
78.18(437B)	Billings
78.19(437B)	Refunds
78.20(437B)	Abatement of tax
78.21(437B)	Taxpayers required to keep records
78.22(437B)	Credentials
78.23(437B)	Audit of records

## CHAPTER 79

## REAL ESTATE TRANSFER TAX AND DECLARATIONS OF VALUE

79.1(428A)	Real estate transfer tax: Responsibility of county recorders
79.2(428A)	Taxable status of real estate transfers
79.3(428A)	Declarations of value: Responsibility of county recorders and city and county assessors
79.4(428A)	Certain transfers of agricultural realty
79.5(428A)	Form completion and filing requirements
79.6(428A)	Public access to declarations of value

## CHAPTER 80

## PROPERTY TAX CREDITS AND EXEMPTIONS

80.1(425)	Homestead tax credit
80.2(22,35,426A)	Military service tax exemption
80.3(427)	Pollution control and recycling property tax exemption
80.4(427)	Low-rent housing for the elderly and persons with disabilities
80.5(427)	Speculative shell buildings
80.6(427B)	Industrial property tax exemption
80.7(427B)	Assessment of computers and industrial machinery and equipment
80.8(404)	Urban revitalization partial exemption
80.9(427C,441)	Forest and fruit-tree reservations
80.10(427B)	Underground storage tanks
80.11(425A)	Family farm tax credit
80.12(427)	Methane gas conversion property
80.13(427B,476B)	Wind energy conversion property
80.14(427)	Mobile home park storm shelter
80.15(427)	Barn and one-room schoolhouse preservation
80.16(426)	Agricultural land tax credit
80.17(427)	Indian housing property
80.18(427)	Property used in value-added agricultural product operations
80.19(427)	Dwelling unit property within certain cities
80.20(427)	Nursing facilities
80.21(368)	Annexation of property by a city
80.22(427)	Port authority
80.23(427A)	Concrete batch plants and hot mix asphalt facilities
80.24(427)	Airport property
80.25(427A)	Car wash equipment
80.26(427)	Web search portal and data center business property
80.27(427)	Privately owned libraries and art galleries

80.28(404B)	Disaster revitalization area
80.29(427)	Geothermal heating and cooling systems installed on property classified as residential
80.30(426C)	Business property tax credit
80.31(427)	Broadband infrastructure
80.32(427,428,433,434,435,437,438)	Property aiding in disaster or emergency-related work
80.33 to 80.48	Reserved
80.49(441)	Commercial and industrial property tax replacement—county replacement claims
80.50(427,441)	Responsibility of local assessors
80.51(441)	Responsibility of local boards of review
80.52(427)	Responsibility of director of revenue
80.53(427)	Application for exemption
80.54(427)	Partial exemptions
80.55(427,441)	Taxable status of property
80.56(427)	Abatement of taxes

TITLE X  
*CIGARETTES AND TOBACCO*

CHAPTER 81  
ADMINISTRATION

81.1(453A)	Definitions
81.2(453A)	Credentials and receipts
81.3(453A)	Examination of records
81.4(453A)	Records
81.5(453A)	Form of invoice
81.6(453A)	Audit of records—cost, supplemental assessments and refund adjustments
81.7(453A)	Bonds
81.8(98)	Penalties
81.9(98)	Interest
81.10(98)	Waiver of penalty or interest
81.11(453A)	Appeal—practice and procedure before the department
81.12(453A)	Permit—license revocation
81.13(453A)	Permit applications and denials
81.14(453A)	Confidential information
81.15(98)	Request for waiver of penalty
81.16(453A)	Inventory tax

CHAPTER 82  
CIGARETTE TAX AND REGULATION OF DELIVERY SALES OF ALTERNATIVE NICOTINE PRODUCTS OR VAPOR PRODUCTS

82.1(453A)	Permits required
82.2(453A)	Partial year permits—payment—refund—exchange
82.3(453A)	Bond requirements
82.4(453A)	Cigarette tax—attachment—exemption—exclusivity of tax
82.5(453A)	Cigarette tax stamps
82.6(453A)	Banks authorized to sell stamps—requirements—restrictions
82.7(453A)	Purchase of cigarette tax stamps—discount
82.8(453A)	Affixing stamps
82.9(453A)	Reports
82.10(453A)	Manufacturer's samples
82.11(453A)	Refund of tax—unused and destroyed stamps
82.12(453A)	Delivery sales of alternative nicotine products or vapor products

CHAPTER 83  
TOBACCO TAX

83.1(453A)	Licenses
83.2(453A)	Distributor bond
83.3(453A)	Tax on tobacco products
83.4(453A)	Tax on little cigars
83.5(453A)	Distributor discount
83.6(453A)	Distributor returns
83.7(453A)	Consumer's return
83.8(453A)	Transporter's report
83.9(453A)	Free samples
83.10(453A)	Credits and refunds of taxes
83.11(453A)	Sales exempt from tax
83.12(81GA,HF339)	Retail permits required
83.13(81GA,HF339)	Permit issuance fee
83.14(81GA,HF339)	Refunds of permit fee
83.15(81GA,HF339)	Application for permit
83.16(81GA,HF339)	Records and reports
83.17(81GA,HF339)	Penalties

CHAPTER 84  
UNFAIR CIGARETTE SALES

84.1(421B)	Definitions
84.2(421B)	Minimum price
84.3(421B)	Combination sales
84.4(421B)	Retail redemption of coupons
84.5(421B)	Exempt sales
84.6(421B)	Notification of manufacturer's price increase
84.7(421B)	Permit revocation

CHAPTER 85  
TOBACCO MASTER SETTLEMENT AGREEMENT

DIVISION I  
TOBACCO MASTER SETTLEMENT AGREEMENT

85.1(453C)	National uniform tobacco settlement
85.2(453C)	Definitions
85.3(453C)	Report required
85.4(453C)	Report information
85.5(453C)	Record-keeping requirement
85.6(453C)	Confidentiality
85.7 to 85.20	Reserved

DIVISION II  
TOBACCO PRODUCT MANUFACTURERS' OBLIGATIONS AND PROCEDURES

85.21(80GA,SF375)	Definitions
85.22(80GA,SF375)	Directory of tobacco product manufacturers

TITLE XI  
*INHERITANCE, ESTATE, GENERATION SKIPPING, AND FIDUCIARY INCOME TAX*

CHAPTER 86  
INHERITANCE TAX

86.1(450)	Administration
86.2(450)	Inheritance tax returns and payment of tax

86.3(450)	Audits, assessments and refunds
86.4(450)	Appeals
86.5(450)	Gross estate
86.6(450)	The net estate
86.7(450)	Life estate, remainder and annuity tables—in general
86.8(450B)	Special use valuation
86.9(450)	Market value in the ordinary course of trade
86.10(450)	Alternate valuation date
86.11(450)	Valuation—special problem areas
86.12(450)	The inheritance tax clearance
86.13(450)	No lien on the surviving spouse's share of the estate
86.14(450)	Computation of shares
86.15(450)	Applicability

CHAPTER 87  
IOWA ESTATE TAX

87.1(451)	Administration
87.2(451)	Confidential and nonconfidential information
87.3(451)	Tax imposed, tax returns, and tax due
87.4(451)	Audits, assessments and refunds
87.5(451)	Appeals
87.6(451)	Applicable rules

CHAPTER 88  
GENERATION SKIPPING TRANSFER TAX

88.1(450A)	Administration
88.2(450A)	Confidential and nonconfidential information
88.3(450A)	Tax imposed, tax due and tax returns
88.4(450A)	Audits, assessments and refunds
88.5(450A)	Appeals
88.6(450A)	Generation skipping transfers prior to Public Law 99-514
88.7(421)	Applicability

CHAPTER 89  
FIDUCIARY INCOME TAX

89.1(422)	Administration
89.2(422)	Confidentiality
89.3(422)	Situs of trusts
89.4(422)	Fiduciary returns and payment of the tax
89.5(422)	Extension of time to file and pay the tax
89.6(422)	Penalties
89.7(422)	Interest or refunds on net operating loss carrybacks
89.8(422)	Reportable income and deductions
89.9(422)	Audits, assessments and refunds
89.10(422)	The income tax certificate of acquittance
89.11(422)	Appeals to the director

CHAPTER 90  
Reserved

TITLE XII  
MARIJUANA AND CONTROLLED  
SUBSTANCES STAMP TAX

CHAPTER 91  
ADMINISTRATION OF MARIJUANA AND  
CONTROLLED SUBSTANCES STAMP TAX

- 91.1(453B) Marijuana and controlled substances stamp tax
- 91.2(453B) Sales of stamps
- 91.3(453B) Refunds pertaining to unused stamps

CHAPTERS 92 to 96  
Reserved

TITLE XIII  
WATER SERVICE EXCISE TAX

CHAPTER 97  
STATE-IMPOSED WATER SERVICE EXCISE TAX

- 97.1(423G) Definitions
- 97.2(423G) Imposition
- 97.3(423G) Administration
- 97.4(423G) Charges and fees included in the provision of water service
- 97.5(423G) When water service is furnished for compensation
- 97.6(423G) Itemization of tax required
- 97.7(423G) Date of billing—effective date and repeal date
- 97.8(423G) Filing returns; payment of tax; penalty and interest
- 97.9(423G) Permits

CHAPTERS 98 to 101  
Reserved

TITLE XIV  
HOTEL AND MOTEL TAX

CHAPTER 102  
Reserved

CHAPTER 103  
STATE-IMPOSED AND LOCALLY IMPOSED HOTEL AND  
MOTEL TAXES

- 103.1(423A) Definitions
- 103.2(423A) Administration
- 103.3(423A) Tax imposition and exemptions
- 103.4(423A) Filing returns; payment of tax; penalty and interest
- 103.5(423A) Permits
- 103.6(423A) Special collection and remittance obligations
- 103.7(423A) Certification of funds

CHAPTERS 104 to 106  
Reserved

TITLE XV  
LOCAL OPTION SALES AND  
SERVICE TAX

CHAPTER 107  
LOCAL OPTION SALES AND SERVICES TAX

- 107.1(423B) Definitions
- 107.2(423B) Imposition of local option taxes and notification to the department
- 107.3(423B) Administration
- 107.4(423B) Filing returns; payment of tax; penalty and interest
- 107.5(423B) Permits
- 107.6(423B) Sales subject to local option sales and services tax
- 107.7(423B,423E) Sales not subject to local option tax, including transactions subject to Iowa use tax
- 107.8(423B) Local option sales and services tax payments to local governments
- 107.9(423B) Allocation procedure when sourcing of local option sales tax remitted to the department is unknown
- 107.10(423B) Application of payments
- 107.11(423B) Motor vehicle, recreational vehicle, and recreational boat rental subject to local option sales and services tax
- 107.12(423B) Computation of local option tax due from mixed sales on excursion boats

CHAPTER 108  
LOCAL OPTION SCHOOL INFRASTRUCTURE  
SALES AND SERVICE TAX

- 108.1(422E) Definitions
- 108.2(422E) Authorization, rate of tax, imposition, use of revenues, and administration
- 108.3(422E) Collection of the tax
- 108.4(422E) Similarities to the local option sales and service tax imposed in Iowa Code chapter 422B and 701—Chapter 107
- 108.5(422E) Sales not subject to local option tax, including transactions subject to Iowa use tax
- 108.6(422E) Deposits of receipts
- 108.7(422E) Local option school infrastructure sales and service tax payments to school districts
- 108.8(422E) Construction contract refunds
- 108.9(422E) 28E agreements

CHAPTER 109  
NEW SCHOOL INFRASTRUCTURE LOCAL OPTION SALES AND SERVICES TAX—  
EFFECTIVE ON OR AFTER APRIL 1, 2003, THROUGH FISCAL YEARS  
ENDING DECEMBER 31, 2022

- 109.1(422E) Use of revenues and definitions
- 109.2(422E) Imposition of tax
- 109.3(422E) Application of law
- 109.4(422E) Collection of tax and distribution
- 109.5(422E) Insufficient funds
- 109.6(422E) Use of revenues by the school district
- 109.7(422E) Bonds
- 109.8(422E) 28E agreements

CHAPTERS 110 to 119  
Reserved

TITLE XVI  
*REASSESSMENT EXPENSE FUND*

CHAPTER 120  
 REASSESSMENT EXPENSE FUND

- 120.1(421) Reassessment expense fund
- 120.2(421) Application for loan
- 120.3(421) Criteria for granting loan

CHAPTER 121  
 Reserved

TITLE XVII  
*ASSESSOR CONTINUING EDUCATION*

CHAPTER 122  
 ADMINISTRATION

- 122.1(441) Establishment
- 122.2(441) General operation
- 122.3(441) Location
- 122.4(441) Purpose

CHAPTER 123  
 CERTIFICATION

- 123.1(441) General
- 123.2(441) Confidentiality
- 123.3(441) Certification of assessors
- 123.4(441) Certification of deputy assessors
- 123.5(441) Type of credit
- 123.6(441) Retaking examination
- 123.7(441) Instructor credit
- 123.8(441) Conference board and assessor notification
- 123.9(441) Director of revenue notification

CHAPTER 124  
 COURSES

- 124.1(441) Course selection
- 124.2(441) Scheduling of courses
- 124.3(441) Petitioning to add, delete or modify courses
- 124.4(441) Course participation
- 124.5(441) Retaking a course
- 124.6(441) Continuing education program for assessors

CHAPTER 125  
 REVIEW OF AGENCY ACTION

- 125.1(441) Decisions final
- 125.2(441) Grievance and appeal procedures

CHAPTER 126  
 PROPERTY ASSESSMENT APPEAL BOARD

- 126.1(421,441) Applicability and definitions
- 126.2(421,441) Appeal and answer
- 126.3(421,441) Nonelectronic service on parties and filing with the board
- 126.4(421,441) Electronic filing system
- 126.5(421,441) Motions and settlements

- 126.6(421,441) Hearing scheduling and discovery plan
- 126.7(421,441) Discovery and evidence
- 126.8(421,441) Hearings before the board
- 126.9(421,441) Posthearing motions
- 126.10(17A,441) Judicial review
- 126.11(22,421) Records access

#### CHAPTERS 127 to 149

Reserved

#### TITLE XVIII DEBT COLLECTION

#### CHAPTER 150

##### FEDERAL OFFSET FOR IOWA INCOME TAX OBLIGATIONS

- 150.1(421,26USC6402) Purpose and general application of offset of a federal tax overpayment to collect an Iowa income tax obligation
- 150.2(421,26USC6402) Definitions
- 150.3(421,26USC6402) Prerequisites for requesting a federal offset
- 150.4(421,26USC6402) Procedure after submission of evidence
- 150.5(421,26USC6402) Notice by Iowa to the Secretary to request federal offset
- 150.6(421,26USC6402) Erroneous payments to Iowa
- 150.7(421,26USC6402) Correcting and updating notice to the Secretary

#### CHAPTER 151

##### COLLECTION OF DEBTS OWED THE STATE OF IOWA OR A STATE AGENCY

- 151.1(421) Definitions
- 151.2(421) Scope and purpose
- 151.3(421) Participation guidelines
- 151.4(421) Duties of the agency
- 151.5(421) Duties of the department—performance of collection
- 151.6(421) Payment of collected amounts
- 151.7(421) Reimbursement for collection of liabilities
- 151.8(421) Confidentiality of information
- 151.9(421) Subpoena of records from public or private utility companies

#### CHAPTER 152

##### DEBT COLLECTION AND SELLING OF PROPERTY TO COLLECT DELINQUENT DEBTS

- 152.1(421,422,626,642) Definitions
- 152.2(421,422,626,642) Sale of property
- 152.3(421,422,626,642) Means of sale

#### CHAPTER 153

##### LICENSE SANCTIONS FOR COLLECTION OF DEBTS OWED THE STATE OF IOWA OR A STATE AGENCY

- 153.1(272D) Definitions
- 153.2(272D) Purpose and use
- 153.3(272D) Challenge to issuance of certificate of noncompliance
- 153.4(272D) Use of information
- 153.5(272D) Notice to person of potential sanction of license
- 153.6(272D) Conference
- 153.7(272D) Issuance of certificate of noncompliance

153.8(272D)	Stay of certificate of noncompliance
153.9(272D)	Written agreements
153.10(272D)	Decision of the unit
153.11(272D)	Withdrawal of certificate of noncompliance
153.12(272D)	Certificate of noncompliance to licensing authority
153.13(272D)	Requirements of the licensing authority
153.14(272D)	District court hearing

## CHAPTER 154

CHALLENGES TO ADMINISTRATIVE LEVIES AND  
PUBLICATION OF NAMES OF DEBTORS

154.1(421)	Definitions
154.2(421)	Administrative levies
154.3(421)	Challenges to administrative levies
154.4(421)	Form and time of challenge
154.5(421)	Issues that may be raised
154.6(421)	Review of challenge
154.7(421)	Actions where there is a mistake of fact
154.8(421)	Action if there is not a mistake of fact
154.9 to 154.15	Reserved
154.16(421)	List for publication
154.17(421)	Names to be published
154.18(421)	Release of information

## CHAPTERS 155 to 210

Reserved

## TITLE XIX

*STREAMLINED SALES AND USE TAX RULES*

## CHAPTER 211

## DEFINITIONS

211.1(423)	Definitions
------------	-------------

## CHAPTER 212

ELEMENTS INCLUDED IN AND EXCLUDED  
FROM A TAXABLE SALE AND SALES PRICE

212.1(423)	Tax not to be included in price
212.2(423)	Finance charge
212.3(423)	Retailers' discounts, trade discounts, rebates and coupons
212.4(423)	Excise tax included in and excluded from sales price
212.5(423)	Trade-ins
212.6(423)	Installation charges when tangible personal property is sold at retail
212.7(423)	Service charge and gratuity
212.8(423)	Payment from a third party

## CHAPTER 213

## MISCELLANEOUS TAXABLE SALES

213.1(423)	Tax imposed
213.2(423)	Athletic events
213.3(423)	Conditional sales contracts
213.4(423)	The sales price of sales of butane, propane and other like gases in cylinder drums, etc.

- 213.5(423) Antiques, curios, old coins, collector's postage stamps, and currency exchanged for greater than face value
- 213.6(423) Communication services furnished by hotel to its guests
- 213.7(423) Consignment sales
- 213.8(423) Electrotypes, types, zinc etchings, halftones, stereotypes, color process plates, wood mounts and art productions
- 213.9(423) Explosives used in mines, quarries and elsewhere
- 213.10(423) Sales on layaway
- 213.11(423) Memorial stones
- 213.12(423) Creditors and trustees
- 213.13(423) Sale of pets
- 213.14(423) Redemption of meal tickets, coupon books and merchandise cards as a taxable sale
- 213.15(423) Rental of personal property in connection with the operation of amusements
- 213.16(423) Repossessed goods
- 213.17(423) Sales of signs at retail
- 213.18(423) Tangible personal property made to order
- 213.19(423) Used or secondhand tangible personal property
- 213.20(423) Carpeting and other floor coverings
- 213.21(423) Goods damaged in transit
- 213.22(423) Snowmobiles, motorboats, and certain other vehicles
- 213.23(423) Photographers and photostaters
- 213.24(423) Sale, transfer or exchange of tangible personal property or taxable enumerated services between affiliated corporations
- 213.25(423) Urban transit systems

#### CHAPTER 214

##### MISCELLANEOUS NONTAXABLE TRANSACTIONS

- 214.1(423) Corporate mergers which do not involve taxable sales of tangible personal property or services
- 214.2(423) Sales of prepaid merchandise cards
- 214.3(423) Demurrage charges
- 214.4(423) Beverage container deposits
- 214.5(423) Exempt sales by excursion boat licensees
- 214.6(423) Advertising agencies, commercial artists and designers as an agent or as a nonagent of a client

#### CHAPTER 215

##### REMOTE SALES AND MARKETPLACE SALES

- 215.1(423) Definitions
- 215.2(423) Retailers with physical presence in Iowa
- 215.3(423) Remote sellers—registration and collection obligations
- 215.4(423) Marketplace facilitators—registration and collection obligations
- 215.5(423) Advertising on a marketplace
- 215.6(423) Commencement of collection obligation and sales tax liability
- 215.7(423) Retailers registered and collecting who fail to meet or exceed sales threshold
- 215.8(423) Coupons; incorporation of rule 701—212.3(423)
- 215.9(423) Customer returns marketplace purchase directly to marketplace seller
- 215.10(423) Exempt and nontaxable sales
- 215.11(423) Other taxes for marketplace sales and items not subject to sales/use tax
- 215.12(423) Administration; incorporation of 701—Chapter 11

- 215.13(423) Filing returns; payment of tax; penalty and interest; incorporation of 701—Chapter 12
- 215.14(423) Permits; incorporation of 701—Chapter 13

CHAPTERS 216 to 218  
Reserved

CHAPTER 219

SALES AND USE TAX ON CONSTRUCTION ACTIVITIES

- 219.1(423) General information
- 219.2(423) Contractors—consumers of building materials, supplies, and equipment by statute
- 219.3(423) Sales of building materials, supplies, and equipment to contractors, subcontractors, builders or owners
- 219.4(423) Contractors, subcontractors or builders who are retailers
- 219.5(423) Building materials, supplies, and equipment used in the performance of construction contracts within and outside Iowa
- 219.6(423) Tangible personal property used or consumed by the manufacturer thereof
- 219.7(423) Prefabricated structures
- 219.8(423) Types of construction contracts
- 219.9(423) Machinery and equipment sales contracts with installation
- 219.10(423) Construction contracts with equipment sales (mixed contracts)
- 219.11(423) Distinguishing machinery and equipment from real property
- 219.12(423) Tangible personal property which becomes structures
- 219.13(423) Tax on enumerated services
- 219.14(423) Transportation cost
- 219.15(423) Start-up charges
- 219.16(423) Liability of subcontractors
- 219.17(423) Liability of sponsors
- 219.18(423) Withholding
- 219.19(423) Resale certificates
- 219.20(423) Reporting for use tax
- 219.21(423) Exempt sale, lease, or rental of equipment used by contractors, subcontractors, or builders

CHAPTERS 220 to 222  
Reserved

CHAPTER 223

SOURCING OF TAXABLE SERVICES, TANGIBLE PERSONAL PROPERTY, AND SPECIFIED DIGITAL PRODUCTS

- 223.1(423) Definitions
- 223.2(423) General sourcing rules for taxable services
- 223.3(423) First use of services performed on tangible personal property
- 223.4(423) Sourcing rules for personal care services
- 223.5(423) Sourcing of tickets or admissions to places of amusement, fairs, and athletic events
- 223.6(423) Sourcing rules for tangible personal property and specified digital products

CHAPTER 224

TELECOMMUNICATION SERVICES

- 224.1(423) Taxable telecommunication service and ancillary service
- 224.2(423) Definitions
- 224.3(423) Imposition of tax
- 224.4(423) Exempt from the tax

- 224.5(423) Bundled transactions in telecommunication service
- 224.6(423) Sourcing telecommunication service
- 224.7(423) General billing issues
- 224.8(34A) Prepaid wireless 911 surcharge
- 224.9(423) State sales tax exemption for central office equipment and transmission equipment

#### CHAPTER 225

#### RESALE AND PROCESSING EXEMPTIONS PRIMARILY OF BENEFIT TO RETAILERS

- 225.1(423) Paper or plastic plates, cups, and dishes, paper napkins, wooden or plastic spoons and forks, and straws
- 225.2(423) A service purchased for resale
- 225.3(423) Services used in the repair or reconditioning of certain tangible personal property
- 225.4(423) Tangible personal property purchased by a person engaged in the performance of a service
- 225.5(423) Maintenance or repair of fabric or clothing
- 225.6(423) The sales price from the leasing of all tangible personal property subject to tax
- 225.7(423) Certain inputs used in taxable vehicle wash and wax services
- 225.8(423) Exemption for commercial enterprises

#### CHAPTER 226

#### AGRICULTURAL RULES

- 226.1(423) Sale or rental of farm machinery and equipment and items used in agricultural production that are attached to a self-propelled implement of husbandry
- 226.2(423) Packaging material used in agricultural production
- 226.3(423) Irrigation equipment used in agricultural production
- 226.4(423) Sale of a draft horse
- 226.5(423) Veterinary services
- 226.6(423) Commercial fertilizer and agricultural limestone
- 226.7(423) Sales of breeding livestock
- 226.8(423) Domesticated fowl
- 226.9(423) Agricultural health promotion items
- 226.10(423) Drainage tile
- 226.11(423) Materials used for seed inoculations
- 226.12(423) Fuel used in agricultural production
- 226.13(423) Water used in agricultural production
- 226.14(423) Bedding for agricultural livestock or fowl
- 226.15(423) Sales by farmers
- 226.16(423) Sales of livestock (including domesticated fowl) feeds
- 226.17(423) Farm machinery, equipment, and replacement parts used in livestock or dairy production
- 226.18(423) Machinery, equipment, and replacement parts used in the production of flowering, ornamental, and vegetable plants
- 226.19(423) Nonexclusive lists

#### CHAPTERS 227 to 229

Reserved

CHAPTER 230  
EXEMPTIONS PRIMARILY BENEFITING MANUFACTURERS AND  
OTHER PERSONS ENGAGED IN PROCESSING

- 230.1 Reserved
- 230.2(423) Carbon dioxide in a liquid, solid, or gaseous form, electricity, steam, and taxable services used in processing
- 230.3(423) Services used in processing
- 230.4(423) Chemicals, solvents, sorbents, or reagents used in processing
- 230.5(423) Exempt sales of gases used in the manufacturing process
- 230.6(423) Sale of electricity to water companies
- 230.7(423) Wind energy conversion property
- 230.8(423) Exempt sales or rentals of core making and mold making equipment, and sand handling equipment
- 230.9(423) Chemical compounds used to treat water
- 230.10(423) Exclusive web search portal business and its exemption
- 230.11(423) Web search portal business and its exemption
- 230.12(423) Large data center business exemption
- 230.13(423) Data center business sales and use tax refunds
- 230.14(423) Exemption for the sale of computers, machinery, equipment, replacement parts, supplies, and materials used to construct or self-construct computers, machinery, equipment, replacement parts, and supplies used for certain manufacturing purposes if the sale occurs on or after July 1, 2016
- 230.15(423) Exemption for the sale of property directly and primarily used in processing by a manufacturer if the sale occurs on or after July 1, 2016
- 230.16(423) Exemption for the sale of property directly and primarily used by a manufacturer to maintain integrity or unique environmental conditions if the sale occurs on or after July 1, 2016
- 230.17(423) Exemption for the sale of property directly and primarily used in research and development of new products or processes of processing if the sale occurs on or after July 1, 2016
- 230.18(423) Exemption for the sale of computers used in processing or storage of data or information by an insurance company, financial institution, or commercial enterprise if the sale occurs on or after July 1, 2016
- 230.19(423) Exemption for the sale of property directly and primarily used in recycling or reprocessing of waste products if the sale occurs on or after July 1, 2016
- 230.20(423) Exemption for the sale of pollution-control equipment used by a manufacturer if the sale occurs on or after July 1, 2016
- 230.21(423) Exemption for the sale of fuel or electricity used in exempt property if the sale occurs on or after July 1, 2016
- 230.22(423) Exemption for the sale of services for designing or installing new industrial machinery or equipment if the sale occurs on or after July 1, 2016

CHAPTER 231  
EXEMPTIONS PRIMARILY OF BENEFIT TO CONSUMERS

- 231.1(423) Newspapers, free newspapers and shoppers' guides
- 231.2(423) Motor fuel, special fuel, aviation fuels and gasoline
- 231.3(423) Sales of food and food ingredients
- 231.4(423) Sales of candy
- 231.5(423) Sales of prepared food
- 231.6(423) Prescription drugs, medical devices, oxygen, and insulin
- 231.7(423) Exempt sales of other medical devices which are not prosthetic devices
- 231.8(423) Prosthetic devices, durable medical equipment, and mobility enhancing equipment

231.9(423)	Raffles
231.10(423)	Exempt sales of prizes
231.11(423)	Modular homes
231.12(423)	Access to on-line computer service
231.13(423)	Sale or rental of information services
231.14(423)	Exclusion from tax for property delivered by certain media
231.15(423)	Exempt sales of clothing and footwear during two-day period in August
231.16(423)	State sales tax phase-out on energies

## CHAPTERS 232 to 234

Reserved

## CHAPTER 235

## REBATE OF IOWA SALES TAX PAID

235.1(423)	Sanctioned automobile racetrack facilities
235.2(423)	Baseball and softball complex sales tax rebate
235.3(423)	Raceway facility sales tax rebate

## CHAPTER 236

Reserved

## CHAPTER 237

## REINVESTMENT DISTRICTS PROGRAM

237.1(15J)	Purpose
237.2(15J)	Definitions
237.3(15J)	New state tax revenue calculations
237.4(15J)	State reinvestment district fund
237.5(15J)	Reinvestment project fund
237.6(15J)	End of deposits—district dissolution

## CHAPTER 238

## FLOOD MITIGATION PROGRAM

238.1(418)	Flood mitigation program
238.2(418)	Definitions
238.3(418)	Sales tax increment calculation
238.4(418)	Sales tax increment fund

## CHAPTER 239

## LOCAL OPTION SALES TAX URBAN RENEWAL PROJECTS

239.1(423B)	Urban renewal project
239.2(423B)	Definitions
239.3(423B)	Establishing sales and revenue growth
239.4(423B)	Requirements for cities adopting an ordinance
239.5(423B)	Identification of retail establishments
239.6(423B)	Calculation of base year taxable sales amount
239.7(423B)	Determination of tax growth increment amount
239.8(423B)	Distribution of tax base and growth increment amounts
239.9(423B)	Examples
239.10(423B)	Ordinance term

CHAPTER 240  
RULES NECESSARY TO IMPLEMENT THE STREAMLINED SALES  
AND USE TAX AGREEMENT

- 240.1(423) Allowing use of the lowest tax rate within a database area and use of the tax rate for a five-digit area when a nine-digit zip code cannot be used
- 240.2(423) Permissible categories of exemptions
- 240.3(423) Requirement of uniformity in the filing of returns and remittance of funds
- 240.4(423) Allocation of bad debts
- 240.5(423) Purchaser refund procedures
- 240.6(423) Relief from liability for reliance on taxability matrix
- 240.7(423) Effective dates of taxation rate increases or decreases when certain services are furnished
- 240.8(423) Prospective application of defining “retail sale” to include a lease or rental

CHAPTER 241  
EXCISE TAXES NOT GOVERNED BY THE STREAMLINED SALES AND  
USE TAX AGREEMENT

- 241.1(423A,423D) Purpose of the chapter
- 241.2(423A,423D) Director’s administration

DIVISION I  
STATE-IMPOSED HOTEL AND MOTEL TAX

- 241.3 to 241.5 Reserved

DIVISION II  
EXCISE TAX ON SPECIFIC CONSTRUCTION MACHINERY AND EQUIPMENT

- 241.6(423D) Definitions
- 241.7(423D) Tax imposed
- 241.8(423D) Exemption

CHAPTER 242  
FACILITATING BUSINESS RAPID RESPONSE TO STATE-DECLARED DISASTERS

- 242.1(29C) Purpose
- 242.2(29C) Definitions
- 242.3(29C) Disaster or emergency-related work

CHAPTERS 243 to 249  
Reserved

CHAPTER 250  
SALES AND USE TAX REFUND FOR BIODIESEL PRODUCTION

- 250.1(423) Biodiesel production refund

CHAPTER 46  
WITHHOLDING

[Prior to 12/17/86, Revenue Department[730]]

**701—46.1(422) Who must withhold.**

**46.1(1) Requirement of withholding.**

*a. General rule.* Every employer maintaining an office or transacting business within this state and required under provisions of Sections 3401 to 3404 of the Internal Revenue Code to withhold and pay federal income tax on compensation paid for services performed in this state to an individual is required to deduct and withhold from such compensation for each payroll period (as defined in Section 3401(b) of the Internal Revenue Code) an amount computed in accordance with subrules 46.2(1) and 46.2(2). Iowa income tax is not required to be withheld on any compensation paid in this state of a character which is not subject to federal income tax withholding (whether or not such compensation is subject to withholding for federal taxes other than income tax, e.g., FICA taxes), except as provided in rule 701—46.4(422).

*b. Examples.* Paragraph “a” above may be illustrated by the following examples:

(1) Temporary help. A is a typist in the offices of B corporation, where she has worked regularly for two months. A is, however, supplied to B corporation by C, a temporary help agency located in Iowa. C renders a weekly bill to B corporation for A’s services, and C then pays A. B corporation is not A’s “employer” within Section 3401(d) of the Internal Revenue Code, and B corporation is therefore not required by the Internal Revenue Code to withhold a tax on A’s compensation. Since B corporation is not required to withhold a tax for federal purposes on A’s compensation, B is not required to do so for Iowa purposes. C, the temporary help agency, however, is required to withhold from A’s compensation for federal purposes and must also do so for Iowa purposes.

(2) Domestic help. A is employed as a cook by Mr. and Mrs. B. The B’s are required to withhold FICA (i.e., Social Security) tax from compensation paid to A, but are not required to withhold income tax from such compensation under the Internal Revenue Code, because under Section 3401(a)(3), A’s compensation does not constitute “wages”. Since the B’s are not required to withhold income tax for federal purposes, they are not required to do so for Iowa purposes.

(3) Executives. A is a corporate executive. On January 1, 1998, A entered into an agreement with B corporation under which he was to be employed by B in an executive capacity for a period of five years. Under the contract, A is entitled to a stated annual salary and to additional compensation of \$10,000 for each year. The additional compensation is to be credited to a bookkeeping reserve account and deferred, accumulated and paid in annual installments of \$5,000 on A’s retirement beginning January 1, 2003. In the event of A’s death prior to exhaustion of the account, the balance is to be paid to A’s personal representative. A is not required to render any service to B after December 31, 2002. During 2003, A is paid \$5,000 while a resident of Iowa. The \$5,000 is not excluded from “wages” under Section 3401(a) of the Internal Revenue Code; therefore, B is required to withhold federal income tax, and, since it is compensation paid in this state, B must withhold Iowa income tax on A’s deferred compensation.

(4) Agricultural labor. Wages paid for agricultural labor are subject to withholding for state income tax purposes to the same extent that the wages are subject to withholding for federal income tax purposes.

*c. Exemption from withholding.* An employer may be relieved of the responsibility to withhold Iowa income tax on an employee who does not anticipate an Iowa income tax liability for the current tax year.

An employee who anticipates no Iowa income tax liability for the current tax year shall file with the employer a withholding allowance certificate claiming exemption from withholding. An employee who meets this criterion may claim an exemption from withholding at any time; however, this exemption from withholding must be renewed by February 15 of each tax year that the criterion is met. If the employee wishes to discontinue or is required to revoke the exemption from withholding, the employee must file a new withholding allowance certificate within ten days from the date the employee anticipates a tax liability or on or before December 31 if a tax liability is anticipated for the next tax year. See subrule 46.3(2).

*d. Withholding from lottery winnings.* Every person, including employees and agents of the Iowa lottery authority, making any payment of “winnings subject to withholding” shall deduct and withhold a tax in an amount equal to 5 percent of the winnings. The tax shall be deducted and withheld upon payment of the winnings to a payee by the person or payer making this payment. Any person or payee receiving a payment of winnings subject to withholding must furnish the payer with a statement as is required under Treasury Regulation §31.3402(q)-1, paragraph “e,” with the information required by that paragraph. Payers of winnings subject to withholding must file Form W-2G with the Internal Revenue Service, the department of revenue, and the payee of the lottery winnings by the dates specified in the Internal Revenue Code and in Iowa Code section 422.16. The W-2G form shall include the information described in Treasury Regulation §31.3402(q)-1, paragraph “f.”

“Winnings subject to withholding” means any payment where the proceeds from a wager exceed \$600. The rules for determining the amount of proceeds from a wager under Treasury Regulation Section 31.3402(q)-1, paragraph “c,” shall apply when determining whether the proceeds from Iowa lottery winnings are great enough so that withholding is required. This rule shall apply to winnings from tickets purchased from the Powerball and Hot Lotto games or any other similar games to the extent the tickets were purchased within the state of Iowa.

*e. Withholding from prizes from games of skill, games of chance, or raffles.* Every person making any payment of a “prize subject to withholding” must deduct and withhold a tax in an amount equal to 5 percent of the prize from a game of skill, a game of chance, or a raffle. Effective July 1, 2015, any person making any payment of a “prize subject to withholding” for bingo must withhold tax in the same manner as persons making payments of prizes subject to withholding for games of skill, games of chance, or raffles. The tax must be deducted and withheld upon payment of the winnings to a payee by the person making this payment. Any person or payee receiving a payment of winnings subject to withholding must furnish the payer with a statement as is required under Treasury Regulation Section 31.3402(q)-1, paragraph “e,” with the information required by that paragraph. Payers of prizes subject to withholding must file Form W-2G with the Internal Revenue Service, the department of revenue, and the payee of the prize by the dates specified in the Internal Revenue Code and in Iowa Code section 422.16. The W-2G form must include the information described in Treasury Regulation Section 31.3402(q)-1, paragraph “f.”

“Prizes subject to withholding” means any payment of a prize where the amount won exceeds \$600.

*f. Withholding from winnings from pari-mutuel wagers.* Every person making any payment of “winnings subject to withholding” must deduct and withhold a tax in an amount equal to 5 percent of the winnings from pari-mutuel wagers. The tax must be deducted and withheld upon payment of the winnings to a payee by the person making this payment. Any person or payee receiving a payment of winnings subject to withholding must furnish the payer with a statement as is required under Treasury Regulation Section 31.3402(q)-1, paragraph “e,” with the information required by that paragraph. Payers of winnings subject to withholding must file Form W-2G with the Internal Revenue Service, the department of revenue, and the payee of the winnings by the dates specified in the Internal Revenue Code and in Iowa Code section 422.16. The W-2G form must include the information described in Treasury Regulation Section 31.3402(q)-1, paragraph “f.”

“Winnings subject to withholding” are winnings in excess of \$1,000.

*g. Withholding from winnings from slot machines on riverboat gambling vessels and from winnings from slot machines at racetracks.* Withholding of state income tax is required if the winnings from slot machines on riverboat gambling vessels or from slot machines at racetracks exceed \$1,200.

**46.1(2)** *Withholding on pensions, annuities and other nonwage payments to Iowa residents.* State income tax is required to be withheld from payments of pensions, annuities, supplemental unemployment benefits and sick pay benefits and other nonwage income payments made to Iowa residents in those circumstances mentioned in the following paragraphs. This subrule covers those nonwage payments described in Sections 3402(o), 3402(p), 3402(s), 3405(a), 3405(b), and 3405(c) of the Internal Revenue Code. This includes, but is not limited to, payments from profit-sharing plans, stock bonus plans, deferred compensation plans, individual retirement accounts, lump-sum distributions from qualified retirement plans, other retirement plans, and annuities, endowments and life insurance contracts issued by life

insurance companies. These payments are subject to Iowa withholding tax if they are also subject to federal withholding tax. However, no state income tax withholding is required from nonwage payments to residents to the extent those payments are not subject to state income tax. See paragraph 46.1(2) "h" for threshold amounts for withholding from payments of pensions, annuities, individual retirement accounts, deferred compensation plans, and other retirement incomes which are made on or after January 1, 2001. In the case of some nonwage payments to residents, such as payments of pensions and annuities, no state income tax is required to be withheld if no federal income tax is being withheld from the payments of the pensions and annuities. The rate of withholding on the nonwage payments described in this subrule is 5 percent of the payment amounts or 5 percent of the taxable amounts unless specified otherwise.

For purposes of this subrule, an individual receiving nonwage payments will be considered to be an Iowa resident and subject to this subrule if the individual's permanent residence is in Iowa. The fact that a nonwage payment is deposited in a recipient's account in a financial institution located outside Iowa does not mean that the recipient's permanent residence is established in the place where the financial institution is situated.

Payers of pension and annuity benefits and other nonwage payments have the option of either withholding Iowa income tax from these payments on the basis of tables and formulas included in the Iowa withholding tax guide of the department of revenue or withholding Iowa income tax from these payments at the rate of 5 percent. State income tax is required to be withheld by payers in situations when federal income tax is being withheld from the nonwage payments.

*a. Withholding from pension and annuity payments to residents.* Withholding of state income tax is required from payments of pensions and annuities to Iowa residents to the extent that the recipients of the payments have not filed with the payers of the benefits election forms which specify that no federal income tax is to be withheld. Therefore, state income tax is to be withheld when federal income tax is being withheld from the pensions or annuities. See paragraph 46.1(2) "h" for threshold amounts for withholding from payments of pensions, annuities, and other retirement incomes which are made on or after January 1, 2001.

However, although Iowa income tax is ordinarily required to be withheld from pension and annuity payments made to Iowa residents if federal income tax is being withheld from the payments, no state income tax is required to be withheld if pension and annuity payments are not subject to Iowa income tax, as in the case of railroad retirement benefits which are exempt from Iowa income tax by a provision of federal law.

*b. Withholding from payments to residents from profit-sharing plans, stock bonus plans, deferred compensation plans, individual retirement accounts and from annuities, endowments and life insurance contracts issued by life insurance companies.* Payments to Iowa residents from profit-sharing plans, stock bonus plans, deferred compensation plans, individual retirement accounts and payments from life insurance companies for contracts for annuities, endowments or life insurance benefits are subject to withholding of state income tax if federal income tax is withheld from the benefits. However, no state income tax is to be withheld from the income tax payments described above to the extent those income tax payments are exempt from Iowa income tax. See paragraph 46.1(2) "h" for thresholds for withholding from payments of pensions, annuities, individual retirement accounts, deferred compensation plans, and other retirement incomes which are made on or after January 1, 2001.

In cases where the recipients elect withholding of state income tax from the income payments, the payers are to withhold from the payments at a rate of 5 percent on the taxable portion of the payment, if that can be determined by the payer or on the entire income payment if the payer does not know how much of the payment is taxable. Once a recipient makes an election for state income tax withholding, that election will remain in effect until a later election is made.

*c. Withholding from payments to residents for supplemental unemployment compensation benefits and sick pay benefits.* Income payments made for supplemental unemployment compensation benefits described in Section 3402(o)(2)(a) of the Internal Revenue Code and for sick pay benefits are subject to withholding of state income tax. In the case of supplemental unemployment compensation benefits, those benefits are treated as wages for purposes of state income tax withholding. Therefore, state income tax should be withheld from these payments when federal income tax is withheld. The amount of state

income tax withholding should be determined by the withholding tables provided in the Iowa employers' "Withholding Tax Guide."

In the case of state income tax withholding for sick pay benefits paid by third-party payers in accordance with Section 3402(o)(1) of the Internal Revenue Code, state income tax is to be withheld from the benefits by the payer only if state income tax withholding is requested by the payee of the benefits. However, payees of sick pay benefits should probably not request withholding from the benefits if the payees are eligible for the disability income exclusion authorized in Iowa Code section 422.7 and described in rule 701—40.22(422). If withholding is requested by the payee, the withholding should be done at a 5 percent rate on the sick pay benefits. Once withholding is started, it should continue until such time as the payee requests that no state income tax be withheld. For sick pay benefits not paid by third-party payers, state income tax is required to be withheld since federal income tax is required to be withheld.

*d. Voluntary state income tax withholding from unemployment benefit payments.* Recipients of unemployment benefit payments described in Section 3402(p)(2) of the Internal Revenue Code may elect to have state income tax withheld from the benefit payments at a rate of 5 percent. An individual's election to have state income tax withheld from unemployment benefits is separate from any election to have federal income tax withheld from the benefits.

*e. Withholding on lump-sum distributions from qualified retirement plans.* For lump-sum distribution payments from qualified retirement plans made to Iowa residents, state income tax is required to be withheld under the conditions described in this paragraph. No state income tax is required to be withheld from a lump-sum distribution payment to an Iowa resident in a situation where the payment is not subject to Iowa income tax. See paragraph 46.1(2) "h" for thresholds for withholding on lump-sum distributions issued on or after January 1, 2001. Iowa income tax is to be withheld from a lump-sum distribution made to an Iowa resident to the extent that federal income tax is being withheld from the distribution. The rate of withholding of state income tax from the lump-sum distribution is 5 percent from the total distribution or 5 percent from the taxable amount if that amount is known by the payer. Note that in the case of a lump-sum distribution, the Iowa income tax imposed on the taxable amount of the distribution is 25 percent of the federal income tax on the distribution.

*f. Withholding of state income tax from nonwage payments to residents on the basis of tax tables and tax formulas.* State income tax from the nonwage payments made to Iowa residents may be withheld on the basis of formulas and tables included in the Iowa withholding tax guide of the department of revenue. See paragraph 46.1(2) "h" for threshold amounts for withholding from payments of pensions, annuities, individual retirement accounts, deferred compensation plans, and other retirement incomes which are made on or after January 1, 2001. When state income tax is being withheld based upon the formulas or tables in the withholding guide, the amounts of the nonwage payments are treated as wage payments for purposes of the tables or the formulas.

The frequency of the nonwage payments determines which of the withholding tables to use or the number of pay periods in the calendar year to use in the formula. For example, if the nonwage payment is made on a monthly basis, the monthly wage bracket withholding table should be utilized for withholding or 12 should be utilized in the formula to indicate that there will be 12 nonwage payments in the year.

The payers of nonwage payments should withhold state income tax from the nonwage payments to Iowa residents when federal income tax is being withheld from the nonwage payments. The payers should withhold from the nonwage payments to Iowa residents from tables or the formulas in the Iowa withholding guide on the basis of the number of withholding exemptions claimed on Form IA W-4 which has been completed by the payees of the payments. However, if a payee of a nonwage payment has not completed an IA W-4 form (Iowa employee's withholding allowance certificate) by the time a nonwage payment is to be made by the payer of the nonwage payment, the payer is to withhold state income tax on the basis that the payee has claimed one withholding allowance or exemption.

In a situation when a payee of a nonwage payment completes Form IA W-4 and claims exemption from state income tax withholding when federal income tax is being withheld from the nonwage payment, the payer of the nonwage payment should withhold state income tax using one withholding allowance or exemption unless the payee has verified exemption from state income tax.

*g. Withholding on distributions from qualified retirement plans that are not directly rolled over.* State income tax is to be withheld at a rate of 5 percent from the gross amount or taxable amount if known by the payer of the distribution made to Iowa residents if the distributions are not transferred directly to an IRA, Section 403(a) annuity or another qualified retirement plan. The distributions that are subject to state income tax withholding are those distributions that are subject to 20 percent withholding for federal income tax purposes. See paragraph 46.1(2) “h” for thresholds for withholding from payments of pensions, annuities, individual retirement accounts, deferred compensation plans, and other retirement plans which are made on or after January 1, 2001.

*h. Withholding from distributions made on or after January 1, 2001, from pensions, annuities, individual retirement accounts, deferred compensation plans, and other retirement plans.* Effective for distributions made on or after January 1, 2001, from pension plans, annuities, individual retirement accounts, deferred compensation plans, and other retirement plans, state income tax is generally required to be withheld from the distributions when federal income tax is being withheld from the distributions, unless one of the exceptions for withholding in this paragraph applies. For purposes of this paragraph, the term “pensions and other retirement plans” includes all distributions of retirement benefits covered by the partial exemption described in rule 701—40.47(422).

State income tax is not required to be withheld from a distribution from a pension or other retirement plan if the distribution is an income which is not subject to Iowa income tax, such as a distribution of railroad retirement benefits. State income tax is also not required to be withheld from a pension plan or other retirement plan if the amount of the distribution is \$500 per month or less or if the taxable amount is \$500 or less and the person receiving the distribution is eligible for the partial exemption of retirement benefits described in rule 701—40.47(422), if the state taxable amount can be determined by the payee of the distribution. There is also no requirement for withholding state income tax from a pension or other retirement plan if the distribution is \$1,000 per month or less or if the taxable amount is \$1,000 or less and the person receiving the distribution is eligible for the partial exemption of retirement benefits described in rule 701—40.47(422) and that person has indicated an intention to file a joint state income tax return for the year in which the distribution is made. In instances where the distribution amount or the taxable amount is more than \$500 per month but less than \$6,000 for the year, no state income tax will be required to be withheld, if the person receiving the distribution is eligible for the partial exemption of retirement benefits.

Finally, there is no requirement for withholding from a lump-sum payment from a qualified retirement plan if the lump-sum payment is \$6,000 or less, the recipient is eligible for the partial exemption of distributions from pensions and other retirement plans, and the lump-sum payment is the only distribution from the retirement plan in the year.

**46.1(3)** *Voluntary state income tax withholding from unemployment benefit payments.* Rescinded IAB 3/2/05, effective 4/6/05.

This rule is intended to implement Iowa Code sections 96.3, 99B.21, 99D.16, 99E.19, 99F.18, 422.5, 422.7, and 422.16.

[ARC 8589B, IAB 3/10/10, effective 4/14/10; ARC 1303C, IAB 2/5/14, effective 3/12/14; ARC 2512C, IAB 4/27/16, effective 6/1/16]

## **701—46.2(422) Computation of amount withheld.**

### **46.2(1) Amount withheld.**

*a. General rules.* Every employer required to deduct and withhold a tax on compensation paid in Iowa to an individual shall deduct and withhold for each payroll period an amount the total of which will approximate the employee’s annual tax liability. “Payroll period” for Iowa withholding purposes shall have the same definition as in Section 3401 of the Internal Revenue Code and shall include “miscellaneous payroll period” as that term is defined and used in that section and the associated regulations.

*b. Methods of computations.* Employers required to withhold Iowa income tax on compensation paid in this state shall compute the amount of tax to be withheld for each payroll period pursuant to the methods and rules provided herein.

(1) Tables. An employer may elect to use the withholding tables provided in the Iowa employers' withholding tax guide and withholding tables, which are available from the department of revenue.

(2) Formulas. Formulas that are provided in the Iowa employers' withholding tax guide and tax tables are available for employers who have a computerized payroll system.

(3) Other methods. An employer may request and be granted the use of an alternate method for computing the amount of Iowa tax to be deducted and withheld for each payroll period so long as the alternate proposal approximates the employee's annual Iowa tax liability. When submitting an alternate formula, the withholding agent should explain the formula and show examples comparing the amount of withholding under the proposed formula with the department's tables or computer formula at various income levels and by using various numbers of personal exemptions. Any alternate formula must be approved by the department prior to its use.

*c. Supplemental wage payments.* A supplemental wage payment is the payment of a bonus, commission, overtime pay, or other special payment that is made in addition to the employee's regular wage payment in a payroll period. When such supplemental wages are paid, the amount of tax required to be withheld shall be determined by using the current withholding tables or formulas. If supplemental wages are paid at the same time as regular wages, the regular tables or formulas are used in determining the amount of tax to be withheld as if the total of the supplemental and regular wages were a single wage payment for the regular payroll period. If supplemental wages are paid at any other time, the regular tables or formulas are used in determining the amount of tax to be withheld as if the supplemental wage were a single wage payment for the regular payroll period. When a withholding agent makes a payment of supplemental wages to an employee and the employer withholds federal income tax on a flat-rate basis, pursuant to Treasury Regulation §31.3402(g)-1, state income tax shall be withheld from the supplemental wages at a rate of 6 percent without consideration for any withholding allowances or exemptions.

*d. Vacation pay.* Amounts of so-called "vacation allowances" shall be subject to withholding as though they were regular wage payments made for the period covered by the vacation. If the vacation allowance is paid in addition to the regular wage payment for such period, the allowance shall be treated as supplemental wage payments.

**46.2(2) Correction of underwithholding or overwithholding.**

*a. Underwithholding.* If an employer erroneously underwithholds an amount of Iowa income tax required to be deducted and withheld from compensation paid to an employee within a payroll period, the employer should correct the error within the same calendar year by deducting the difference between the amount withheld and the amount required to be withheld from any compensation still owed the employee, even though such compensation may not be subject to withholding. If the error is discovered in a subsequent calendar year, no correction shall be made by the employer.

*b. Overwithholding.* If an employer erroneously overwithholds an amount of tax required to be deducted and withheld from compensation paid to an employee, repayment of such overwithheld amount shall be made in the same calendar year. Repayment may be made in either of two ways: (1) the amount of overwithholding may be repaid directly to the employee, in which case the employer must obtain written receipt showing the date and amount of the repayment, or (2) the employer may reimburse the employee by applying the overcollection against the tax required to be deducted and withheld on compensation to be paid in the same calendar year in which the overcollection occurred. If the error is discovered in a subsequent calendar year, no repayment shall be made.

*c. Cross-reference.* Rescinded IAB 3/2/05, effective 4/6/05.

**46.2(3) Withholding on supplemental wage payments.** Rescinded IAB 3/2/05, effective 4/6/05.

This rule is intended to implement Iowa Code section 422.16.

**701—46.3(422) Forms, returns and reports.**

**46.3(1) Employer registration.** Every employer or payer required to deduct and withhold Iowa income tax must register with the department of revenue by filing an "Iowa Business Tax Registration Form." The form shall indicate the employer's or payer's federal identification number. If an employer or payer has not received a federal employer's identification number, the department will issue a

temporary identification number. The employer or payer must notify the department when the federal employer identification number is assigned.

When initial payment of wages subject to Iowa withholding tax occurs late in the calendar quarter, or before the employer's or payer's federal employer's identification number is assigned by the Internal Revenue Service, the Iowa business tax registration form shall be forwarded along with the first quarterly withholding return. The responsible party(ies) shall be listed on the form.

If an employer deducts and withholds Iowa income tax but does not file the Iowa business tax registration form, the department may register the employer using the best information available. If an employer uses a service provider to report and remit Iowa withholding tax on behalf of the employer, the department may use information obtained from the service provider to register the employer if an Iowa business tax registration form is not filed. This information would include, but is not limited to, the name, address, federal employer's identification number, filing frequency, withholding agent and responsible party(ies) of the employer.

**46.3(2) Allowance certificate.**

*a. General rules.* On or before the date on which an individual commences employment with an employer, the individual shall furnish the employer with a signed Iowa employee's withholding allowance certificate (IA W-4) indicating the number of withholding allowances which the individual claims, which in no event shall exceed the number to which the individual is entitled. The employer is required to request a withholding allowance certificate from each employee. If the employee fails to furnish a certificate, the employee shall be considered as claiming no withholding allowances. See subrule 46.3(4) for information on Form IA W-4P which is to be used by payers of pensions, annuities, deferred compensation, individual retirement accounts and other retirement incomes.

The employer must submit to the department of revenue a copy of a withholding allowance certificate received from an employee if:

- (1) The employee claimed more than a total of 22 withholding allowances, or
- (2) The employee is claiming an exemption from withholding and it is expected that the employee's wages from that employer will normally exceed \$200 per week.

Employers required to submit withholding certificates should use the following address:

Iowa Department of Revenue  
Compliance Division  
Examination Section  
Hoover State Office Building  
P.O. Box 10456  
Des Moines, Iowa 50306

The department will notify the employer whether to honor the withholding certificate or to withhold as though the employee is claiming no withholding allowances.

*b. Form and content.* The "Iowa Employee's Withholding Allowance Certificate" (IA W-4) must be used to determine the number of allowances that may be claimed by an employee for Iowa income tax withholding purposes. Generally, the greater number of allowances an employee is entitled to claim, the lower the amount of Iowa income tax to be withheld for the employee. The following withholding allowances may be claimed on the IA W-4 form:

(1) Personal allowances. An employee can claim one personal allowance or two if the individual is eligible to claim head of household status. The employee can claim an additional allowance if the employee is 65 years of age or older and another additional allowance if the employee is blind.

If the employee is married and the spouse either does not work or is not claiming an allowance on a separate W-4 form, the employee can claim an allowance for the spouse. The employee may also claim an additional allowance if the spouse is 65 years of age or older and still another allowance if the spouse is blind.

(2) Dependent allowances. The employee can claim an allowance for each dependent that the employee will be able to claim on the employee's Iowa return.

(3) Allowances for itemized deductions. The employee can claim allowances for itemized deductions to the extent the total amount of estimated itemized deductions for the tax year for the

employee exceeds the applicable standard deduction amount by \$200. In instances where an employee is married and the employee's spouse is a wage-earner, the total allowances for itemized deductions for the employee and spouse should not exceed the aggregate amount itemized deduction allowances to which both taxpayers are entitled.

(4) Allowances for the child/dependent care credit. Employees who expect to be eligible for the child/dependent care credit for the tax year can claim withholding allowances for the credit. The allowances are determined from a chart included on the IA W-4 form on the basis of net income shown on the Iowa return for the employee. If the employee is married and has filed a joint federal return with a spouse who earns Iowa wages subject to withholding, the withholding allowances claimed by both spouses for the child/dependent care credit should not exceed the aggregate number of allowances to which both taxpayers are entitled. Taxpayers that expect to have a net income of \$45,000 or more for a tax year beginning on or after January 1, 2006, should not claim withholding allowances for the child and dependent care credit, since these taxpayers are not eligible for the credit.

(5) Allowances for adjustments to income. For tax years beginning on or after January 1, 2008, employees can claim allowances for adjustments to income which are set forth in Treasury Regulation §31.3402(m)-1, paragraph "b." This includes adjustments to income such as alimony, deductible IRA contributions, student loan interest and moving expenses which are allowed as deductions in computing income subject to Iowa income tax. In instances where an employee is married and the employee's spouse is a wage earner, the withholding allowances claimed by both spouses for adjustments to income for the employee and spouse should not exceed the aggregate number of allowances to which both taxpayers are entitled.

*c. Change in allowances which affect the current calendar year.*

(1) Decrease. If, on any day during the calendar year, the number of withholding allowances to which an employee is entitled is less than the number of withholding allowances claimed by the individual on a withholding certificate then in effect, the employee must furnish the employer with a new Iowa withholding allowance certificate relating to the number of withholding allowances which the employee then claims, which must in no event exceed the number to which the employee is entitled on such day.

(2) Increase. If, on any day during the calendar year, the number of withholding allowances to which an employee is entitled is more than the number of withholding allowances claimed by the employee on the withholding allowance certificate then in effect, the employee may furnish the employer with a new Iowa withholding allowance certificate on which the employee must in no event claim more than the number of withholding allowances to which the employee is entitled on such day.

*d. Change in allowances which affect the next calendar year.* If, on any day during the calendar year, the number of withholding allowances to which the employee will be, or may reasonably be expected to be, entitled to for the employee's taxable year which begins in, or with, the next calendar year is different from the number to which the employee is entitled on such day, the following rules shall apply:

(1) If such number is less than the number of withholding allowances claimed by an employee on an Iowa withholding allowance certificate in effect on such day, the employee must within a reasonable time furnish the employee's employer with a new withholding allowance certificate reflecting the decrease.

(2) If such number is greater than the number of withholding allowances claimed by the employee on an Iowa withholding allowance certificate in effect on such day, the employee may furnish the employee's employer with a new withholding allowance certificate reflecting the increase.

*e. Duration of allowance certificate.* An Iowa withholding allowance certificate which is in effect pursuant to these regulations shall continue in effect until another withholding allowance certificate takes effect. Employers should retain copies of the IA W-4 forms for at least four years.

**46.3(3) Reports and payments of income tax withheld.**

*a. Returns of income tax withheld from wages.*

(1) Quarterly returns. Every withholding agent required to withhold tax on compensation paid for personal services in Iowa shall make a return for the first calendar quarter in which tax is withheld and for each subsequent calendar quarter, whether or not compensation is paid therein, until a final return

is filed. The withholding agent's "Quarterly Withholding Return is the form prescribed for making the return required under this paragraph. Monthly tax deposits or semimonthly tax deposits may be required in addition to quarterly returns. See subparagraphs (2) and (3) of paragraph 46.3(3)"a." In some circumstances, only an annual return and payment of withheld taxes will be required; see paragraph 46.3(3)"c."

Payments shall be based upon the tax required to be withheld and must be remitted in full.

A withholding agent is not required to list the name(s) of the agent's employee(s) when filing quarterly returns, nor is the withholding agent required to show on the employee's paycheck or voucher the amount of Iowa income tax withheld.

If a withholding agent's payroll is not constant, and the agent finds that no wages or other compensation was paid during the current quarter, the agent shall enter the numeral "zero" on the return and submit the return as usual.

(2) Monthly deposits. Every withholding agent required to file a quarterly withholding return shall also file a monthly deposit if the amount of tax withheld during any calendar month exceeds \$500, but is less than \$10,000. A withholding agent needs to file a monthly deposit even if no payment is due. No monthly deposit is required for the third month in any calendar quarter. The information otherwise required to be reported on the monthly deposit for the third month in a calendar quarter shall be reported on the quarterly return filed for that quarter, and no monthly deposit need be filed for such month.

(3) Semimonthly deposits. Every withholding agent who withholds more than \$5,000 in a semimonthly period must file a semimonthly tax deposit. A semimonthly period is defined as the period from the first day of a calendar month through the fifteenth day of a calendar month, or the period from the sixteenth day of a calendar month through the last day of a calendar month. When semimonthly deposits are required, a withholding agent must still file a quarterly return.

(4) Final returns. A withholding agent who in any return period permanently ceases doing business shall file the returns required by subparagraphs (1), (2) and (3) of paragraph 46.3(3)"a" as final returns for such period. The withholding agent shall cancel the withholding tax registration by notifying the department.

*b. Time for filing returns.*

(1) Quarterly returns. Each return required by subparagraph 46.3(3)"a"(1) shall be filed on or before the last day of the first calendar month following the calendar quarter for which such return is made.

(2) Monthly tax deposits. Monthly deposits required by subparagraph 46.3(3)"a"(2) shall be filed on or before the fifteenth day of the second and third months of each calendar quarter for the first and second months of each calendar quarter, respectively.

(3) Semimonthly tax deposits. Semimonthly deposits required by subparagraph 46.3(3)"a"(3) for the semimonthly period from the first day of the month through the fifteenth day of the month shall be filed with payment of the tax on or before the twenty-fifth day of the same month. The semimonthly deposits required by subparagraph 46.3(3)"a"(3) for the semimonthly period from the sixteenth day of the month through the last day of the month shall be filed with payment of the tax on or before the tenth day of the month following the month in which the tax is withheld.

For withholding that occurs on or after January 1, 2005, quarterly returns, amended returns, monthly deposits and semimonthly deposits shall be made electronically in a format and by means specified by the department of revenue. Tax payments are considered to have been made on the date that the tax is transmitted and released by the vendor to the department.

(4) Determination of filing status. Effective July 1, 2002, the department and the department of management have the authority to change filing thresholds by department rule. This paragraph sets forth the filing thresholds for each filer based on the amount withheld for withholding that occurs on or after January 1, 2003.

The following criteria will be used by the department to determine if a change in filing status is warranted.

<u>Filing Status</u>	<u>Threshold</u>	<u>Test Criteria</u>
Semimonthly	Greater than \$120,000 in annual withholding taxes (more than \$5,000 in a semimonthly period).	Tax remitted in 3 of most recent 4 quarters examined exceeds \$30,000.
Monthly	Between \$6,000 and \$120,000 in annual withholding taxes (more than \$500 in a monthly period).	Tax remitted in 3 of most recent 4 quarters examined exceeds \$1,500 per quarter.
Quarterly	Less than \$6,000 in annual withholding taxes.	Tax remitted in 3 of most recent 4 quarters examined is less than \$1,500 per quarter.
Annual	Less than 3 employees.	

When it is determined that a withholding agent's filing status is to be changed, the withholding agent shall be notified in writing. A withholding agent has the option of requesting, within 30 days of the department's notice of a change in filing frequency, that the withholding agent file more or less frequently than required by the department. To request filing on a less frequent basis than assigned by the department, the request must be in writing and submitted to the department. A withholding agent's written request to be allowed to file less frequently than the filing status assigned by the department will be reviewed by the department, and a written determination will be issued to the withholding agent who made the request.

A change in assigned filing status to file on a less frequent basis will be granted in only two instances:

- Incorrect historical data is used in the conversion. A business may meet the criteria based on the original filing data, but, upon investigation, the filing history may prove that the business does not meet the dollar criteria because of adjustments, amended returns, or requests for refunds.
- Data available may have been distorted by the fact that the data reflected an unusual pattern in tax collection. The factors causing such a distortion must be documented and approved by the department.

A withholding agent may also request to file more frequently than assigned by the department. This request may be made orally, in writing, in person, or by telephone.

The department and the department of management may perform review of filing thresholds every five years or as needed based on department discretion. Factors the departments will consider in determining if the filing thresholds need to be changed include, but are not limited to: tax rate changes, inflation, the need to maintain consistency with required multistate compacts, changes in law, and migration between filing brackets.

*c. Reporting annual withholding.*

(1) Any withholding agent who does not have employee withholding but who is required to withhold state income tax from other distributions is exempted from the provisions of subparagraphs (2) and (3) of paragraph 46.3(3) "a," if these distributions are made annually in one calendar quarter. These withholding agents need only comply with the reporting requirements of the one calendar quarter in which the tax is withheld, and make the required year-end reports.

(2) Every withholding agent employing not more than two individuals and who expects to employ either or both for the full calendar year may pay with the withholding tax return due for the first calendar quarter of the year the full amount of income taxes which would be required to be withheld from the wages for the full calendar year. The withholding agent shall advise the department of revenue that annual reporting is contemplated and shall also state the number of persons employed. The withholding agent shall compute the annual withholding from wages by determining the normal withholding for one pay period and multiply this amount by the total number of pay periods within the calendar year. The withholding agent shall be entitled to recover from the employee(s) any part of such lump-sum payment that represents an advance to the employee(s). If a withholding agent pays a lump sum with the first quarterly return, the agent shall be excused from filing further quarterly returns for the calendar year

involved unless the agent hires other or additional employees. The “Verified Summary of Payments Report” shall be filed at the end of the tax year.

*d. Reports for employee.*

(1) General rule. Every employer required to deduct and withhold tax from compensation of an employee must furnish to each employee with respect to the compensation paid in Iowa by such employer during the calendar year, a statement containing the following information: the name, address, and federal employer identification number of the employer; the name, address, and social security number of the employee; the total amount of compensation paid in Iowa; the total amount deducted and withheld as tax under subrule 46.1(1).

(2) Form of statement. The information required to be furnished an employee under the preceding paragraph shall be furnished on an Internal Revenue Service combined Wage and Tax Statement, Form W-2, hereinafter referred to as “combined W-2.” Any reproduction, modification or substitution for a combined W-2 by the employer must be approved by the department. Employers should keep copies of the combined W-2 for four years from the end of the year for which the combined W-2 applies.

(3) Time for furnishing statement. Each statement required by paragraph “d” to be furnished for a calendar year and each corrected statement required for any prior year shall be furnished to the employee on or before February 15 of the year succeeding such calendar year, or if an employee’s employment is terminated before the close of a calendar year without expectation that it will resume during the same calendar year, within 30 days from the day on which the last payment of compensation is made, if requested by such employee. See paragraph 46.3(3) “e” for provisions relating to the filing of copies of the combined W-2 with the department of revenue.

(4) Corrections. An employer must furnish a corrected combined W-2 to an employee if, after the original statement has been furnished, an error is discovered in either the amount of compensation shown to have been paid in Iowa for the prior year or the amount of tax shown to have been deducted and withheld in the prior year. Such statement shall be marked “corrected by the employer.” See paragraph 46.3(3) “e” for provisions relating to the filing of a corrected combined W-2 with the department.

(5) Undelivered combined W-2. Any employee’s copy of the combined W-2 which, after reasonable effort, cannot be delivered to an employee shall be transmitted to the department with a letter of explanation.

(6) Lost or destroyed. If the combined W-2 is lost or destroyed, the employer shall furnish a substitute copy to the employee. The copy shall be clearly marked “Reissued by Employer.”

*e. Annual verified summary of payments reports.*

(1) Every withholding agent required to withhold Iowa income tax under subrules 46.1(1), 46.1(2), 46.1(3), and 46.4(1) is to furnish to the department of revenue on or before February 15 following the tax year an annual Verified Summary of Payments Report (VSP).

The withholding agent completing the VSP form must enter the total Iowa income tax withheld that is shown on the W-2 forms and 1099 forms for the year, the new jobs credits, supplemental jobs credits, accelerated career education credits and housing assistance credits claimed on withholding returns for the year. In addition, the withholding agent must enter on the VSP the withholding payments made for the year. If the amount of Iowa income tax withholding remitted to the department of revenue for the year is less than the withholding tax and withholding credits claimed, the withholding agent is to report the additional withholding tax due on an amended return and submit payment to the department.

If the Iowa income tax shown as withheld on the W-2s and 1099s issued for the tax year is less than the amount of withholding tax remitted to the department of revenue by the withholding agent, the agent should file an amended return with the department reflecting the excess tax paid.

(2) For Verified Summary of Payments Report forms filed with the department of revenue for the year 2000 through the year 2016, the withholding agents are not to submit W-2 forms and 1099 forms with the reports. However, the withholding agents should supply W-2 forms or 1099 forms as requested by personnel of the department of revenue if the request for the forms is made within three years from the end of the year for which the W-2 forms or 1099 forms apply. Therefore, if a request is made to a withholding agent for a W-2 form or a 1099 form for the year 2013, the request is valid if the request is postmarked, faxed or made on or before December 31, 2016.

(3) Penalty. Failure to meet the filing requirements set out in this paragraph will subject withholding agents to the penalties under Iowa Code section 422.16(10).

*f. W-2 forms.*

(1) For tax year 2019 and all subsequent tax years, all withholding agents are required to electronically file W-2 forms for employees from whom tax was withheld with the department of revenue on or before February 15 following the tax year.

(2) The department of revenue may, in a case involving a hardship, extend the requirement to electronically file to the 2020 tax year. No extension of time shall be granted unless the withholding agent makes a written request to the department of revenue for such action.

(3) Penalty. Failure to meet the filing requirements set out in this paragraph will subject withholding agents to the penalties under Iowa Code section 422.16(10).

*g. 1099 forms and W-2G forms.*

(1) For tax year 2019 and all subsequent tax years, all withholding agents are required to electronically file all 1099 forms and W-2G forms for persons from whom tax was withheld on or before February 15 following the tax year.

(2) The department of revenue may, in a case involving a hardship, extend the requirement to electronically file to the 2020 tax year. No extension of time shall be granted unless the withholding agent makes a written request to the department of revenue for such action.

(3) Penalty. Failure to meet the filing requirements set out in this paragraph will subject withholding agents to the penalties under Iowa Code section 422.16(10).

*h. Withholding deemed to be held in trust.* Funds withheld from wages for Iowa income tax purposes are deemed to be held in trust for payment to the department of revenue. The state and the department shall have a lien upon all the assets of the employer and all the property used in the conduct of the employer's business to secure the payment of the tax as withheld under the provisions of this rule. An owner, conditional vendor, or mortgagee of property subject to such lien may exempt the property from the lien granted to Iowa by requiring the employer to obtain a certificate from the department, certifying that such employer has posted with the department security for the payment of the amounts withheld under this rule.

*i. Payment of tax deducted and withheld.* The amount of tax shown to be due on each deposit or return required to be filed under subrule 46.3(3) shall be due on or before the date on which such deposit or return is required to be filed.

*j. Correction of underpayment or overpayment of taxes withheld.*

(1) Underpayment. If a return is filed for a return period under rule 701—46.3(422) and less than the correct amount of tax is reported on the return and paid to the department, the employer shall report and pay the additional amount due by filing an amended withholding tax return.

(2) Overpayment. If an employer remits more than the correct amount of tax for a return period, the employer must file an amended withholding tax return and request a refund of the withholding tax paid which was not due.

**46.3(4) Iowa W-4P—withholding certificate for pension or annuity payments.** For payments made from pension plans, annuity plans, individual retirement accounts, or deferred compensation plans to residents of Iowa, payers of these retirement benefits are to use Form IA W-4P for withholding of state income tax from the benefits. Generally, state income tax is required to be withheld from payments of distributions from the retirement incomes described above when federal income tax is being withheld from the payments. However, no state income tax is required to be withheld to the extent the monthly payment amount is \$500 or less or the taxable amount per month is \$500 or less if the payee is eligible for the retirement benefits exclusion described in rule 701—40.47(422). In addition, no state income tax is required to be withheld to the extent the monthly payment amount is \$1,000 or less or the taxable amount per month is \$1,000 or less if the payee is married and eligible for the retirement benefits exclusion described in rule 701—40.47(422).

Form IA W-4P is available from the department for payers of retirement benefits that intend to withhold at a rate of 5 percent from the payment amount or taxable payment amount after the \$6,000 to \$12,000 exclusion is considered. Note that the \$6,000 to \$12,000 exclusion is to be allocated to all

retirement benefit payments made in the year and not just the first \$6,000 to \$12,000 in payments made in the year to an individual. If an individual receives retirement benefits and has not completed Form IA W-4P, the payer is directed to withhold Iowa income tax from the retirement benefit payment after a \$6,000 exclusion is allowed on an annual basis.

Payers of retirement benefits that want to use withholding formulas or tables to withhold state income tax instead of at the 5 percent rate may design their own IA W-4P withholding certificate form without approval of the department.

The payers are not responsible for improper choices made by a payee in completion of the IA W-4P. However, payers cannot accept a request for exemption from the withholding of state income tax made by a payee if federal income tax is being withheld unless the payee is eligible for exemption from withholding.

This rule is intended to implement Iowa Code sections 422.7 and 422.12C, and section 422.16 as amended by 2007 Iowa Acts, House File 904, section 3.

[ARC 8589B, IAB 3/10/10, effective 4/14/10; ARC 2739C, IAB 9/28/16, effective 11/2/16; ARC 3429C, IAB 10/25/17, effective 11/29/17; ARC 4678C, IAB 9/25/19, effective 10/30/19]

### **701—46.4(422) Withholding on nonresidents.**

**46.4(1) General rules.** Payers of Iowa income to nonresidents are required to withhold Iowa income tax and to remit the tax to the department on all payments of Iowa income to nonresidents except payments of wages to nonresidents engaged in film production or television production described in subrule 46.4(5); income payments for agricultural commodities or products described in subrule 46.4(6); deferred compensation payments, pension, and annuity payments attributable to personal services in Iowa by nonresidents described in subrule 46.4(7); and partnership distributions from certain publicly traded partnerships described in subrule 46.4(8). Withholding agents should use the following methods and rates in withholding for nonresidents:

*a. Wages or salaries.* Use the same withholding procedures, tables, formulas, and rates as are used for residents. See rule 701—46.2(422). Subrule 46.4(5) is an exception to the general rule. In addition, in accordance with the reciprocal tax agreement between Iowa and Illinois described in 701—subrule 38.13(1), Iowa withholding tax is not withheld on wages of Illinois residents who perform personal services in Iowa.

*b. Payments other than wages, salaries, and other compensation for personal services.* In lieu of using withholding tables or computer formulas to determine the amount of Iowa income tax to be withheld from payments made to nonresidents other than for salaries, wages, or other compensation for personal services, or income payments to nonresidents for agricultural commodities or products, Iowa income tax should be withheld at a rate of 5 percent of the amount of the payment. Subrule 46.4(6) describes the optional exemption from withholding of income payments made to nonresidents for the sale of agricultural commodities or products.

Nonresidents who prefer to make Iowa estimate payments instead of having Iowa income tax withheld from income payments from Iowa sources should refer to subrule 46.4(3) and rule 701—49.3(422).

**46.4(2) Income of nonresidents subject to withholding.** Listed below are various types of income paid to nonresidents which are subject to withholding tax. The list is for illustrative purposes only and is not deemed to be all-inclusive.

1. Personal service, including salaries, wages, commissions and fees for personal service wholly performed within this state and such portions of similar income of nonresident traveling salespersons or agents as may be derived from services rendered in this state.
2. Rents and royalties from real or personal property located within this state.
3. Interest or dividends derived from securities or investments within this state, when such interests or dividends constitute income of any business, trade, profession or occupation carried on within this state and subject to taxation.
4. Income derived from any business of a temporary nature carried on within this state by a nonresident, such as contracts for construction and similar contracts.

5. The distributive share of a nonresident beneficiary of an estate or trust, limited, however, to the portion thereof subject to Iowa income tax in the hands of the nonresident.

6. Income derived from sources within this state by attorneys, physicians, engineers, accountants, and similar sources as compensation for services rendered to clients in this state.

7. Compensation received by nonresident actors, singers, performers, entertainers, and wrestlers for performances in this state. See subrule 46.4(5) for an exception to this rule.

8. Income received by a nonresident partner or shareholder of a partnership or S corporation doing business in Iowa. See subrule 46.4(8) for the exemption from withholding for partnership distributions from certain publicly traded partnerships.

9. The Iowa gross income of a nonresident who is employed and receiving compensation for services shall include compensation for personal services which are rendered within this state. Compensation for personal services rendered by a nonresident wholly without the state is excluded from gross income of the nonresident even though the payment of such compensation may be made by a resident individual, partnership or corporation.

10. The gross income from commissions earned by a nonresident traveling salesperson, agent or other employee for services performed or sales made whose compensation depends directly on volume of business transacted by the nonresident, includes that proportion of the total compensation received which the volume of business or sales by the employee within this state bears to the total volume of business or sales within and without the state.

11. Payments made to landlords by agents, including elevator operators, for grain or other commodities which have been received by the landlord as rent constitute taxable income of the landlord when sold by the landlord. See subrule 46.4(6) for the exemption from withholding on incomes paid to nonresidents for the sale of agricultural commodities or products.

12. Wages paid to nonresidents of Iowa who earn the compensation from regularly assigned duties in Iowa and one or more other states for a railway company or for a motor carrier are not taxable to Iowa. Pursuant to the Amtrak Reauthorization and Improvement Act of 1990, the nonresidents in this situation are subject only to the income tax laws of their states of residence. Thus, when an Iowa resident performs regularly assigned duties in two or more states for a railroad or a motor carrier, the only state income tax that should be withheld from the wages paid for these duties is Iowa income tax.

13. Wages paid to nonresidents of Iowa who earn compensation from regularly assigned duties in Iowa and one or more states for an airline company. In accordance with Public Law 103-272 enacted by Congress, airline employees who are nonresidents of Iowa are subject only to the income tax laws of their states of residence or the state in which they perform 50 percent or more of their duties.

14. Wages paid to nonresidents of Iowa who earn compensation from regularly assigned duties in Iowa for a merchant marine company. In accordance with Public Law 106-489 enacted by Congress, interstate waterway workers who are nonresidents of Iowa are subject only to the income tax laws of their states of residence.

**46.4(3) *Nonresident certificate of release.*** Where a nonresident payee makes the option to pay estimated Iowa income tax, a certificate of release from withholding will be issued by the Iowa department of revenue to the designated payers. The certificate of release will be forwarded to the specified withholding agent(s) and payer(s), and will state the amount of income covered by the estimated tax payment. Any income paid in excess of the amount so stated will be subject to withholding tax at the current rate. See 701—Chapter 49 for information on making estimate payments.

**46.4(4) *Recovering excess tax withheld.*** A nonresident payee may recover any excess Iowa income tax withheld from income of the payee by filing an Iowa income tax return after the close of the tax year and reporting income from Iowa sources in accordance with the income tax return instructions.

**46.4(5) *Exemption from withholding of nonresidents engaged in film production or television production in this state.*** Nonresidents engaged in film production or television production in this state are not subject to state withholding on wages earned from this activity if the nonresidents' employer has applied to the department for exemption from withholding of state income tax and the employer's application includes the following information about the nonresident employees:

a. The employees' names.

- b. The employees' permanent mailing addresses.
- c. The employees' social security numbers.
- d. The estimated amounts the employees are to be paid for services provided by the employees in this state.

The employer's application for exemption from withholding for the nonresident employees will not be approved by the department if the employer fails to provide all the required information.

Only those nonresident employees described in the application for exemption from withholding will be covered when the application is approved by the department. If additional nonresident employees are hired after the initial application for exemption is filed, those employees should be described in an amendment to the application for exemption which must be filed with the department of revenue.

Applications for exemption from withholding for nonresident employees engaged in film production or television production should be directed to the Iowa Department of Revenue, Compliance Division, Examination Section, Hoover State Office Building, P.O. Box 10456, Des Moines, Iowa 50306.

**46.4(6) Exemption from withholding for the sale of agricultural commodities or products.** Withholding agents are not required to withhold state income tax from income payments made to nonresidents or representatives of the nonresidents for the sales of agricultural commodities or products, if the withholding agents provide certain information to the department of revenue about the sales. The following paragraphs describe the agricultural commodities and products that are included in the exemption from withholding, specify the information needed on the sales and clarify other issues related to the exemption from withholding. 701—subrule 49.3(4) describes an election for withholding agents to make estimate payments on behalf of nonresident taxpayers for net incomes of the nonresidents from agricultural commodities or products.

a. Agricultural commodities or products included in the exemption from withholding. Withholding agents are not required to withhold state income tax from income payments they make to nonresidents or representatives of the nonresidents for the sale of commodity credit certificates, grain (corn, soybeans, wheat, oats, etc.), livestock (cattle, hogs, sheep, horses, etc.), domestic fowl (chickens, ducks, turkeys, geese, etc.), or any other agricultural commodities or products, if the withholding agents provide the department of revenue with the information specified in paragraph "b" of this subrule.

b. Information to be provided to the department by withholding agents claiming exemption from withholding on income payments made to nonresidents for the sales of agricultural items. The following information is to be provided on a listing to the department of revenue by withholding agents electing exemption from withholding of state income tax on income payments made in the calendar year to nonresidents or representatives of the nonresidents on the sales of agricultural commodities or products made in the year:

- (1) Name of the nonresident (last name, first name and middle initial).
- (2) Home address of the nonresident.
- (3) Social security number of the nonresident.
- (4) Aggregate payments made in the calendar year for the nonresident (includes payments made to a representative of the nonresident on behalf of the nonresident).
- (5) Two-digit Iowa county code number of the first one of the following that applies to the nonresident:
  1. County in which the nonresident owns real property or personal property.
  2. County in which the nonresident leases real property or personal property.
  3. County in which the nonresident has agricultural products stored or in which livestock is located.
  4. County where the nonresident has performed custom farming activities in the year.
  5. County where the nonresident has other business activities in Iowa other than merely sales activities.

If a nonresident does not own or lease property in Iowa or have other connection with Iowa as described in subparagraph 46.4(6)"b"(5), items "3," "4," and "5," the nonresident is not subject to Iowa income tax on the income payments for agricultural commodities or products and the nonresident's income payments should not be included on the listing.

In a situation where a withholding agent is unable to get all the information that is to be provided to the department on income payments on sales of agricultural items, the agent is relieved of the requirement to withhold if the agent can provide written evidence showing an attempt was made to acquire all the information.

The listing of aggregate income payments to nonresidents with an Iowa connection for sales of agricultural commodities and products in the calendar year should be sent to the department by the withholding agent on or before April 1 of the year following the year in which the income payments were made. In lieu of the listing, the withholding agent may compile the information on aggregate income payments to nonresidents on a magnetic tape, diskette or other electronic reporting, provided the submission meets departmental guidelines described in 701—paragraph 8.3(1) “e.”

The listing, magnetic tape or other electronic submission should be sent to the following address: Iowa Department of Revenue, Compliance Division, Examination Section, Hoover State Office Building, P.O. Box 10456, Des Moines, Iowa 50306; [idr@iowa.gov](mailto:idr@iowa.gov).

A withholding agent is not exempt from withholding of state income tax on income payments to nonresidents on sales of agricultural commodities or products if the withholding agent does not provide the department of revenue with information on income payments made during the year by April 1 of the subsequent year.

c. Rescinded IAB 3/2/05, effective 4/6/05.

**46.4(7)** *Exemption from withholding of payments made to nonresidents for deferred compensation, pensions, and annuities.* Iowa income tax withholding is not required from payments of deferred compensation, pensions, and annuities made to nonresidents which are attributable to personal services of the nonresidents in Iowa since these payments are not subject to Iowa income tax. See rule 701—40.45(422) for the exclusion from Iowa income tax for these payments received by nonresidents.

**46.4(8)** *Exemption from withholding of partnership distributions made to nonresidents of certain publicly traded partnerships.* For tax years beginning on or after January 1, 2008, a nonresident who is a partner in a publicly traded partnership as defined in Section 7704(b) of the Internal Revenue Code is not subject to state withholding tax on the partner’s pro rata share, provided that the publicly traded partnership submits the following information to the department for each partner whose Iowa income from the partnership exceeded \$500:

- a. Partner’s name.
- b. Partner’s address.
- c. Partner’s taxpayer identification number.
- d. Partner’s pro rata share of Iowa income from the partnership for the tax year.

A partnership is a publicly traded partnership if the interests in the partnership are traded on an established securities market or the interests in the partnership are readily traded on a secondary market or its substantial equivalent.

**46.4(9)** *Exemption from withholding of payments made to an out-of-state business or out-of-state employee due to state-declared disaster.* On or after January 1, 2016, see 701—Chapter 242 for withholding requirements of an out-of-state business or out-of-state employee who enters Iowa to perform disaster and emergency-related work during a disaster response period as those terms are defined in Iowa Code section 29C.24.

This rule is intended to implement Iowa Code section 422.15, Iowa Code section 422.16 as amended by 2007 Iowa Acts, House File 923, section 3, and Iowa Code sections 422.17 and 422.73.  
[ARC 7761B, IAB 5/6/09, effective 6/10/09; ARC 3085C, IAB 5/24/17, effective 6/28/17]

#### **701—46.5(422) Penalty and interest.**

**46.5(1)** *Penalty.* See rule 701—10.6(421) for penalty for tax periods beginning on or after January 1, 1991. See rule 701—10.8(421) for statutory exemptions to penalty for tax periods beginning on or after January 1, 1991.

**46.5(2)** *Computation of interest on unpaid tax.* Interest shall accrue on tax due from the original due date of the return. Interest on refunds of any portion of the tax imposed by statute which has been erroneously refunded and which is recoverable by the department shall bear interest as provided by law

from the date of payment of the refund, with each fraction of a month considered to be an entire month. See rule 701—10.2(421) for the statutory interest rate.

All payments shall be first applied to the penalty and then to the interest, and the balance, if any, to the amount of tax due.

**46.5(3) Computation of interest on overpayments.** If the amount of tax determined to be due by the department is less than the amount paid, the excess to be refunded will accrue interest from the first day of the second calendar month following the date of payment or the date the return was due to be filed or was filed, whichever is the later.

This rule is intended to implement Iowa Code sections 421.27, 422.16 and 422.25.

**701—46.6(422) Withholding tax credit to workforce development fund.** Upon payment in full of a certificate of participation or other obligation issued to fund a job training program under Iowa Code chapter 260E, the community college which provided the training is to notify the economic development authority of the amount paid by the employer or business to the community college during the previous 12 months. The economic development authority is to notify the department of revenue of this amount. The department is to credit 25 percent of this amount to the workforce development fund in each quarter for the next ten years from the withholding tax paid by the employer or business. If the withholding tax paid by the employer or business for a quarter is not sufficient to cover the sum to be credited to the workforce development fund, the sum to be credited is to be reduced accordingly. The aggregate amount from all employers to be transferred to the workforce development fund in a year is not to exceed \$4 million for fiscal years beginning on or after July 1, 2001, but before July 1, 2014. The aggregate amount is not to exceed \$5,750,000 for the fiscal year beginning July 1, 2014, and the aggregate amount is not to exceed \$6,000,000 for fiscal years beginning on or after July 1, 2015.

This rule is intended to implement Iowa Code section 422.16A as amended by 2014 Iowa Acts, House File 2460.

[ARC 1665C, IAB 10/15/14, effective 11/19/14]

**701—46.7(422) ACE training program credits from withholding.** The accelerated career education (ACE) program is a training program administered by the Iowa department of economic development to provide technical training in state community colleges for employees in highly skilled jobs in the state to the extent that the training is authorized in an agreement between an employer or group of employers and a community college for the training of certain employees of the employer or group of employers. If a community college and an employer or group of employers enter into a program agreement for ACE training, a copy of the agreement is to be sent to the department of revenue. No costs incurred prior to the date of the signing between a community college and an employer or group of employers may be reimbursed or are eligible for program job credits, including job credits from withholding unless the costs are incurred on or after July 1, 2000.

**46.7(1)** The costs of the ACE training program may be paid from the following sources:

- a.* Program job credits which the employer receives on the basis of the number of program job positions agreed to by the employer for the training program;
- b.* Cash or in-kind contributions by the employer toward the costs of the program which must be at least 20 percent of the total cost of the program;
- c.* Tuition, student fees, or special charges fixed by the board of directors of the community college to defray costs of the program;
- d.* Guarantee by the employer of payments to be received under paragraphs “*a*” and “*b*” of this subrule.

This rule pertains only to the program job credits from withholding described in paragraph “*a*.”

**46.7(2)** ACE training programs financed by job credits from withholding. In situations when an employer or group of employers and a community college have entered into an agreement for training under the ACE program and the agreement provides that the training will be financed by credits from withholding, the amount of funding will be determined by the program job credits identified in the agreement. Eligibility for the program job credits is based on certification of program job positions

and program job wages by the employer at the time established in the agreement with the community college. An amount of up to 10 percent of the gross program job wage as certified by the employer in the agreement shall be credited from the total amount of Iowa income tax withheld by the employer. For example, if there were 20 employees designated to be trained in the agreement and their gross wages were \$600,000, the gross program job wage would be \$600,000. Therefore, 10 percent of the gross program job wage in this case would be \$60,000, and this amount would be credited against Iowa income tax which would ordinarily be withheld from the wages of all employees of the employer and remitted to the department of revenue on a quarterly basis. The amount credited against the withholding tax liability of the employer would be paid to the community college training the employer's employees under the ACE program. The employer may take the credits against withholding tax on returns filed with the department of revenue until such time as the program costs of the ACE program are considered to be satisfied.

This rule is intended to implement Iowa Code sections 260G.4A and 422.16.

**701—46.8(260E) New job tax credit from withholding.** The Iowa industrial new jobs training program is a program administered by the economic development authority for projects established by a community college for the creation of jobs by providing education and training of workers for new jobs for new or expanding industries. For employers that have entered into an agreement with a community college under Iowa Code chapter 260E, a credit equal to 1.5 percent of the wages paid by the employer to each employee covered by the agreement can be taken on the Iowa withholding tax return. If the amount of withholding by the employer is less than 1.5 percent of the wages paid to the employees covered by the agreement, the employer can take the remaining credit against Iowa tax withheld for other employees. An employee does not include a resident of Illinois who earns wages in Iowa since these employees are not subject to Iowa withholding tax in accordance with the Iowa-Illinois reciprocal tax agreement discussed in 701—subrule 38.13(1). The administrative rules for the Iowa industrial new jobs training program administered by the economic development authority may be found in 261—Chapter 5.

This rule is intended to implement Iowa Code section 260E.2 as amended by 2012 Iowa Acts, Senate File 2212, and section 260E.5.

[ARC 0337C, IAB 9/19/12, effective 10/24/12]

**701—46.9(15) Supplemental new jobs credit from withholding and alternative credit for housing assistance programs.**

**46.9(1) Supplemental new jobs credit from withholding.** For eligible businesses approved by the economic development authority under Iowa Code section 15A.7, a credit equal to an additional 1.5 percent of the wages paid to employees in new jobs for these eligible businesses can be taken on the Iowa withholding tax return. This supplemental new jobs credit is in addition to the credit described in rule 701—46.8(260E). The administrative rules for the supplemental new jobs credit from withholding may be found in 261—paragraph 59.6(3) "a."

**46.9(2) Alternative credit for housing assistance programs.** As an alternative to the credit described in subrule 46.9(1) for eligible businesses in an enterprise zone, a business may provide a housing assistance program in the form of down payment assistance or rental assistance for employees in new jobs. A credit equal to 1.5 percent of the wages paid to employees participating in a housing assistance program may be claimed on the Iowa withholding tax return for wages paid prior to July 1, 2009. Effective July 1, 2009, the alternative credit for housing assistance programs was repealed. The administrative rules for the enterprise zone program administered by the Iowa department of economic development may be found in 261—Chapter 59.

This rule is intended to implement Iowa Code section 15A.7 and 2014 Iowa Code sections 15E.196 and 15E.197.

[ARC 8605B, IAB 3/10/10, effective 4/14/10; ARC 1744C, IAB 11/26/14, effective 12/31/14]

**701—46.10(403) Targeted jobs withholding tax credit.** For employers that enter into a withholding agreement with pilot project cities approved by the economic development authority and create or retain targeted jobs in a pilot project city, a credit equal to 3 percent of the gross wages paid to employees

under the withholding agreement can be taken on the Iowa withholding tax return. The employer shall remit the amount of the credit to the pilot project city. The administrative rules for the targeted jobs withholding tax credit program administered by the economic development authority may be found in 261—Chapter 71.

If the amount of withholding by the employer is less than 3 percent of the wages paid to the employees covered under the withholding agreement, the employer can take the remaining credit against Iowa tax withheld for other employees or may carry the credit forward for up to ten years or until depleted, whichever is the earlier.

If an employer also has a new job credit from withholding provided in rule 701—46.8(260E) or the supplemental new jobs credit from withholding provided in subrule 46.9(1), these credits shall be collected and disbursed prior to the collection and disbursement of the targeted jobs withholding tax credit.

The following nonexclusive examples illustrate how this rule applies:

**EXAMPLE 1:** Company A does not have a withholding credit under Iowa Code chapter 260E or a supplemental new jobs credit under Iowa Code chapter 15E. Company A enters into a withholding agreement, and the withholding rate for employees covered under the agreement is 4 percent of the wages paid. Company A will be allowed a credit on the Iowa withholding return equal to 3 percent of the wages paid to each employee covered under the withholding agreement, since the targeted jobs withholding tax credit cannot exceed 3 percent.

**EXAMPLE 2:** Company B does not have a withholding credit under Iowa Code chapter 260E or a supplemental new jobs credit under Iowa Code chapter 15E. Company B enters into a withholding agreement, and the withholding rate for employees covered under the agreement is 2.5 percent of the wages paid. Company B will be allowed a credit on the Iowa withholding return equal to 3 percent of the wages paid to each employee covered under the withholding agreement. The extra withholding credit equal to 0.5 percent may be used to offset withholding tax for Company B's employees not covered under the withholding agreement.

**EXAMPLE 3:** Company C has a withholding credit under Iowa Code chapter 260E of 1.5 percent of the wages paid to new employees and a supplemental new jobs credit under Iowa Code chapter 15E of 1.5 percent of the wages paid to new employees. Company C also enters into a withholding agreement for the same employees covered under the 260E agreement and supplemental new jobs credit agreement, and the withholding rate for employees covered under these agreements is 5 percent of the wages paid. Company C will be allowed a credit on the Iowa withholding return equal to 5 percent of the wages paid to each employee covered under these agreements. Since the community college receives disbursement of the credit before the pilot project city, the community college will receive 3 percent of the wages paid to each employee covered under the agreements, and the pilot project city will receive the remaining 2 percent of the wages paid to each employee covered under the agreements.

**EXAMPLE 4:** Company D has a withholding credit under Iowa Code chapter 260E of 1.5 percent of the wages paid to new employees and a supplemental new jobs credit under Iowa Code chapter 15E of 1.5 percent of the wages paid to new employees. Company D also enters into a withholding agreement for the same employees covered under the 260E agreement and supplemental new jobs credit agreement, and the withholding rate for employees covered under the agreement is 2.5 percent of the wages paid. Company D will be allowed a credit on the Iowa withholding tax return equal to 6 percent of the wages paid to each employee covered under these agreements. The extra withholding credit equal to 3.5 percent may be used to offset withholding tax for Company D's employees not covered under these agreements.

**46.10(1) Notification by the employer.** Once a withholding agreement is entered into with a pilot project city, the employer shall notify the department of revenue that an agreement has been executed. With this notification, the employer must also provide its address, tax identification number and the number of new jobs created under the agreement. In addition, for each year that the withholding agreement is in place, the employer must notify the department of revenue by January 31 of the number of new jobs created as of December 31 of the preceding year.

**46.10(2) Notification by the pilot project city.** The pilot project city must notify the department of revenue on a quarterly basis of the amount of the targeted jobs withholding credit that each employer

covered by a withholding agreement remitted to the city. This notification must occur within 45 days after the end of each calendar quarter. In addition, the pilot project city must notify the department of revenue immediately when a withholding agreement with an employer is terminated.

This rule is intended to implement Iowa Code section 403.19A as amended by 2013 Iowa Acts, Senate File 433.

[ARC 1138C, IAB 10/30/13, effective 12/4/13]

[Filed 12/12/74]

- [Filed 12/10/76, Notice 9/22/76—published 12/29/76, effective 2/2/77]
- [Filed emergency 4/28/78—published 5/17/78, effective 4/28/78]
- [Filed emergency 3/2/79—published 3/21/79, effective 3/2/79]
- [Filed emergency 7/17/80—published 8/6/80, effective 7/17/80]
- [Filed 11/20/81, Notice 10/14/81—published 12/9/81, effective 1/13/82]
- [Filed emergency 3/5/82—published 3/31/82, effective 4/1/82]
- [Filed 7/16/82, Notice 6/9/82—published 8/4/82, effective 9/8/82]
- [Filed 12/16/83, Notice 11/9/83—published 1/4/84, effective 2/8/84]
- [Filed 7/27/84, Notice 6/20/84—published 8/15/84, effective 9/19/84]
- [Filed 10/19/84, Notice 9/12/84—published 11/7/84, effective 12/12/84]
- [Filed 5/31/85, Notice 4/24/85—published 6/19/85, effective 7/24/85]
- [Filed 9/6/85, Notice 7/31/85—published 9/25/85, effective 10/30/85]
- [Filed 3/7/86, Notice 1/29/86—published 3/26/86, effective 4/30/86]
- [Filed 8/22/86, Notice 7/16/86—published 9/10/86, effective 10/15/86]
- [Filed 9/5/86, Notice 7/30/86—published 9/24/86, effective 10/29/86]
- [Filed emergency 11/14/86—published 12/17/86, effective 11/14/86]
- [Filed emergency 7/2/87—published 7/29/87, effective 7/2/87]
- [Filed 11/12/87, Notice 7/29/87—published 12/2/87, effective 1/6/88]
- [Filed 3/3/88, Notice 1/27/88—published 3/23/88, effective 4/27/88]
- [Filed 8/19/88, Notice 7/13/88—published 9/7/88, effective 10/12/88]
- [Filed 1/4/89, Notice 11/30/88—published 1/25/89, effective 3/1/89]
- [Filed 9/29/89, Notice 8/23/89—published 10/18/89, effective 11/22/89]
- [Filed 11/22/89, Notice 10/18/89—published 12/13/89, effective 1/17/90]
- [Filed 8/30/90, Notice 7/25/90—published 9/19/90, effective 10/24/90]
- [Filed 11/9/90, Notice 10/3/90—published 11/28/90, effective 1/2/91]
- [Filed 1/4/91, Notice 11/28/90—published 1/23/91, effective 2/27/91]
- [Filed 11/20/91, Notice 10/16/91—published 12/11/91, effective 1/15/92]
- [Filed emergency 2/14/92—published 3/4/92, effective 2/14/92]
- [Filed 4/10/92, Notice 3/4/92—published 4/29/92, effective 6/3/92]
- [Filed 10/9/92, Notice 9/2/92—published 10/28/92, effective 12/2/92]
- [Filed 11/20/92, Notice 10/14/92—published 12/9/92, effective 1/13/93]
- [Filed 7/1/93, Notice 5/26/93—published 7/21/93, effective 8/25/93]
- [Filed 9/10/93, Notice 8/4/93—published 9/29/93, effective 11/3/93]
- [Filed 5/20/94, Notice 4/13/94—published 6/8/94, effective 7/13/94]
- [Filed 9/23/94, Notice 8/17/94—published 10/12/94, effective 11/16/94]
- [Filed 2/24/95, Notice 1/4/95—published 3/15/95, effective 4/19/95]
- [Filed 7/14/95, Notice 6/7/95—published 8/2/95, effective 9/6/95]
- [Filed 1/12/96, Notice 12/6/95—published 1/31/96, effective 3/6/96]
- [Filed 8/23/96, Notice 7/17/96—published 9/11/96, effective 10/16/96]
- [Filed 5/15/98, Notice 4/8/98—published 6/3/98, effective 7/8/98]
- [Filed 10/2/98, Notice 8/26/98—published 10/21/98, effective 11/25/98]
- [Filed 12/23/99, Notice 11/17/99—published 1/12/00, effective 2/16/00]
- [Filed 3/30/00, Notice 2/23/00—published 4/19/00, effective 5/24/00]
- [Filed 1/5/01, Notice 11/29/00—published 1/24/01, effective 2/28/01]
- [Filed 5/24/01, Notice 4/18/01—published 6/13/01, effective 7/18/01]

[Filed 3/15/02, Notice 1/23/02—published 4/3/02, effective 5/8/02]  
[Filed 11/8/02, Notice 10/2/02—published 11/27/02, effective 1/1/03]  
[Filed 1/30/04, Notice 12/24/03—published 2/18/04, effective 3/24/04]  
[Filed 11/4/04, Notice 9/29/04—published 11/24/04, effective 12/29/04]  
[Filed 2/11/05, Notice 1/5/05—published 3/2/05, effective 4/6/05]  
[Filed 1/27/06, Notice 12/21/05—published 2/15/06, effective 3/22/06]  
[Filed 7/28/06, Notice 6/21/06—published 8/16/06, effective 9/20/06]  
[Filed 12/13/06, Notice 11/8/06—published 1/3/07, effective 2/7/07]  
[Filed 10/19/07, Notice 9/12/07—published 11/7/07, effective 12/12/07]  
[Filed 3/7/08, Notice 1/30/08—published 3/26/08, effective 4/30/08]  
[Filed ARC 7761B (Notice ARC 7632B, IAB 3/11/09), IAB 5/6/09, effective 6/10/09]  
[Filed ARC 8589B (Notice ARC 8430B, IAB 12/30/09), IAB 3/10/10, effective 4/14/10]  
[Filed ARC 8605B (Notice ARC 8481B, IAB 1/13/10), IAB 3/10/10, effective 4/14/10]  
[Filed ARC 0337C (Notice ARC 0232C, IAB 7/25/12), IAB 9/19/12, effective 10/24/12]  
[Filed ARC 1138C (Notice ARC 0998C, IAB 9/4/13), IAB 10/30/13, effective 12/4/13]  
[Filed ARC 1303C (Notice ARC 1231C, IAB 12/11/13), IAB 2/5/14, effective 3/12/14]  
[Filed ARC 1665C (Notice ARC 1590C, IAB 8/20/14), IAB 10/15/14, effective 11/19/14]  
[Filed ARC 1744C (Notice ARC 1654C, IAB 10/1/14), IAB 11/26/14, effective 12/31/14]  
[Filed ARC 2512C (Notice ARC 2434C, IAB 3/2/16), IAB 4/27/16, effective 6/1/16]  
[Filed ARC 2739C (Notice ARC 2616C, IAB 7/6/16), IAB 9/28/16, effective 11/2/16]  
[Filed ARC 3085C (Notice ARC 2942C, IAB 2/15/17), IAB 5/24/17, effective 6/28/17]  
[Filed ARC 3429C (Notice ARC 3284C, IAB 8/30/17), IAB 10/25/17, effective 11/29/17]  
[Filed ARC 4678C (Notice ARC 4561C, IAB 7/31/19), IAB 9/25/19, effective 10/30/19]



CHAPTER 225  
RESALE AND PROCESSING EXEMPTIONS PRIMARILY  
OF BENEFIT TO RETAILERS

Rules in this chapter include cross references to provisions in 701—Chapters 15, 17, 18 and 26 that were applicable prior to July 1, 2004.

**701—225.1(423) Paper or plastic plates, cups, and dishes, paper napkins, wooden or plastic spoons and forks, and straws.** When paper or plastic cups, plates, and dishes, paper napkins, and wooden or plastic spoons, forks, and other utensils are sold with food or other items to a buyer, and the buyer uses or consumes the utensils, sales of those utensils to retailers shall be considered sales for resale. The sales price from the sale of such items by retailers to consumers or users shall be subject to tax.

When these articles are transferred in connection with a service or sold for free distribution by retailers apart from a retail sale, the transaction shall be deemed to be a retail sale to the retailer and shall be taxable.

Sales of reusable placemats to retailers that sell meals shall be subject to tax.

EXAMPLE 1. A retailer purchases napkins and disposable forks and knives for the retailer's restaurant. The retailer provides these items free of charge, apart from the retail sale of food at the retailer's restaurant. Sale of these items to the retailer is a retail sale and is subject to tax.

EXAMPLE 2. A retailer purchases napkins and disposable forks and knives for the retailer's restaurant. The retailer sells these items with tangible personal property to the retailer's customers. The sale of these items to the retailer is considered a sale for resale and is not subject to Iowa sales tax at the time of purchase.

This rule is intended to implement Iowa Code section 423.3(2).

**701—225.2(423) A service purchased for resale.** A service is purchased for resale when it is subcontracted by the person who is contracted to perform the service.

**225.2(1) Services purchased for resale are purchased exempt from tax.**

EXAMPLE 1. X is a printer and enters into a contract with Y to print 500 bulletins. X subcontracts the job to Z. Z prints the 500 bulletins for X. There is no tax on the contracts between X and Z since X is purchasing the printing service from Z for resale to Y.

EXAMPLE 2. B owns a used car lot. E purchases an automobile from B. As a condition of such sale, B agrees to make repairs to the automobile. However, B subcontracts such repair work to C. E has agreed to pay B for the repair services and for the sale price of the automobile. Under these circumstances, the repair services furnished by C to B constitute a sale of such services to B for resale to E, who is the consumer of these services.

EXAMPLE 3. B owns an auto repair shop and C brings an automobile in to have the air conditioner fixed. B is unable to fix the air conditioner so the auto is sent to G, who is an air-conditioning specialist. The sale of G's service to B is a sale for resale by B to C.

**225.2(2) Services not purchased for resale.** The tax on services must be collected at the time the service is complete even if the service is not purchased by the ultimate beneficiary.

EXAMPLE. A operates a test laboratory business. A agrees to provide testing services to B. In the course of conducting the tests, A rents equipment from C. In computing the fee which B has agreed to pay A for testing services, A will include A's costs, including the rental A paid to C in rendering the testing services. Under these circumstances, A furnished B with testing services, and not with the equipment rental services which C furnished to A. A is the consumer of the equipment rental services which are not resold to B, and B is the consumer of the testing services.

This rule is intended to implement Iowa Code section 423.3(2).

**701—225.3(423) Services used in the repair or reconditioning of certain tangible personal property.** Services are exempt from tax when used in the reconditioning or repairing of tangible

personal property of the type which is normally sold in the regular course of the retailer's business and which is held for sale by the retailer.

EXAMPLE 1. A owns a retail appliance store and contracts with B to repair a refrigerator that A is going to resell. A can purchase the repair service from B tax-free because A is regularly engaged in selling refrigerators and will offer the refrigerator for sale when it is repaired.

EXAMPLE 2. B, a used car dealer, owns a used car lot and contracts with C to repair a used car that B is going to sell. B can purchase the repair service from C tax-free because B is regularly engaged in selling used cars and will sell the used car after it is repaired.

EXAMPLE 3. C operates a retail farm implement dealership. C accepts a motorboat as part consideration for a piece of farm equipment. C then contracts with D to repair the motor on the boat. C does not normally sell motorboats in the regular course of C's business. Therefore, the service performed by D for C is subject to tax.

EXAMPLE 4. XYZ owns a retail radio and television store in Iowa and contracts with W to repair a television that XYZ is going to sell. XYZ can purchase television repair service tax-free from W because XYZ is regularly engaged in selling televisions subject to sales tax. However, in this instance XYZ sells the used television and delivers it into interstate commerce with the result that the Iowa sales tax is not collectible. Regardless of this fact, the exemption is applicable, and no Iowa tax is due for the television repair services performed.

This rule is intended to implement Iowa Code sections 423.1(50) and 423.1(51).

#### **701—225.4(423) Tangible personal property purchased by a person engaged in the performance of a service.**

##### **225.4(1) In general.**

a. Tangible personal property purchased by a person engaged in the performance of a service is purchased for resale and not subject to tax if (1) the provider and user of the service intend that a sale of the property will occur, and (2) the property is transferred to the user of the service in connection with the performance of the service in a form or quantity capable of a fixed or definite price value, and (3) the sale is evidenced by a separate charge for the identifiable piece or quantity of property.

b. Tangible personal property which is not sold in the manner set forth in "a" above is not purchased for resale and thus is subject to tax at the time of purchase by a person engaged in the performance of a service. Such tangible personal property is considered to be consumed by the purchaser who is engaged in the performance of a service, and the person performing the service shall pay tax upon the sale at the time of purchase.

EXAMPLE 1. An investment counselor purchases envelopes. These envelopes are used to send out monthly reports to the investment counselor's clients regarding their accounts. Tax is due at the time the investment counselor purchases the envelopes if the clients are not billed for these items. Each envelope is transferred to a client in a form or quantity which is capable of a fixed or definite price value. However, there must also be an actual sale to the client (customer) of an item of personal property in order that there be a "resale" of the item.

EXAMPLE 2. An automobile repair shop purchases solvents which are used in cleaning automobile parts and thus in performing its automobile repair service. Tax is due at the time the automobile repair shop purchases the solvents since the solvents are not sold to the customer and, in this case, the items are not transferred to a customer in a form or quantity which is capable of a fixed or definite price value. Thus, the solvents are deemed consumed by the purchaser engaged in the performance of the service.

EXAMPLE 3. A retailer purchases television picture tubes tax-free and makes a separate charge for the picture tube to the customer. Since the tube is transferred to the customer in a form or quantity capable of a fixed or definite price value, the retailer may purchase the picture tube exempt from tax for subsequent resale.

EXAMPLE 4. A beauty shop or barber shop purchases shampoo and other items to be used in the performance of its service. Tax is due at the time the beauty shop or barber shop purchases such items from its supplier because the customers of the beauty shop or barber shop are not separately billed for

the items and because the items are not transferred to the customer in a form or quantity capable of a fixed or definite price value. The items are consumed by the beauty shop or barber shop.

EXAMPLE 5. A car wash purchases water, electricity, or gas used in the washing of a car. The car wash would be the consumer of the water, electricity, or gas, and tax is due at the time of purchase. The items purchased by the car wash are not transferred to the customer in a form or quantity capable of a fixed or definite price value, and the customer is not billed for the items.

EXAMPLE 6. An accounting firm purchases plastic binders which are used to cover the reports issued to its customers. These binders would be subject to tax at the time of purchase by the firm where the customer of the firm is not billed for the item, because there is no sale to the customer.

EXAMPLE 7. A meat locker purchases materials such as wrapping paper and tape which it uses to wrap meat for customers who provide the locker with the meat. These materials would be subject to tax at the time of purchase by the meat locker because they are not sold to the customer in a form or quantity capable of a fixed or definite price value.

EXAMPLE 8. A jeweler purchases materials such as main springs and crystals to be used in the performance of a service. These items are purchased by the jeweler for resale when they are transferred to the customer in a form or quantity capable of a fixed or definite price value, and each item is actually sold to the customer as evidenced by a separate charge therefor.

EXAMPLE 9. A lawn care service applies fertilizer, herbicides, and pesticides to its customers' lawns. The following are examples of invoices to customers which are suitable to indicate a lawn care service's purchase of the fertilizer, herbicides, and pesticides for resale to those customers: "Chemicals...31 Gal....\$60"; "Fertilizer...50 lbs....\$100"; and "Materials applied to lawn...4 bushel...\$40". The following are examples of information placed upon an invoice which would not indicate a purchase for resale to the customers invoiced: "Fifty percent of the charge for this service is for materials placed on a lawn," or "Lawn chemicals...\$30" or "Fifty pounds of fertilizer was applied to this lawn."

**225.4(2)** *Purchases made by automobile body shops or garages with body shops.* Tangible personal property purchased by body shops can be purchased for resale provided both of the following conditions are met:

a. The property purchased for resale is actually transferred to the body shop's customer by becoming an ingredient or component part of the repair work. See Iowa Code section 423.3(2).

b. The property purchased for resale is itemized as a separate item on the invoice to the body shop's customer and is transferred to the customer in a form or quantity capable of a fixed or definite price value.

If either of the above two conditions is not met, there is no purchase for resale and the body shop is deemed the consumer of the item purchased.

When body shops purchase items which will be resold (see list of items in this rule) in the course of the repair activity, the vendors selling to the body shops are encouraged to accept a valid resale certificate at the time of purchase. Reference rule 701—15.3(422,423). Failure of the vendor to accept a valid resale certificate may subject that vendor to sales tax liability since the burden of proof would be on the vendor that a sale was made for resale. If the vendor cannot meet that burden, the vendor will be liable for the sales tax. Such burden is not met merely by a showing that the purchaser had obtained from the department an Iowa retail sales tax permit or retail use tax permit.

For insurance purposes, body shops are reimbursed by insurance companies for "materials" which such shops consume in rendering repair services. Some of the materials are transferred to the recipients of the repair services and some are not. Of those so transferred, such transfer is in irregular quantities and is not in a form or quantity capable of a fixed or definite price value. Therefore, body shops are generally deemed to be the consumers of materials and must pay tax on these items at the time of purchase. Nonexclusive examples of items most likely to be included in this category of "materials," whether actually transferred to customers of body shops or not, are as follows:

Abrasives

Battery water

Body filler or putty

Body lead

Bolts, nuts and washers  
Brake fluid  
Buffing pads  
Chamois  
Cleaning compounds  
Degreasing compounds  
Floor dry  
Hydraulic jack oil  
Lubricants  
Masking tape  
Paint  
Polishes  
Rags  
Rivets and cotter pins  
Sanding discs  
Sandpaper  
Scuff pads  
Sealer and primer  
Sheet metal  
Solder  
Solvents  
Spark plug sand  
Striping tape  
Thinner  
Upholstery tacks  
Waxes  
White sidewall cleaner

The following are nonexclusive examples of parts which can be purchased for resale since they are generally transferred to the body shop's customer during the course of the repair in a form or quantity capable of a fixed or definite price value and are generally itemized separately as parts.

Accessories  
Batteries  
Brackets  
Bulbs  
Bumpers  
Cab corners  
Chassis parts  
Door guards  
Door handles  
Doors  
Engine parts  
Fenders  
Floor mats  
Grilles  
Headlamps  
Hoods  
Hubcaps  
Radiators  
Rocker panels  
Shock absorbers  
Side molding  
Spark plugs

Tires  
Trim  
Trunk lids  
Wheels  
Window glass  
Windshield ribbon  
Windshields

The following are nonexclusive examples of tools and supplies which are generally not transferred to the body shop's customer during the course of the repair and, therefore, could not be purchased for resale. The body shop is deemed the consumer of these items since they are not transferred to a customer. Therefore, the body shop must pay tax to the vendor at the time of purchase.

Air compressors and parts  
Body frame straightening equipment  
Brooms and mops  
Buffers  
Chisels  
Drill bits  
Drop cords  
Equipment parts  
Fire extinguisher fluids  
Floor jacks  
Hand soap  
Hand tools  
Office supplies  
Paint brushes  
Paint sprayers  
Sanders  
Signs  
Spreaders for putty  
Washing equipment and parts  
Welding equipment and parts

Because of the nature of the body shop business and the formulas devised by the insurance industry to reimburse body shops for cost of "materials," it is possible for body shops, in their invoices to their customers, to separately set forth labor, resold parts, and materials. While the materials can be separately invoiced as one general item, there is no way to ascertain a definite and fixed price for each item of the materials listed in this rule and consumed by the body shops, and some of such individual materials are not even transferred by body shops to their customers. Therefore, the body shops are generally the "consumers" of "materials" and do not purchase them for resale. See *W. J. Sandberg Co. v. Iowa State Board of Assessments and Review*, 225 Iowa 103, 278 N.W. 643 (1938). Thus, body shops should pay tax to their suppliers on all materials purchased and consumed by body shops. If materials are purchased from non-Iowa suppliers that do not collect Iowa tax from body shops, such body shops should remit consumer use tax to the department of revenue on such materials.

Body shops must collect sales tax on the taxable service of repairing motor vehicles. See rule 701—221.62(423). However, due to the nature of the insurance formulas, it is possible for body shops to itemize that portion of their billing which would be for repair services and that portion relating to consumed "materials." It is also possible for body shops to itemize that portion of their charges for parts which they purchase for resale to their customers. Body shops do not and cannot resell the tools and supplies previously listed in this rule; their purchases of such items are taxable.

Therefore, as long as body shops separately itemize on their invoices to their customers the amounts for labor, parts, and for "materials," body shops should collect sales tax on the labor and the parts, but not on the materials as enumerated in this rule.

EXAMPLE. A body shop repairs a motor vehicle by replacing a fender and painting the vehicle. In doing the repair work, the body shop uses rags, sealer and primer, paint, solder, thinner, bolts, nuts and washers, masking tape, sandpaper, waxes, buffing pads, chamois, and polishes. In its invoice to the customer, the labor is separately listed at \$600, the part (fender) is separately listed at \$600, and the category of “materials” is separately listed for a lump sum of \$200, for a total billing of \$1,400. The Iowa sales tax computed by the body shop should be on \$1,200, which is the amount attributable to the labor and the parts. The materials consumed by the body shop were separately listed and would not be included in the tax base for the taxable “sales price,” as defined in Iowa Code section 423.1(47), which is taxable under Iowa Code section 423.2.

In this example, if the “materials” were not separately listed on the invoice, but had been included in either or both of the labor or parts charges by marking up such charges, the body shop would have to collect sales tax on the full charges for parts or labor even though tax was paid on materials by the body shop to its supplier at the time of purchase.

This rule is intended to implement Iowa Code sections 423.1(35) and 423.3(2).

**701—225.5(423) Maintenance or repair of fabric or clothing.** Sales of chemicals, solvents, sorbents, or reagents directly used and consumed in the maintenance or repair of fabric or clothing are exempt from tax. See 701—Chapter 211 for definitions of the terms “chemical,” “solvent,” “sorbent,” and “reagent.” This rule’s exemption is mainly applicable to dry-cleaning and laundry establishments; however, it is also applicable to soap or any chemical or solvent used to clean carpeting. The department presumes that a substance is “directly used” in the maintenance or repair of fabric or clothing if the substance comes in contact with the fabric or clothing during the maintenance or repair process. Substances which do not come into direct contact with fabric or clothing may, under appropriate circumstances, be directly used in the maintenance or repair of the fabric or clothing, but direct use will not be presumed.

The following are examples of substances directly used and consumed in the maintenance or repair of fabric or clothing: perchloroethylene (also known as “perch”) or petroleum solvents used in dry-cleaning machines and coming in direct contact with the clothing being dry-cleaned. Substances used to clean or filter the “perch” or petroleum solvents would also be exempt from tax, even though these substances do not come in direct contact with the clothing being cleaned. The sale of soap or detergents especially made for mixing with “perch” or petroleum solvents is exempt from tax. The sale of stain removers to dry cleaners is exempt from tax.

A commercial laundry’s purchase of detergents, bleaches, and fabric softeners is exempt from tax. A commercial laundry’s purchase of water, which is a solvent, is also exempt from tax if purchased for use in the cleaning of clothing.

The purchase of starch by laundries and “sizing” by dry cleaners is not exempt from tax.

This rule is intended to implement Iowa Code section 423.3(50).

**701—225.6(423) The sales price from the leasing of all tangible personal property subject to tax.** See 701—Chapter 211 for the definitions of the words “lease or rental” and “tangible personal property” which are applicable to this rule.

**225.6(1) Past and present taxation of leases.** Prior to July 1, 2004, the rental of tangible personal property was treated as a taxable service for the purposes of Iowa sales and use tax law; reference 2003 Iowa Code section 422.43(11) and 701—subrule 26.18(2). The “rental” of tangible personal property was not a “sale” of that property, and therefore a purchase for subsequent leasing or rental was not a purchase for resale. See *Cedar Valley Leasing, Inc. v. Iowa Department of Revenue*, 274 N.W.2d 357 (Iowa 1979).

On and after July 1, 2004, the rental of tangible personal property is treated as the sale of that property for the purposes of Iowa sales and use tax law because “leases” and “rentals” of tangible personal property are taxable retail “sales” of that property. The rental of tangible personal property is no longer listed as a taxable enumerated service. The resale exemption in favor of sales for resale of tangible personal property is now applicable to sales and leases of tangible personal property for subsequent rental or lease.

EXAMPLE A. Al's Rent All buys blowers, hand tools, ladders, plumbers' snakes, sanders, and tillers for subsequent short-term rental to various customers. Al's purchases of these items of equipment are purchases for resale and are exempt from tax as of July 1, 2004.

EXAMPLE B. In addition to its purchases of equipment for subsequent rental, Al's Rent All leases from its suppliers, long-term, items of heavier equipment such as backhoes, forklifts, manlifts, tractors, and trenchers, again for subsequent leasing to various customers. Since the leasing of tangible personal property is now a purchase of that property, Al's leasing for later sublease is a purchase of tangible personal property and is exempt from tax at the time of purchase as the purchase of tangible personal property for subsequent resale.

**225.6(2)** *Distinguishing leases and rentals of tangible personal property from the furnishing of nontaxable services.* In order to determine whether a particular fee is charged for the rental of tangible personal property or for the furnishing of a nontaxable service, the department looks at the substance, rather than the form, of the transaction. When the possession and use of tangible personal property by the recipient is merely incidental as compared to the nontaxable service performed, all of the sales price is derived from the furnishing of such nontaxable service and, unless a separate fee or charge is made for the possession and use of tangible personal property, no sales price is derived from the rental of tangible personal property. When the nontaxable service is merely incidental to the possession and use of the tangible personal property by the recipient, all of the sales price is derived from the furnishing of tangible personal property rental and, unless a separate fee or charge is made for the nontaxable service, no sales price is derived from the nontaxable service. When a tangible personal property rental agreement contains separate fee schedules for rent and for nontaxable service, only the sales price derived from the tangible personal property rental is subject to tax. This rule is not to be so construed as to be at variance with Iowa Code sections 423.2(8) and 423.3(70) concerning bundled service contracts and transportation services respectively.

**225.6(3)** *Rental of real property distinguished from rental of tangible personal property.* If a rental contract allows the renter exclusive possession or use of a defined area of real property and, incidental to that contract, tangible personal property is provided which allows the renter to utilize the real property, if there is no separate charge for rental of tangible personal property, the sales price is for the rental of real property and is not subject to tax, unless taxable room rental is involved; reference rule 701—18.40(422,423).

If a person rents tangible personal property and, incidental to the rental of the property, space is provided for the property's use, the sales price from the rental shall be subject to tax. It may at times be difficult to determine whether a particular transaction involves the rental of real property with an incidental use of tangible personal property or the rental of tangible personal property with an incidental use of real property.

**225.6(4)** *Rental of tangible personal property and rental of fixtures.* The rental of tangible personal property which shall, prior to its use by the renter under the rental contract, become a fixture shall not be subject to tax. Such a rental is the rental of real property rather than tangible personal property. In general, any tangible personal property which is connected to real property in a way that it cannot be removed without damage to itself or to the real property is a fixture. See *Equitable Life Assurance Society of the United States v. Chapman*, 282 N.W. 355 (Iowa 1983) and *Marty v. Champlin Refining Co.*, 36 N.W.2d 360 (Iowa 1949). The rental of a mobile home or manufactured housing, not sufficiently attached to realty to constitute a fixture, is room rental rather than tangible personal property rental and subject to tax on that basis; see *Broadway Mobile Home Sales Corp. v. State Tax Commission*, 413 N.Y.S.2d 231 (N.Y. 1979). Reference also rule 701—18.40(422,423).

**225.6(5)** *Rental of tangible personal property embodying intangible personal property rights—transactions taxable and exempt.* Under the law, the sales price from rental of tangible personal property includes royalties and copyright and license fees. The rental of all property which is a tangible medium of expression for the intangible rights of royalties and copyright and license fees is subject to tax. Thus the sales price from the rental of films, videodiscs, videocassettes, and any computer software (other than rental of custom programs, reference 701—paragraph 18.34(3) "a") which is the tangible means of expression of intangible property rights is subject to tax. The rental of such tangible property

shall be subject to tax whether the property is held for rental to the general public or for rental to one or a few persons. See *Boswell v. Paramount Television Sales, Inc.*, 282 So.2d 892 (Ala. 1973). Reference also rule 701—17.18(422,423) regarding the exemption from the requirements of this subrule for rental of films, videotapes and other media to lessees imposing a taxable charge for viewing or rental of the media or to lessees that broadcast the contents of these media for public viewing or listening.

**225.6(6) Deposits and additional fees.** Taxability of a deposit required by an owner of rental property as a condition of the rental depends upon the type of deposit required. A deposit subject to forfeiture for the lessee's failure to comply with the rental agreement is not subject to tax. This type of deposit is separate from the rental payments and therefore is not taxable as part of the rental. Such deposits may include those for reservation, late return of the rental property or damage to the rental property. Deposits not subject to forfeiture which represent part of the rental receipts are considered part of the taxable rental and are subject to tax. Such deposits may include a deposit of the first rental payment which is applied to the rental receipts.

When tangible personal property is rented for a flat fee per month, per year, or for other designated periods, plus an additional fee based on quantity and capacity of production or use, the entire charge is taxable.

**225.6(7) Leasing of tangible personal property moving in interstate commerce.**

*a.* On and after July 1, 2004, in the case of a lease or rental that requires recurring periodic payments, the first periodic payment is taxed to Iowa if the property was delivered to the lessee in Iowa. Periodic payments made subsequent to the first payment may be taxed only by the state in which the property is primarily located for the period covered by the payment. The primary property location shall be as indicated by an address for the property provided by the lessee that is available to the lessor from its records maintained in the ordinary course of business, when use of this address does not constitute bad faith. The property location shall not be altered by intermittent use at different locations, such as use of business property that accompanies employees on business trips and service calls.

*b.* Where a nonresident lessor leases tangible personal property to a resident or nonresident lessee and the lessee uses the property in Iowa, the nonresident lessor has the responsibility of collecting Iowa use tax on the lease payments if Iowa is the primary location of the property, provided the lessor maintains a place of business in Iowa as described in 2005 Iowa Code sections 423.1(43) and 423.14(2). Whether the lease agreement is executed in Iowa or not is irrelevant. *State Tax Commission v. General Trading Co.*, 322 U.S. 335, 64 S.Ct. 1028, 88 L.Ed 1309 (1944).

*c.* Where a lessee is the recipient of equipment rental services sourced to Iowa and no tax has been collected from such lessee by the lessor, the lessee should remit Iowa use tax to the department of revenue. In the event no tax is remitted, the department, in its discretion, may seek to collect the tax from the lessor or lessee. In the event that the lessee rents tangible personal property, and the lessor does not maintain a place of business in Iowa and does not collect use tax pursuant to 2005 Iowa Code section 423.14, such lessee shall remit tax on its rental payments to the department.

*d.* Where a resident lessor leases equipment to a nonresident lessee outside Iowa and the equipment is delivered to the lessee outside Iowa, the act of leasing is exempt from the Iowa sales tax on the rental payments. However, in the event the lessee brings the equipment into Iowa, uses it in Iowa, and Iowa becomes the primary location of the property, Iowa use tax applies to subsequent rental payments.

*e.* If a sales or use tax has already been paid to another state on the sales price of tangible personal property prior to the use of that property in Iowa, a tax credit against the Iowa use tax on the purchase price will be given. After the equipment is brought into Iowa, if a sales or use tax is properly payable and is paid to another state on the rental payments of equipment, for the same time the Iowa tax is imposed on such rentals, a tax credit against the Iowa use tax on such rental payments will be given.

This rule is intended to implement Iowa Code sections 423.1(22), 423.1(43), 423.1(45), 423.1(54), 423.2(1), and 423.15(2).

**701—225.7(423) Certain inputs used in taxable vehicle wash and wax services.** On or after May 25, 2012, sales of water, electricity, chemicals, solvents, sorbents, or reagents to a retailer to be used in providing a service that includes a vehicle wash and wax that is subject to Iowa Code section 423.2(6)

are exempt from tax. This rule applies to bills received or sales occurring, as the case may be, on or after May 25, 2012.

**225.7(1) Definitions.** For the purposes of this rule, the following definitions apply:

*“Chemical”* means a substance which is primarily used for producing a chemical effect. A chemical effect results from a chemical process wherein the number and kind of atoms in a molecule are changed in form (e.g., where oxygen and hydrogen are combined to make water). A chemical process is distinct from a physical process wherein only the state of matter changes (e.g., where water is frozen into ice or heated into steam).

*“Reagent”* means a substance used for various purposes (i.e., in detecting, examining, or measuring other substances; in preparing materials; in developing photographs) because it takes part in one or more chemical reactions or biological processes. A reagent is also a substance used to convert one substance into another by means of the reaction that it causes. To be a reagent for purpose of the exemption, a substance must be primarily used as a reagent.

*“Retailer”* or *“supplier”* means and includes every person engaged in the business of selling tangible personal property or taxable services at retail or the furnishing of gas, electricity, water, pay television, or communication service, and tickets or admissions to places of amusement and athletic events or operating amusement devices or other forms of commercial amusement from which revenues are derived. However, when in the opinion of the director it is necessary for the efficient administration of this rule to regard any salespersons, representatives, truckers, peddlers, or canvassers as agents of the dealers, distributors, supervisors, employers, or persons under whom the salespersons, representatives, truckers, peddlers, or canvassers operate or from whom they obtain tangible personal property sold by them irrespective of whether or not they are making sales on their own behalf or on behalf of such dealers, distributors, supervisors, employers, or persons, the director may so regard them, and may regard such dealers, distributors, supervisors, employers, or persons as retailers for the purposes of this rule. *“Retailer”* includes a seller obligated to collect sales or use tax.

*“Secondary vehicle wash and wax facility”* means a vehicle wash and wax facility whose primary purpose is to sell tangible personal property or services other than vehicle wash and wax services, but which also provides vehicle wash and wax services that are taxable under Iowa Code section 423.2(6). Examples of *“secondary vehicle wash and wax facilities”* include, but are not limited to, vehicle dealerships, convenience stores, service stations, and wholesale and retail fuel marketing locations that provide taxable vehicle wash and wax services in addition to their primary business purpose. A facility that provides vehicle wash and wax services that also sells tangible personal property or other services is presumed to be a *“secondary vehicle wash and wax facility”* unless it can prove otherwise.

*“Solvent”* means a substance in which another substance can be dissolved and which is primarily used for that purpose.

*“Sorbent”* means a solid material, often in a powder or granular form, which acts to retain another substance, usually on the sorbent’s surface, thereby removing the other substance from the gas or liquid phase. The sorbent and the second material bond together at the molecular or atomic scale via physiochemical interactions. A substance is not a sorbent based on an ability to absorb heat or thermal energy.

*“Stand-alone vehicle wash and wax facility”* means a vehicle wash and wax facility whose primary purpose is to provide vehicle wash and wax services that are taxable under Iowa Code section 423.2(6). A vehicle wash and wax facility is considered a *“stand-alone vehicle wash and wax facility”* although it sells a de minimis amount of products and services related to vehicle wash and wax services. Nonexclusive examples of products and services related to vehicle wash and wax services include coin-operated vacuum stations and air fresheners and vehicle wipes which are sold out of vending machines.

*“Vehicle”* means any self-propelled motor vehicle designed primarily for carrying passengers (nine or fewer) excluding motorcycles and motorized bicycles; any pickup truck designed to carry both passengers and cargo; or any vehicle which is commonly on a highway and propelled by any power other than muscular power. Nonexclusive examples of a vehicle are motorcycles, motorized bicycles, pickup trucks, tractors, and trailers.

“*Vehicle wash and wax facility*” means any retailer that provides vehicle wash and wax services.

“*Vehicle wash and wax services*” or “*vehicle wash and wax*” means washing and waxing services performed inside or outside of the vehicle or both whether the services are performed by hand, machine, or coin-operated devices.

“*Water*” means water directly consumed or used in providing the taxable vehicle wash and wax service. “*Water*” does not include, for example, charges or fees for storm water, sanitary sewer, or solid waste services as these are not fees for water directly used or consumed in providing the taxable vehicle wash and wax service.

**225.7(2)** *Purchases made by a stand-alone vehicle wash and wax facility.* Purchases of water, electricity, chemicals, solvents, sorbents, or reagents by a stand-alone vehicle wash and wax facility are presumed to be 100 percent exempt from sales tax. The stand-alone vehicle wash and wax facility is not required to provide the suppliers of such items with an exemption certificate. See 701—paragraph 15.3(2) “g.”

**225.7(3)** *Purchases made by a secondary vehicle wash and wax facility.*

*a. Sales price of electricity and water.* The exemption for the sales price of electricity and water purchased by secondary vehicle wash and wax facilities applies only to the sales price from the sale of electricity and water directly consumed or used in providing vehicle wash and wax services, as distinguished from electricity and water used and consumed for other purposes not related to vehicle wash and wax services (e.g., electricity to operate office equipment or lighting; water used for cleaning the inside of a gas station or for irrigation).

(1) Separately metered electricity and water. Ideally, a secondary vehicle wash and wax facility will have separate meters to measure its nonexempt electricity and water usage and its exempt electricity and water used for providing taxable vehicle wash and wax services. A secondary vehicle wash and wax facility that separately meters its exempt and nonexempt electricity and water usage and does not use the exempt electricity and water for any other purpose than providing a taxable vehicle wash and wax service does not have to file an exemption certificate with the suppliers. See 701—paragraph 15.3(2) “g.” The supplier should not charge tax on the charges associated with the meters that measure electricity and water used solely for providing the taxable vehicle wash and wax services.

However, if water or electricity which is measured by the meter which separately measures the vehicle wash and wax facility is used for both taxable vehicle wash and wax services and nonexempt purposes (e.g., consumed in performance of its business operations), the secondary vehicle wash and wax facility must allocate the use of the electricity or water according to exempt and nonexempt use if an exemption for nontaxable use is to be claimed. To obtain the exemption for electricity or water under this rule, a secondary vehicle wash and wax facility that has both exempt and nonexempt electricity or water usage measured by the same meter must request the exemption by providing an exemption certificate to the electricity or water supplier.

The exemption certificate shall indicate what percentage of the electricity or water is used for taxable vehicle wash and wax services and is therefore exempt. The exemption certificate shall be in writing and detail how the percentages of exempt and nonexempt usage were developed. The rationale provided for the percentage of exempt water and electricity must be reasonable after the nature of the secondary vehicle wash and wax service facility’s primary purpose and all other facts and circumstances are considered. A secondary vehicle wash and wax facility that cannot, or does not want to, determine the percentage of exempt electricity or water usage may forego the exemption. The exemption certificate is valid for three years, but the secondary vehicle wash and wax facility must amend its exemption certificate to reflect any changes that would affect the exemption amount (e.g., summer month water usage compared to winter month water usage).

(2) Exempt and nonexempt usage measured by the same meter. When electricity and water are purchased for vehicle wash and wax services as well as for taxable uses, and the use of the electricity or water is recorded on a single meter, a secondary vehicle wash and wax facility must allocate the use of the electricity or water according to exempt and nonexempt use if an exemption for nontaxable use is to be claimed. To obtain the exemption for electricity or water under this subparagraph, a secondary vehicle wash and wax facility that has both exempt and nonexempt electricity or water usage measured

by the same meter must request the exemption by providing an exemption certificate to the electricity or water supplier.

The exemption certificate must indicate what percentage of the electricity or water is used for taxable vehicle wash and wax services and is therefore exempt. The exemption certificate shall be in writing and detail how the percentages of exempt and nonexempt usage were developed. The rationale provided for the percentages of exempt water and electricity must be reasonable after the nature of the secondary vehicle wash and wax service provider's primary purpose and all other facts and circumstances are considered. A secondary vehicle wash and wax facility that cannot, or does not want to, determine the percentages of exempt electricity and water usage may either forego the exemption or install a separate meter. The exemption certificate is valid for three years, but the secondary vehicle wash and wax facility must amend its exemption certificate to reflect any changes that would affect the exemption amount (e.g., summer month water usage compared to winter month water usage).

Exemption statutes are strictly construed against the taxpayer in favor of taxation (See *Dial Corp. v. Iowa Dep't of Revenue*, 634 N.W.2d 643, 646 (Iowa 2001)). The secondary vehicle wash and wax facility has the burden of proof regarding the exempt percentages (See *id.* and Iowa Code section 421.60(6)) and is liable for any mistakes or misrepresentations made regarding the computation or for failure to notify the electricity or water supplier in writing of the percentage of exempt usage, if required.

(3) Credit. A supplier of electricity or water that sells electricity or water to vehicle wash and wax facilities may bill customers for sales tax even if the facility qualifies for the exemption from sales tax under this rule if the supplier cannot adjust its billing process in time to accommodate this exemption. Subsequently, the electricity or water supplier shall provide a credit for tax collected from a vehicle wash and wax facility, and the credit is to appear on the first possible billing date after May 25, 2012.

*b. Sales price of chemicals, solvents, sorbents, or reagents.* The sales price of chemicals, solvents, sorbents, or reagents sold to a secondary vehicle wash and wax facility to be used in providing a taxable vehicle wash and wax service is presumed to be 100 percent exempt from sales tax if the secondary vehicle wash and wax facility's primary business does not consume or sell the same chemicals, solvents, sorbents, or reagents that are used in providing taxable vehicle wash and wax services. If the secondary vehicle wash and wax facility's primary business does not use or sell the same products used in providing the taxable vehicle wash and wax service, the facility does not have to provide the retailer with an exemption certificate. However, if the secondary vehicle wash and wax facility may consume the chemicals, solvents, sorbents, or reagents for any purpose other than providing taxable vehicle wash and wax services, the secondary vehicle wash and wax facility shall either:

(1) Purchase such items without tax liability if the majority of the chemicals, solvents, sorbents, or reagents are used in performing the vehicle wash and wax service and remit the tax to the department at the time such items are consumed in the operation of the primary business. The secondary vehicle wash and wax facility shall provide to the retailer an exemption certificate which indicates that not all items will be used in providing a taxable vehicle wash and wax service and the tax on such items will be remitted at a later date; or

(2) Pay tax to retailers at the time of purchase if the majority of the chemicals, solvents, sorbents, or reagents will be consumed in the operation of the primary business and deduct the original cost of any such items subsequently used in the vehicle wash and wax service when reporting tax on the facility's returns.

EXAMPLE A: An automobile dealership offers a taxable drive-through vehicle wash and wax service in addition to its primary business purpose of selling vehicles. The automobile dealership is a "secondary vehicle wash and wax facility" because the taxable vehicle wash and wax service is offered secondarily to its primary purpose of selling and servicing vehicles. In addition to providing vehicle wash and wax services to the general public (a taxable vehicle wash and wax service), the automobile dealership uses its vehicle wash and wax facility to wash and wax its inventory. Using the vehicle wash and wax facility to wash or wax inventory is not a taxable vehicle wash and wax service because the vehicle wash and wax service is not sold to customers; the service is "consumed" in performance of the automobile dealership's business operations. See 701—paragraph 18.3(1)"c."

The automobile dealership has electricity and water meters that each separately measure the electricity and water used and consumed in using the vehicle wash and wax facility. Although the automobile dealership separately meters electricity and water, the separate meters do not measure only taxable vehicle wash and wax services. Therefore, to claim the exemption, the automobile dealership shall provide the electricity and water suppliers with an exemption certificate that states the percentages of water and electricity used in providing taxable vehicle wash and wax services. The electricity and water suppliers shall separately state and bill for the taxable and exempt amounts.

The automobile dealership also uses some of the chemicals, solvents, sorbents, or reagents while washing and waxing its inventory, so the automobile dealership may either (1) purchase such items without tax liability if the majority of the chemicals, solvents, sorbents, or reagents are used in performing the vehicle wash and wax service and remit the tax at the time such items are consumed in the operation of the primary business, or (2) pay tax to retailers at the time of purchase if the majority of the chemicals, solvents, sorbents, or reagents will be consumed in the operation of the primary business and deduct the original cost of any such items subsequently used in the vehicle wash and wax service when reporting tax on the dealership's returns.

The exemption is available for the quantity of items used in providing the taxable vehicle wash and wax services even though the automobile dealership does not separately itemize on its receipts the amounts of electricity, water, chemicals, solvents, sorbents, or reagents used in providing the taxable vehicle wash and wax services.

EXAMPLE B: A gas station that also sells vehicle wash and wax services does not separately meter the electricity or water used and consumed in providing the taxable vehicle wash and wax services. With the exception of providing vehicle wash and wax services, the gas station does not provide any other additional services. The gas station wants to claim the exemption. To obtain the exemption for electricity or water under this rule, the gas station shall calculate, and has the burden of proving, the amount of exempt electricity or water it uses in providing taxable vehicle wash and wax services. The automobile dealership shall furnish to the electricity or water supplier an exemption certificate that indicates what percentage of the electricity or water is exempt.

Additionally, because the gas station only sells gasoline and taxable vehicle wash and wax services, it is unlikely that the gas station will consume the chemicals, solvents, sorbents, or reagents for any purpose other than providing taxable vehicle wash and wax services. Therefore, the sales price of the chemicals, solvents, sorbents, or reagents that the gas station purchased for use in providing taxable vehicle wash and wax services is 100 percent exempt from sales tax. The gas station does not have to provide the retailers of the chemicals, solvents, sorbents, or reagents with an exemption certificate.

EXAMPLE C: Same facts as Example B, except the gas station does not believe it is feasible to accurately determine the amount of electricity or water usage that can be attributed to the vehicle wash and wax facility. The gas station also does not believe it is economically beneficial to install separate meters to measure the usage of electricity or water for the sole purpose of claiming the exemption. Therefore, the gas station does not claim the exemption and pays sales tax on the full sales price of water or electricity.

This rule is intended to implement 2011 Iowa Code Supplement section 423.3 as amended by 2012 Iowa Acts, Senate File 2342, section 13.  
[ARC 0403C, IAB 10/17/12, effective 11/21/12]

### **701—225.8(423) Exemption for commercial enterprises.**

**225.8(1)** *Commercial enterprise as purchaser.* A purchaser seeking this exemption must be a commercial enterprise as defined in Iowa Code section 423.3(104) "b"(1). For purposes of Iowa Code section 423.3(104) "b"(1), the terms "profession" and "occupation" mean the same as defined in 701—paragraph 230.18(3) "c."

**225.8(2)** *Exclusive use by a commercial enterprise.* A commercial enterprise must be the exclusive user of the product. Use in the ordinary course of a commercial enterprise's business constitutes exclusive use by a commercial enterprise. Uses by all other users, including entities other than commercial enterprises, do not constitute uses by a commercial enterprise.

*a. Examples of exclusive uses.* The following are examples of exclusive uses by a commercial enterprise in the normal course of business:

- (1) Word processing software loaded onto employees' work computers.
- (2) Software that displays a menu on a tablet used by customers at a restaurant.
- (3) Information services used by temporary employees of a commercial enterprise in the ordinary course of business.

*b. Examples of disqualifying nonexclusive uses.* The following are examples of uses that are not exclusive uses by a commercial enterprise or uses in the ordinary course of business:

- (1) Software shared by a commercial enterprise with an entity that is not a commercial enterprise.
- (2) Video games that customers may purchase on a tablet that is provided at a restaurant for customers to use while waiting for service.

**225.8(3) Noncommercial purposes.** "Noncommercial purposes" means purposes that are outside of carrying out the business purpose of a commercial enterprise or purposes outside of the ordinary course of business of a commercial enterprise. The following are examples of uses for noncommercial purposes:

- a.* Personal and recreational use.
- b.* Holding a product for future use for a noncommercial purpose.

**225.8(4) De minimis.** "De minimis" means an amount of use of a product for noncommercial purposes that, when considering the product's value and the frequency with which the use for noncommercial purposes occurs during the product's total use time, is so small as to make accounting for that use unreasonable or impractical. Whether a use is de minimis is a fact-based determination that shall be made on a case-by-case basis.

This rule is intended to implement Iowa Code section 423.3(104).

[ARC 4679C, IAB 9/25/19, effective 10/30/19]

[Filed 11/16/05, Notice 10/12/05—published 12/7/05, effective 1/11/06]

[Filed ARC 0403C (Notice ARC 0294C, IAB 8/22/12), IAB 10/17/12, effective 11/21/12]

[Filed ARC 4679C (Notice ARC 4562C, IAB 7/31/19), IAB 9/25/19, effective 10/30/19]