

*State of Iowa*

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

Biweekly  
October 2, 2013



**STEPHANIE A. HOFF**  
ADMINISTRATIVE CODE EDITOR

---

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

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

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

# INSTRUCTIONS

## FOR UPDATING THE

# IOWA ADMINISTRATIVE CODE

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

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

### **Soil Conservation Division[27]**

Replace Chapters 101 to 106

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

Replace Analysis

Replace Chapter 50

### **Engineering and Land Surveying Examining Board[193C]**

Replace Chapter 8

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

Replace Analysis

Replace Chapters 76 to 80

Replace Chapter 83

Replace Chapter 88

Replace Chapter 92

Replace Chapter 150

Replace Chapter 156

Replace Chapter 170

Replace Chapter 187

### **Inspections and Appeals Department[481]**

Replace Analysis

Replace Chapters 56 to 58

Replace Chapters 62 and 63

Replace Chapter 65

Replace Chapter 67

### **Public Health Department[641]**

Replace Chapters 95 and 96

Replace Chapter 99

Replace Chapters 134 and 135

Replace Chapter 137

### **Medicine Board[653]**

Replace Analysis

Replace Chapter 13

**Regents Board[681]**

Replace Analysis  
Replace Chapter 13

**Transportation Department[761]**

Replace Chapter 601  
Replace Chapters 604 and 605  
Replace Chapter 630

**Labor Services Division[875]**

Replace Chapter 26

*DIVISION II*  
*WATERSHED IMPROVEMENT REVIEW BOARD*  
CHAPTER 101  
ORGANIZATION AND PURPOSE

**27—101.1(466A) Watershed improvement review board composition.** The watershed improvement review board shall be comprised of one member from each of the following entities: the Agribusiness Association of Iowa; the Iowa Association of Water Agencies; the Iowa Environmental Council; the Iowa Farm Bureau Federation; the Iowa Pork Producers Association; the Iowa Rural Water Association; the Iowa Soybean Association; the soil and water conservation districts of Iowa; the Iowa Association of County Conservation Boards; the department of agriculture and land stewardship; and the department of natural resources.

Two state senators shall be appointed, one by the majority leader of the senate and one by the minority leader of the senate. Two state representatives shall be appointed, one by the speaker of the house of representatives and one by the minority leader of the house of representatives. The four members of the general assembly serve as ex officio, nonvoting members.

These members are appointed according to Iowa Code section 466A.3. The board awards grants and monitors the progress, assists with the development of monitoring plans for local watershed improvement projects, and reviews costs and benefits of mitigation practices utilized by a project.

[ARC 1053C, IAB 10/2/13, effective 1/1/14]

**27—101.2(466A) Officers.** The officers of the board shall be the chairperson and vice chairperson. Each officer shall be elected by vote of the board for a term of one year and may be reelected by vote of the board to serve one subsequent term in the same office. Members representing the department of agriculture and land stewardship, the department of natural resources and the general assembly are not eligible to serve as an officer of the board.

**101.2(1)** The chairperson shall set the date for meetings, preside at meetings, and sign documents approved by the board.

**101.2(2)** The vice chairperson shall act in the chairperson's place when the chairperson is unable to act.

**27—101.3(466A) Staff.** The division of soil conservation of the department of agriculture and land stewardship shall provide administrative support to the board to aid in the completion of its duties.

**27—101.4(466A) Meetings.** The board shall meet at the time designated by the chairperson at least once annually and at other times the board determines are necessary. All meetings shall be held at such locations as are determined by the board.

**27—101.5(466A) Quorum.** A majority of the voting members of the board shall constitute a quorum. A majority of the voting members present during a meeting is necessary to carry out the duties and exercise the powers of the board as provided in this chapter.

**27—101.6(466A) Conflict of interest.** A voting member of the board shall abstain from participating on any issues relating to a local watershed improvement grant application submitted by a local watershed improvement committee or soil and water conservation district of which the person is a member. A member of the general assembly shall abstain from participating on any issues relating to a watershed which is in the member's legislative district.

**27—101.7(466A) Board responsibilities.** The board shall do all of the following:

1. Award local watershed improvement grants and evaluate and review through reports the progress of local watershed improvement projects awarded grants.
2. Assist with the development of monitoring plans for local watershed improvement projects.

3. Review monitoring results before, during, and after completion of a local watershed improvement project.
4. Review costs and benefits of mitigation practices utilized by a project.
5. By January 31, annually, submit an electronic report to the governor and the general assembly regarding the progress of the watershed improvement projects during the previous calendar year.
6. Develop and adopt administrative rules pursuant to Iowa Code chapter 17A to administer this chapter.

**27—101.8(466A) Technical assistance.** The board shall elicit the expertise of other organizations for technical assistance in the work of the board. The organizations may include but are not limited to all of the following: the State University of Iowa; the Iowa State University of Science and Technology; the U.S. Geological Survey; the U.S. Department of Agriculture, Agricultural Research Service, National Laboratory for Agriculture and the Environment; the U.S. Department of Agriculture, Natural Resource Conservation Service; the Leopold Center for Sustainable Agriculture; the Iowa Association of Municipal Utilities; the Iowa chapter of the American Waterworks Association; the Iowa Water Pollution Control Association; the Iowa League of Cities; the Iowa Cattlemen's Association; the Iowa Association of Business and Industry; the Iowa Environmental Health Association; the Iowa Corn Growers Association; the Iowa Poultry Association; the Iowa Farmers' Union; and the Iowa Land Improvement Contractors Association.

[ARC 1053C, IAB 10/2/13, effective 1/1/14]

These rules are intended to implement Iowa Code chapter 466A.

[Filed emergency 8/25/05—published 9/14/05, effective 8/25/05]

[Filed 1/27/06, Notice 9/14/05—published 2/15/06, effective 4/3/06]

[Filed ARC 1053C (Notice ARC 0927C, IAB 8/7/13), IAB 10/2/13, effective 1/1/14]

CHAPTER 102  
RULES OF PRACTICE

**27—102.1(466A) Definitions.** All words and terms defined in Iowa Code Supplement chapter 466A and employed in these rules are given the definitions found in that legislation. The following words and terms used in these rules shall have the meanings hereafter ascribed to them:

“*Auditor*” means the auditor of the state of Iowa.

“*Board*” means the watershed improvement review board as established in Iowa Code Supplement section 466A.3.

“*Committee*” means a local watershed improvement committee as provided in Iowa Code Supplement section 466A.4.

“*Division*” means the division of soil conservation within the department of agriculture and land stewardship as established in Iowa Code section 161A.4.

“*Eligible applicant*” means a nonprofit organization authorized by the secretary of state; a soil and water conservation district; a public water supply utility; a county; a city; or a county conservation board.

“*Fund*” means the watershed improvement fund as created pursuant to Iowa Code Supplement section 466A.2.

“*State*” means the state of Iowa.

“*Treasurer*” means the treasurer of the state of Iowa.

[ARC 1053C, IAB 10/2/13, effective 1/1/14]

**27—102.2(466A) Public information.** The public is invited to obtain information or make informal requests of the board by addressing these matters, either orally or in writing, to the chairperson of the Iowa Watershed Improvement Review Board, Department of Agriculture and Land Stewardship, Wallace State Office Building, 502 E. 9th St., Des Moines, Iowa 50319, or from the department’s Web site at [www.iowaagriculture.gov/IWIRB.asp](http://www.iowaagriculture.gov/IWIRB.asp).

[ARC 1053C, IAB 10/2/13, effective 1/1/14]

**27—102.3(466A) Informal settlement of controversies.** Every possible attempt will be made to handle all complaints and controversies, whether raised by the board or by members of the public, in an informal manner.

**102.3(1)** In cases of a routine nature, the chairperson shall attempt to settle the matter. In cases indicating a need for interpretation of board policy or legal interpretation, the chairperson may defer action until after consultation with legal counsel, or the chairperson may defer action until after discussion of the subject at a board meeting.

**102.3(2)** In cases not of a routine nature, or in cases in which the efforts of the chairperson are unsuccessful, the board itself shall act to resolve the matter. In cases indicating a need for legal advice, the board may defer action until after consultation with legal counsel.

**27—102.4(466A) Declaratory orders.** On petition by an interested party who is aggrieved or adversely affected by the question contained in the petition, the board may issue a declaratory order with respect to the interpretation or applicability of any statutory provision, rule, or other written statement of the law or policy, decision, or order of the board.

**102.4(1)** Petitions shall be titled “PETITION FOR DECLARATORY ORDER” and shall include the name and address of all petitioners. The body of the petition must state the precise factual situation involved, the exact question to which an answer is desired, and the exact words, passages, sentences, or paragraphs which are the subject of inquiry.

**102.4(2)** The petition shall be filed at the office of the board at Wallace State Office Building, 502 E. 9th St., Des Moines, Iowa 50319.

**102.4(3)** The board will refuse to issue a declaratory order if the petition does not state with enough specificity the factual situation or the question presented; if the issuance of the order would not be in the best interests of the public; or for any other reason the board deems just and proper.

**102.4(4)** The board shall issue an order or dismiss the petition within 60 days of the filing of the petition except that when additional information is requested, the order shall be issued within 60 days following receipt of the requested information.

**27—102.5(466A) Petition for adoption of rules.** Any interested person may file with the board a written request that the board adopt, amend, or repeal a rule. The petition shall be addressed to the Iowa Watershed Improvement Review Board, Department of Agriculture and Land Stewardship, Wallace State Office Building, 502 E. 9th St., Des Moines, Iowa 50319, and shall include:

1. The names of those requesting the change.
2. The proposed rule or present rule as it would read following the desired amendment.
3. The reason for the proposed rule or amendment.
4. The statutory authority for the proposed rule or amendment.

Within 60 days following receipt of the petition, the board shall either deny the petition in writing on the merits, stating the board's reason for denial, or initiate rule-making proceedings.

These rules are intended to implement Iowa Code chapter 466A.

[Filed emergency 8/25/05—published 9/14/05, effective 8/25/05]

[Filed 1/27/06, Notice 9/14/05—published 2/15/06, effective 4/3/06]

[Filed ARC 1053C (Notice ARC 0927C, IAB 8/7/13), IAB 10/2/13, effective 1/1/14]

CHAPTER 103  
APPOINTMENT AND TERMS OF MEMBERS

**27—103.1(466A) Appointments.**

**103.1(1)** Not later than three months prior to the end of its board member's term, each organization identified in 27—101.1(466A) shall submit to the governor a name for appointment to the board.

**103.1(2)** Not later than 60 days prior to the end of each board member's term of office, the governor shall name a successor pursuant to 103.1(1).

**27—103.2(466A) Terms.** An appointed member shall not serve more than three consecutive terms.

These rules are intended to implement Iowa Code chapter 466A.

[Filed emergency 8/25/05—published 9/14/05, effective 8/25/05]

[Filed 1/27/06, Notice 9/14/05—published 2/15/06, effective 4/3/06]

[Filed ARC 1053C (Notice ARC 0927C, IAB 8/7/13), IAB 10/2/13, effective 1/1/14]



CHAPTER 104  
LOCAL WATERSHED IMPROVEMENT COMMITTEES

**27—104.1(466A) Purpose.** A committee shall be organized for the purposes of applying for a local watershed improvement grant and implementing a local watershed project.

**27—104.2(466A) Structure.** A committee must be authorized by the secretary of state as a not-for-profit organization. The majority of the members of the committee shall represent a cause of the impairment of the watershed.

**27—104.3(466A) Governmental entities.** A federal, state or local governmental entity may not be a recipient of a grant from the board, with the exception of a soil and water conservation district, public water supply utility, county, county conservation board, or city. A federal, state or local governmental entity may partner with an eligible applicant to implement a local watershed project.

[ARC 1053C, IAB 10/2/13, effective 1/1/14]

**27—104.4(466A) Responsibilities.** A committee or an eligible applicant shall be responsible for application for and implementation of an approved local watershed grant, including providing authorization for project bids and project expenditures under the grant.

**104.4(1)** The committee or an eligible applicant shall monitor local performance throughout the local watershed grant project and shall submit a report at six-month intervals or at a frequency set forth in the grant agreement regarding the progress and findings of the project.

**104.4(2)** The committee or an eligible applicant shall provide oversight data before, during, and after the project's completion.

[ARC 1053C, IAB 10/2/13, effective 1/1/14]

**27—104.5(466A) Audit.** A committee or an eligible applicant receiving a grant from the board may be subject to an audit performed by the auditor.

[ARC 1053C, IAB 10/2/13, effective 1/1/14]

These rules are intended to implement Iowa Code chapter 466A.

[Filed emergency 8/25/05—published 9/14/05, effective 8/25/05]

[Filed 1/27/06, Notice 9/14/05—published 2/15/06, effective 4/3/06]

[Filed ARC 1053C (Notice ARC 0927C, IAB 8/7/13), IAB 10/2/13, effective 1/1/14]



CHAPTER 105  
WATERSHED IMPROVEMENT GRANT PROGRAM

**27—105.1(466A) Program purpose.** The board shall issue grant awards to eligible applicants to address water quality impairments including but not limited to agricultural runoff and drainage; stream bank erosion; municipal discharge; stormwater runoff; unsewered communities; industrial discharge; livestock runoff; structures and conservation systems for the prevention and mitigation of floods within the watershed of the project; or removal of channels of waterways to allow waterways to meander.

[ARC 1053C, IAB 10/2/13, effective 1/1/14]

**27—105.2(466A) Grant awards.**

**105.2(1)** The board shall issue a request for applications.

**105.2(2)** The board shall determine the date for submission of grant requests.

**105.2(3)** Projects will be evaluated by the board based on criteria established in the request for applications.

**105.2(4)** Eligible applicants that have been awarded a grant by the board shall be notified not more than 60 days from the date that the request for applications closes.

**105.2(5)** Eligible applicants that have been awarded a grant by the board shall be required to sign a contract with the state before any funds are disbursed. Changes to the grant agreement must be negotiated and meet with the approval of the board.

**105.2(6)** Grant awards shall be for not more than five years and may be extended for an additional five years after the date that the original period would have ended. Each local watershed improvement grant awarded shall not exceed 10 percent of the funds appropriated to the board. A grant recipient shall not be precluded from applying for future grant awards. Grant awards given by the board to an eligible applicant will have the full amount of awarded watershed improvement funds set aside for the entire project length when initially awarded.

**105.2(7)** The board may act to award less than all of the funds appropriated for this program if it deems that applications do not meet the program's objectives. Additional requests for applications may be solicited by the board if all available funds have not been expended.

[ARC 1053C, IAB 10/2/13, effective 1/1/14]

**27—105.3(466A) Disbursement of funds.**

**105.3(1)** Funds will be disbursed according to the grant agreement.

**105.3(2)** An eligible applicant that fails to meet the terms and obligations of its grant agreement shall reimburse the state for the portion of the grant received attributed to this failure.

**27—105.4(466A) Reports.**

**105.4(1)** Eligible applicants that have been awarded a grant by the board shall submit an electronic report at six-month intervals. This report shall include but not be limited to a statement of expenditures; progress toward performance measures established in the grant agreement; progress toward deliverables established in the grant agreement; monitoring methods and results; and the time line for project completion.

**105.4(2)** Eligible applicants that have been awarded a grant by the board shall submit a final electronic report at the conclusion of the grant agreement. This report shall include but not be limited to a final statement of expenditures; performance measures established in the grant agreement; deliverables established in the grant agreement; monitoring methods and results; and findings of the project.

[ARC 1053C, IAB 10/2/13, effective 1/1/14]

These rules are intended to implement Iowa Code chapter 466A.

[Filed emergency 8/25/05—published 9/14/05, effective 8/25/05]

[Filed 1/27/06, Notice 9/14/05—published 2/15/06, effective 4/3/06]

[Filed ARC 1053C (Notice ARC 0927C, IAB 8/7/13), IAB 10/2/13, effective 1/1/14]



CHAPTER 106  
WATERSHED IMPROVEMENT FUND

**27—106.1(466A) Purpose.** The fund shall be used for the enhancement of water quality through a variety of impairment-based, locally directed watershed improvement projects; to positively affect the management and use of water for the purposes of drinking, agriculture, recreation, sport and economic development; and to ensure public participation in the process of determining priorities related to water quality.

**27—106.2(466A) Administration.** The treasurer shall administer the fund upon the direction of the board.

**106.2(1)** Moneys in the fund shall be used exclusively for carrying out the purposes of the fund.

**106.2(2)** Moneys appropriated to the fund and any other moneys available to and obtained or accepted by the treasurer for placement in the fund shall be deposited in the fund.

**106.2(3)** Moneys appropriated to the treasurer and deposited in the fund shall not be used by the treasurer for administrative purposes.

**106.2(4)** Notwithstanding Iowa Code section 12C.7, subsection 2, interest or earnings on moneys in the fund shall be credited to the fund.

**106.2(5)** Notwithstanding Iowa Code section 8.33, moneys in the fund that remain unencumbered or unobligated at the end of the fiscal year shall not revert, but shall remain available for the same purpose in the succeeding fiscal year.

These rules are intended to implement Iowa Code chapter 466A.

[Filed emergency 8/25/05—published 9/14/05, effective 8/25/05]

[Filed 1/27/06, Notice 9/14/05—published 2/15/06, effective 4/3/06]

[Filed ARC 1053C (Notice ARC 0927C, IAB 8/7/13), IAB 10/2/13, effective 1/1/14]



**INSURANCE DIVISION[191]**

[Prior to 10/22/86, see Insurance Department[510], renamed Insurance Division[191] under the “umbrella” of Department of Commerce by the 1986 Iowa Acts, Senate File 2175]

*ORGANIZATION AND PROCEDURES*

## CHAPTER 1

## ORGANIZATION OF DIVISION

- 1.1(502,505) Organization
- 1.2(502,505) Location and contact information
- 1.3(22,502,505) Public information and inspection of records
- 1.4(505) Service of process

## CHAPTER 2

## DECLARATORY ORDERS

- 2.1(17A) Petition for declaratory order
- 2.2(17A) Notice of petition
- 2.3(17A) Intervention
- 2.4(17A) Briefs
- 2.5(17A) Inquiries
- 2.6(17A) Service and filing of petitions and other papers
- 2.7(17A) Consideration
- 2.8(17A) Action on petition
- 2.9(17A) Refusal to issue order
- 2.10(17A) Contents of declaratory order—effective date
- 2.11(17A) Copies of orders
- 2.12(17A) Effect of a declaratory order

## CHAPTER 3

## CONTESTED CASES

- 3.1(17A) Scope and applicability
- 3.2(17A) Definitions
- 3.3(17A) Time requirements
- 3.4(17A) Requests for contested case proceeding
- 3.5(17A) Commencement of hearing; notice
- 3.6(17A) Presiding officer
- 3.7(17A) Waiver of procedures
- 3.8(17A) Telephone proceedings
- 3.9(17A) Disqualification
- 3.10(17A) Consolidation—severance
- 3.11(17A) Pleadings
- 3.12(17A) Service and filing of pleadings and other papers
- 3.13(17A) Discovery
- 3.14(17A) Subpoenas
- 3.15(17A) Motions
- 3.16(17A) Prehearing conference
- 3.17(17A) Continuances
- 3.18(17A) Withdrawals
- 3.19(17A) Intervention
- 3.20(17A) Hearing procedures
- 3.21(17A) Evidence
- 3.22(17A) Default
- 3.23(17A) Ex parte communication
- 3.24(17A) Recording costs

3.25(17A)	Interlocutory appeals
3.26(17A)	Final decision
3.27(17A)	Appeals and review
3.28(17A)	Applications for rehearing
3.29(17A)	Stay of agency action
3.30(17A)	No factual dispute contested cases
3.31(17A)	Emergency adjudicative proceedings
3.32(502,505,507B)	Summary cease and desist orders
3.33(17A,502,505)	Informal settlement
3.34(17A,502,505)	Witness fees

## CHAPTER 4

### AGENCY PROCEDURE FOR RULE MAKING AND WAIVER OF RULES

#### DIVISION I

##### AGENCY PROCEDURE FOR RULE MAKING

4.1(17A)	Applicability
4.2(17A)	Advice on possible rules before notice of proposed rule adoption
4.3(17A)	Public rule-making docket
4.4(17A)	Notice of proposed rule making
4.5(17A)	Public participation
4.6(17A)	Regulatory analysis
4.7(17A,25B)	Fiscal impact statement
4.8(17A)	Time and manner of rule adoption
4.9(17A)	Variance between adopted rule and rule proposed in Notice of Intended Action
4.10(17A)	Exemptions from public rule-making procedures
4.11(17A)	Concise statement of reasons
4.12(17A)	Contents, style, and form of rule
4.13(17A)	Agency rule-making record
4.14(17A)	Filing of rules
4.15(17A)	Effectiveness of rules prior to publication
4.16(17A)	General statements of policy
4.17(17A)	Review of rules by division
4.18(17A)	Petition for rule making
4.19 and 4.20	Reserved

#### DIVISION II

##### WAIVER AND VARIANCE RULES

4.21(17A)	Definition
4.22(17A)	Scope
4.23(17A)	Applicability of Division II of Chapter 4
4.24(17A)	Criteria for waiver or variance
4.25(17A)	Filing of petition
4.26(17A)	Content of petition
4.27(17A)	Additional information
4.28(17A)	Notice
4.29(17A)	Hearing procedures
4.30(17A)	Ruling
4.31(17A)	Public availability
4.32(17A)	Summary reports
4.33(17A)	Cancellation of a waiver
4.34(17A)	Violations
4.35(17A)	Defense
4.36(17A)	Judicial review

*REGULATION OF INSURERS*

## CHAPTER 5

## REGULATION OF INSURERS—GENERAL PROVISIONS

- 5.1(507) Examination reports
- 5.2(505,507) Examination for admission
- 5.3(507,508,515) Submission of quarterly financial information
- 5.4(505,508,515,520) Surplus notes
- 5.5(505,515,520) Maximum allowable premium volume
- 5.6(505,515,520) Treatment of various items on the financial statement
- 5.7(505) Ordering withdrawal of domestic insurers from states
- 5.8(505) Monitoring
- 5.9(505) Rate and form filings
- 5.10(511) Life companies—permissible investments
- 5.11(511) Investment of funds
- 5.12(515) Collateral loans
- 5.13(508,515) Loans to officers, directors, employees, etc.
- 5.14 Reserved
- 5.15(508,512B,514,514B,515,520) Accounting practices and procedures manual and annual statement instructions
- 5.16 to 5.19 Reserved
- 5.20(508) Computation of reserves

## UNEARNED PREMIUM RESERVES ON MORTGAGE GUARANTY INSURANCE POLICIES

- 5.21(515C) Unearned premium reserve factors
- 5.22(515C) Contingency reserve
- 5.23(507C) Standards
- 5.24(507C) Commissioner's authority
- 5.25 Reserved
- 5.26(508,515) Participation in the NAIC Insurance Regulatory Information System
- 5.27(508,515,520) Asset valuation
- 5.28(508,515,520) Risk-based capital and surplus
- 5.29(508,515) Actuarial certification of reserves
- 5.30(515) Single maximum risk—fidelity and surety risks
- 5.31(515) Reinsurance contracts
- 5.32(511,515) Investments in medium grade and lower grade obligations
- 5.33(510) Credit for reinsurance
- 5.34(508) Actuarial opinion and memorandum
- 5.35 to 5.39 Reserved
- 5.40(515) Premium tax
- 5.41(508) Tax on gross premiums—life companies
- 5.42(432) Cash refund of premium tax
- 5.43(510) Managing general agents

## DISCLOSURE OF MORTGAGE LOAN APPLICATIONS

- 5.44 to 5.49 Reserved
- 5.50(535A) Purpose
- 5.51(535A) Definitions
- 5.52(535A) Filing of reports
- 5.53(535A) Form and content of reports
- 5.54(535A) Additional information required
- 5.55(535A) Written complaints

## CHAPTER 6

## ORGANIZATION OF DOMESTIC INSURANCE COMPANIES

6.1(506)	Definitions
6.2(506)	Promoters contributions
6.3(506)	Escrow
6.4(506)	Alienation
6.5(506)	Sales to promoters
6.6(506)	Options
6.7(506)	Qualifications of management
6.8(506)	Chief executive
6.9(506)	Directors

## CHAPTER 7

## DOMESTIC STOCK INSURERS PROXIES

## PROXY REGULATIONS

7.1(523)	Application of regulation
7.2(523)	Proxies, consents and authorizations
7.3(523)	Disclosure of equivalent information
7.4(523)	Definitions
7.5(523)	Information to be furnished to stockholders
7.6(523)	Requirements as to proxy
7.7(523)	Material required to be filed
7.8(523)	False or misleading statements
7.9(523)	Prohibition of certain solicitations
7.10(523)	Special provisions applicable to election contests

## SCHEDULE A

## INFORMATION REQUIRED IN PROXY STATEMENT

## SCHEDULE B

INFORMATION TO BE INCLUDED IN STATEMENTS FILED BY OR ON BEHALF  
OF A PARTICIPANT (OTHER THAN THE INSURER) IN A PROXY SOLICITATION  
IN AN ELECTION CONTEST  
POLICYHOLDER PROXY SOLICITATION

7.11(523)	Application
7.12(523)	Conditions—revocation
7.13(523)	Filing proxy
7.14(523)	Solicitation by agents—use of funds
7.15 to 7.19	Reserved

## STOCK TRANSACTION REPORTING

7.20(523)	Statement of changes of beneficial ownership of securities
-----------	--

## CHAPTER 8

## BENEVOLENT ASSOCIATIONS

8.1 and 8.2	Reserved
8.3(512A)	Organization
8.4(512A)	Membership
8.5(512A)	Fees, dues and assessments
8.6(512A)	Reserve fund
8.7(512A)	Certificates
8.8(512A)	Beneficiaries
8.9(512A)	Mergers
8.10(512A)	Directors and officers
8.11(512A)	Stockholders
8.12(512A)	Bookkeeping and accounts

## CHAPTER 9

## Reserved

*INSURANCE PRODUCERS*

## CHAPTER 10

## LICENSING OF INSURANCE PRODUCERS

## DIVISION I

## LICENSING OF INSURANCE PRODUCERS

10.1(522B)	Purpose and authority
10.2(522B)	Definitions
10.3(522B)	Requirement to hold a license
10.4(522B)	Licensing of resident producers
10.5(522B)	Licensing of nonresident producers
10.6(522B)	Issuance of license
10.7(522B)	License lines of authority
10.8(522B)	License renewal
10.9(522B)	License reinstatement
10.10(522B)	Reinstatement or reissuance of a license after suspension, revocation or forfeiture in connection with disciplinary matters; and forfeiture in lieu of compliance
10.11(522B)	Temporary licenses
10.12(522B)	Change in name, address or state of residence
10.13(522B)	Reporting of actions
10.14(522B)	Commissions and referral fees
10.15(522B)	Appointments
10.16(522B)	Appointment renewal
10.17(522B)	Appointment terminations
10.18(522B)	Licensing of a business entity
10.19(522B)	Use of senior-specific certifications and professional designations in the sale of life insurance and annuities
10.20(522B)	Violations and penalties
10.21(252J)	Suspension for failure to pay child support
10.22(261)	Suspension for failure to pay student loan
10.23(82GA,SF2428)	Suspension for failure to pay state debt
10.24(522B)	Administration of examinations
10.25(522B)	Forms
10.26(522B)	Fees
10.27 to 10.50	Reserved

## DIVISION II

## LICENSING OF CAR RENTAL COMPANIES AND EMPLOYEES

10.51(522A)	Purpose
10.52(522A)	Definitions
10.53(522A)	Requirement to hold a license
10.54(522A)	Limited licensee application process
10.55(522A)	Counter employee licenses
10.56(522A)	Duties of limited licensees
10.57(522A)	License renewal
10.58(522A)	Limitation on fees
10.59(522A)	Change in name or address
10.60(522A)	Violations and penalties

CHAPTER 11  
CONTINUING EDUCATION FOR  
INSURANCE PRODUCERS

11.1(505,522B)	Statutory authority—purpose—applicability
11.2(505,522B)	Definitions
11.3(505,522B)	Continuing education requirements for producers
11.4(505,522B)	Proof of completion of continuing education requirements
11.5(505,522B)	Course approval
11.6(505,522B)	Topic guidelines
11.7(505,522B)	CE course renewal
11.8(505,522B)	Appeals
11.9(505,522B)	CE provider approval
11.10(505,522B)	CE provider's responsibilities
11.11(505,522B)	Prohibited conduct—CE providers
11.12(505,522B)	Outside vendor
11.13(505,522B)	CE course audits
11.14(505,522B)	Fees and costs

CHAPTER 12  
PORT OF ENTRY REQUIREMENTS

12.1(508,515)	Purpose
12.2(508,515)	Trust and other admission requirements
12.3(508,515)	Examination and preferred supervision
12.4(508,515)	Surplus required
12.5(508,515)	Investments

CHAPTER 13  
CONSENT FOR PROHIBITED PERSONS  
TO ENGAGE IN THE BUSINESS OF INSURANCE

13.1(505,522B)	Purpose and authority
13.2(505,522B)	Definitions
13.3(505,522B)	Requirement for prohibited persons to obtain consent
13.4(505,522B)	Applications for consent
13.5(505,522B)	Consideration of applications for consent
13.6(505,522B)	Review of application by the division
13.7(505,522B)	Consent effective for specified positions and responsibilities only
13.8(505,522B)	Change in circumstances
13.9(505,522B)	Burden of proof
13.10(505,522B)	Violations and penalties

*UNFAIR TRADE PRACTICES*

CHAPTER 14  
LIFE INSURANCE ILLUSTRATIONS MODEL REGULATION

14.1(507B)	Purpose
14.2(507B)	Authority
14.3(507B)	Applicability and scope
14.4(507B)	Definitions
14.5(507B)	Policies to be illustrated
14.6(507B)	General rules and prohibitions
14.7(507B)	Standards for basic illustrations
14.8(507B)	Standards for supplemental illustrations
14.9(507B)	Delivery of illustration and record retention

14.10(507B)	Annual report; notice to policyowners
14.11(507B)	Annual certifications
14.12(507B)	Penalties
14.13(507B)	Separability
14.14(507B)	Effective date

## CHAPTER 15 UNFAIR TRADE PRACTICES

### DIVISION I SALES PRACTICES

15.1(507B)	Purpose
15.2(507B)	Definitions
15.3(507B)	Advertising
15.4(507B)	Life insurance cost and benefit disclosure requirements
15.5(507B)	Health insurance sales to individuals 65 years of age or older
15.6(507B)	Preneed funeral contracts or prearrangements
15.7(507B)	Twisting prohibited
15.8(507B)	Producer responsibilities
15.9(507B)	Right to return a life insurance policy or annuity (free look)
15.10(507B)	Uninsured/underinsured automobile coverage—notice required
15.11(507B)	Unfair discrimination
15.12(507B)	Testing restrictions of insurance applications for the human immunodeficiency virus
15.13(507B)	Records maintenance
15.14(505,507B)	Enforcement section—cease and desist and penalty orders
15.15 to 15.30	Reserved

### DIVISION II CLAIMS

15.31(507B)	General claims settlement guidelines
15.32(507B)	Prompt payment of certain health claims
15.33(507B)	Audit procedures for medical claims
15.34 to 15.40	Reserved
15.41(507B)	Claims settlement guidelines for property and casualty insurance
15.42(507B)	Acknowledgment of communications by property and casualty insurers
15.43(507B)	Standards for settlement of automobile insurance claims
15.44(507B)	Standards for determining replacement cost and actual cost values
15.45(507B)	Guidelines for use of aftermarket crash parts in motor vehicles
15.46 to 15.50	Reserved

### DIVISION III DISCLOSURE FOR SMALL FACE AMOUNT LIFE INSURANCE POLICIES

15.51(507B)	Purpose
15.52(507B)	Definition
15.53(507B)	Exemptions
15.54(507B)	Disclosure requirements
15.55(507B)	Insurer duties
15.56 to 15.60	Reserved

### DIVISION IV ANNUITY DISCLOSURE REQUIREMENTS

15.61(507B)	Purpose
15.62(507B)	Applicability and scope
15.63(507B)	Definitions
15.64(507B)	Standards for the disclosure document and Buyer's Guide

15.65(507B)	Content of disclosure documents
15.66(507B)	Standards for annuity illustrations
15.67(507B)	Report to contract owners
15.68(507B)	Penalties
15.69(507B)	Severability
15.70 and 15.71	Reserved

DIVISION V  
SUITABILITY IN ANNUITY TRANSACTIONS

15.72(507B)	Purpose
15.73(507B)	Applicability and scope
15.74(507B)	Definitions
15.75(507B)	Duties of insurers and of insurance producers
15.76(507B)	Insurance producer training
15.77(507B)	Compliance; mitigation; penalties
15.78(507B)	Record keeping
15.79	Reserved

DIVISION VI  
INDEXED PRODUCTS TRAINING REQUIREMENT

15.80(507B,522B)	Purpose
15.81(507B,522B)	Definitions
15.82(507B,522B)	Special training required
15.83(507B,522B)	Conduct of training course
15.84(507B,522B)	Insurer duties
15.85(507B,522B)	Verification of training
15.86(507B,522B)	Penalties
15.87(507B,522B)	Compliance date

CHAPTER 16  
REPLACEMENT OF LIFE INSURANCE AND ANNUITIES

DIVISION I

16.1 to 16.20	Reserved
---------------	----------

DIVISION II

16.21(507B)	Purpose
16.22(507B)	Definitions
16.23(507B)	Exemptions
16.24(507B)	Duties of producers
16.25(507B)	Duties of all insurers that use producers on or after January 1, 2001
16.26(507B)	Duties of replacing insurers that use producers
16.27(507B)	Duties of the existing insurer
16.28(507B)	Duties of insurers with respect to direct-response solicitations
16.29(507B)	Violations and penalties
16.30(507B)	Severability

CHAPTER 17  
LIFE AND HEALTH REINSURANCE AGREEMENTS

17.1(508)	Authority and purpose
17.2(508)	Scope
17.3(508)	Accounting requirements
17.4(508)	Written agreements
17.5(508)	Existing agreements

CHAPTER 18  
CEMETERIES

- 18.1(523I,566A) Perpetual care cemeteries
- 18.2(523I,566A) Administration
- 18.3(523I,566A) Public access to hearings
- 18.4 Reserved
- 18.5(523I,566A) Forms—content
- 18.6(523I,566A) Annual report by perpetual care cemeteries
- 18.7(523I,566A) Annual reports and perpetual care cemetery permits

CHAPTER 19  
Reserved

*PROPERTY AND CASUALTY INSURANCE*

CHAPTER 20  
PROPERTY AND CASUALTY INSURANCE

DIVISION I  
FORM AND RATE REQUIREMENTS

- 20.1(505,509,514A,515,515A,515F) General filing requirements
- 20.2(505) Objection to filing
- 20.3 Reserved
- 20.4(505,509,514A,515,515A,515F) Policy form filing
- 20.5(515A) Rate or manual rule filing
- 20.6(515A) Exemption from filing requirement
- 20.7 Reserved
- 20.8(515A) Rate filings for crop-hail insurance
- 20.9 and 20.10 Reserved
- 20.11(515) Exemption from form and rate filing requirements
- 20.12 to 20.40 Reserved

DIVISION II  
IOWA FAIR PLAN ACT

- 20.41(515,515F) Purpose
- 20.42(515,515F) Scope
- 20.43(515,515F) Definitions
- 20.44(515,515F) Eligible risks
- 20.45(515,515F) Membership
- 20.46(515,515F) Administration
- 20.47(515,515F) Duties of the governing committee
- 20.48(515,515F) Annual and special meetings
- 20.49(515,515F) Application for insurance
- 20.50(515,515F) Inspection procedure
- 20.51(515,515F) Procedure after inspection and receipt of application
- 20.52(515,515F) Reasonable underwriting standards for property coverage
- 20.53(515,515F) Reasonable underwriting standards for liability coverage
- 20.54(515,515F) Cancellation; nonrenewal and limitations; review of eligibility
- 20.55(515,515F) Assessments
- 20.56(515,515F) Commission
- 20.57(515,515F) Public education
- 20.58(515,515F) Cooperation and authority of producers
- 20.59(515,515F) Review by commissioner
- 20.60(515,515F) Indemnification
- 20.61 to 20.69 Reserved

DIVISION III  
CERTIFICATES OF INSURANCE FOR COMMERCIAL LENDING TRANSACTIONS

- 20.70(515) Purpose  
20.71(515) Definitions  
20.72(515) Evidence of insurance

CHAPTER 21  
REQUIREMENTS FOR EXCESS AND SURPLUS LINES,  
RISK RETENTION GROUPS AND PURCHASING GROUPS

- 21.1(515) Definitions  
21.2(515) Qualified surplus lines carriers' duties  
21.3(515) Producers' duties  
21.4(515) Producers' duty to insured; evidence of coverage  
21.5(515) Procedures for qualification and renewal of a nonadmitted insurer as a qualified surplus lines carrier  
21.6(515E) Risk retention groups  
21.7(515E) Procedures for qualification as a risk retention group  
21.8(515E) Procedures for qualification as a purchasing group  
21.9(515,515E) Failure to comply; penalties

CHAPTER 22  
FINANCIAL GUARANTY INSURANCE

- 22.1(515C) Definitions  
22.2(515) Financial requirements and reserves

CHAPTER 23  
MOTOR VEHICLE SERVICE CONTRACTS

- 23.1(516E) Purpose  
23.2(516E) Applicability and scope  
23.3(516E) Application of insurance laws  
23.4(516E) Administration  
23.5(516E) Public access to hearings  
23.6(516E) Public access to records  
23.7(516E) Filing procedures  
23.8(516E) Fees  
23.9(516E) Forms  
23.10(516E) Prohibited acts—unfair discrimination or trade practices  
23.11(516E) Prohibited acts—unfair or deceptive trade practices involving used or rebuilt parts  
23.12(516E) Violations  
23.13(516E) Procedures for public complaints

CHAPTER 24  
IOWA RETIREMENT FACILITIES

- 24.1(523D) Purpose  
24.2(523D) Title  
24.3(523D) Definitions  
24.4(523D) Administration  
24.5(523D) Misrepresentations  
24.6(523D) Complaints  
24.7(523D) Address for filings  
24.8(523D) Fees  
24.9(523D) Forms  
24.10(523D) Financial statements, studies, and forecasts

- 24.11(523D) Amendments to the disclosure statement
- 24.12(523D) Standards for the disclosure statement

CHAPTER 25  
MILITARY SALES PRACTICES

- 25.1(505) Purpose and authority
- 25.2(505) Scope
- 25.3(505) Exemptions
- 25.4(505) Definitions
- 25.5(505) Practices declared false, misleading, deceptive or unfair on a military installation
- 25.6(505) Practices declared false, misleading, deceptive or unfair regardless of location
- 25.7(505) Reporting requirements
- 25.8(505) Violation and penalties
- 25.9(505) Severability

CHAPTER 26  
Reserved

CHAPTER 27  
PREFERRED PROVIDER ARRANGEMENTS

- 27.1(514F) Purpose
- 27.2(514F) Definitions
- 27.3(514F) Preferred provider arrangements
- 27.4(514F) Health benefit plans
- 27.5(514F) Preferred provider participation requirements
- 27.6(514F) General requirements
- 27.7(514F) Civil penalties
- 27.8(514F) Health care insurer requirements

CHAPTER 28  
CREDIT LIFE AND CREDIT  
ACCIDENT AND HEALTH INSURANCE

- 28.1(509) Purpose
- 28.2(509) Definitions
- 28.3(509) Rights and treatment of debtors
- 28.4(509) Policy forms and related material
- 28.5(509) Determination of reasonableness of benefits in relation to premium charge
- 28.6 Reserved
- 28.7(509) Credit life insurance rates
- 28.8(509) Credit accident and health insurance
- 28.9(509) Refund formulas
- 28.10(509) Experience reports and adjustment of prima facie rates
- 28.11(509) Use of rates—direct business only
- 28.12(509) Supervision of credit insurance operations
- 28.13(509) Prohibited transactions
- 28.14(509) Disclosure and readability
- 28.15(509) Severability
- 28.16(509) Effective date
- 28.17(509) Fifteen-day free examination

CHAPTER 29  
CONTINUATION RIGHTS UNDER GROUP ACCIDENT  
AND HEALTH INSURANCE POLICIES

- 29.1(509B) Definitions
- 29.2(509B) Notice regarding continuation rights
- 29.3(509B) Qualifying events for continuation rights
- 29.4(509B) Interplay between chapter 509B and COBRA
- 29.5(509B) Effective date for compliance

*LIFE AND HEALTH INSURANCE*

CHAPTER 30  
LIFE INSURANCE POLICIES

- 30.1(508) Purpose
- 30.2(508) Scope
- 30.3(508) Definitions
- 30.4(508) Prohibitions, regulations and disclosure requirements
- 30.5(508) General filing requirements
- 30.6(508) Back dating of life policies
- 30.7(508,515) Expiration date of policy vs. charter expiration date
- 30.8(509) Electronic delivery of group life insurance certificates

CHAPTER 31  
LIFE INSURANCE COMPANIES—VARIABLE ANNUITIES CONTRACTS

- 31.1(508) Definitions
- 31.2(508) Insurance company qualifications
- 31.3(508) Filing, policy forms and provision
- 31.4(508) Separate account or accounts and investments
- 31.5(508) Required reports
- 31.6(508) Producers
- 31.7(508) Foreign companies

CHAPTER 32  
DEPOSITS BY A DOMESTIC LIFE COMPANY IN A  
CUSTODIAN BANK OR CLEARING CORPORATION

- 32.1(508) Purpose
- 32.2(508) Definitions
- 32.3(508) Requirements upon custodial account and custodial agreement
- 32.4(508) Requirements upon custodians
- 32.5(508,511) Deposit of securities

CHAPTER 33  
VARIABLE LIFE INSURANCE MODEL REGULATION

- 33.1(508A) Authority
- 33.2(508A) Definitions
- 33.3(508A) Qualification of insurer to issue variable life insurance
- 33.4(508A) Insurance policy requirements
- 33.5(508A) Reserve liabilities for variable life insurance
- 33.6(508A) Separate accounts
- 33.7(508A) Information furnished to applicants
- 33.8(508A) Applications
- 33.9(508A) Reports to policyholders
- 33.10(508A) Foreign companies

33.11 Reserved  
 33.12(508A) Separability article

#### CHAPTER 34

##### NONPROFIT HEALTH SERVICE CORPORATIONS

34.1(514) Purpose  
 34.2(514) Definitions  
 34.3(514) Annual report requirements  
 34.4(514) Arbitration  
 34.5(514) Filing requirements  
 34.6(514) Participating hospital contracts  
 34.7(514) Composition, nomination, and election of board of directors

#### CHAPTER 35

##### ACCIDENT AND HEALTH INSURANCE

###### BLANKET ACCIDENT AND SICKNESS INSURANCE

35.1(509) Purpose  
 35.2(509) Scope  
 35.3(509) Definitions  
 35.4(509) Required provisions  
 35.5(509) Application and certificates not required  
 35.6(509) Facility of payment  
 35.7(509) General filing requirements  
 35.8(509) Electronic delivery of accident and health group insurance certificates  
 35.9 to 35.19 Reserved  
 35.20(509A) Life and health self-funded plans  
 35.21(509) Review of certificates issued under group policies

###### LARGE GROUP HEALTH INSURANCE COVERAGE

35.22(509) Purpose  
 35.23(509) Definitions  
 35.24(509) Eligibility to enroll  
 35.25(509) Special enrollments  
 35.26(509) Group health insurance coverage policy requirements  
 35.27(509) Methods of counting creditable coverage  
 35.28(509) Certificates of creditable coverage  
 35.29(509) Notification requirements  
 35.30 Reserved  
 35.31(509) Disclosure requirements  
 35.32(514C) Treatment options  
 35.33(514C) Emergency services  
 35.34(514C) Provider access  
 35.35(509) Reconstructive surgery

###### CONSUMER GUIDE

35.36(514K) Purpose  
 35.37(514K) Information filing requirements  
 35.38(514K) Limitation of information published  
 35.39(514C) Contraceptive coverage  
 35.40(514C) Autism spectrum disorders coverage

CHAPTER 36  
INDIVIDUAL ACCIDENT AND HEALTH—MINIMUM  
STANDARDS AND RATE HEARINGS

DIVISION I  
MINIMUM STANDARDS

36.1(514D)	Purpose
36.2(514D)	Applicability and scope
36.3(514D)	Effective date
36.4(514D)	Policy definitions
36.5(514D)	Prohibited policy provisions
36.6(514D)	Accident and sickness minimum standards for benefits
36.7(514D)	Required disclosure provisions
36.8(507B)	Requirements for replacement
36.9(514D)	Filing requirements
36.10(514D)	Loss ratios
36.11(514D)	Certification
36.12(514D)	Severability
36.13(513C,514D)	Individual health insurance coverage for children under the age of 19
36.14 to 36.19	Reserved

DIVISION II  
RATE HEARINGS

36.20(514D,83GA,SF2201)	Rate hearings
-------------------------	---------------

CHAPTER 37  
MEDICARE SUPPLEMENT INSURANCE

DIVISION I  
MEDICARE SUPPLEMENT INSURANCE MINIMUM STANDARDS

37.1(514D)	Purpose
37.2(514D)	Applicability and scope
37.3(514D)	Definitions
37.4(514D)	Policy definitions and terms
37.5(514D)	Policy provisions
37.6(514D)	Minimum benefit standards for prestandardized Medicare supplement benefit plan policies or certificates issued for delivery prior to January 1, 1992
37.7(514D)	Benefit standards for 1990 standardized Medicare supplement benefit plan policies or certificates issued for delivery on or after January 1, 1992, and with an effective date for coverage prior to June 1, 2010
37.8(514D)	Benefit standards for 2010 standardized Medicare supplement benefit plan policies or certificates issued for delivery with an effective date for coverage on or after June 1, 2010
37.9(514D)	Standard Medicare supplement benefit plans for 1990 standardized Medicare supplement benefit plan policies or certificates with an effective date for coverage prior to June 1, 2010
37.10(514D)	Standard Medicare supplement benefit plans for 2010 standardized Medicare supplement benefit plan policies or certificates with an effective date for coverage on or after June 1, 2010
37.11(514D)	Medicare Select policies and certificates
37.12(514D)	Open enrollment
37.13(514D)	Standards for claims payment
37.14(514D)	Loss ratio standards and refund or credit of premium
37.15(514D)	Filing and approval of policies and certificates and premium rates
37.16(514D)	Permitted compensation arrangements

37.17(514D)	Required disclosure provisions
37.18(514D)	Requirements for application forms and replacement coverage
37.19(514D)	Standards for marketing
37.20(514D)	Appropriateness of recommended purchase and excessive insurance
37.21(514D)	Reporting of multiple policies
37.22(514D)	Prohibition against preexisting conditions, waiting periods, elimination periods and probationary periods in replacement policies or certificates
37.23(514D)	Prohibition against use of genetic information and requests for genetic testing
37.24(514D)	Prohibition against using SHIP prepared materials
37.25(514D)	Guaranteed issue for eligible persons
37.26(514D)	Severability
37.27 to 37.49	Reserved

DIVISION II  
MEDICARE SUPPLEMENT ADVERTISING

37.50(507B,514D)	Purpose
37.51(507B,514D)	Applicability
37.52(507B,514D)	Definitions
37.53(507B,514D)	Form and content of advertisements
37.54(507B,514D)	Testimonials or endorsements by third parties
37.55(507B,514D)	Use of statistics; jurisdictional licensing; status of insurer
37.56(507B,514D)	Identity of insurer
37.57(507B,514D)	Introductory, initial or special offers
37.58(507B,514D)	Enforcement procedures—certificate of compliance
37.59(507B,514D)	Filing for prior review

CHAPTER 38  
COORDINATION OF BENEFITS

DIVISION I

38.1 to 38.11	Reserved
---------------	----------

DIVISION II

38.12(509,514)	Purpose and applicability
38.13(509,514)	Definitions
38.14(509,514)	Use of model COB contract provision
38.15(509,514)	Rules for coordination of benefits
38.16(509,514)	Procedure to be followed by secondary plan to calculate benefits and pay a claim
38.17(509,514)	Notice to covered persons
38.18(509,514)	Miscellaneous provisions

CHAPTER 39  
LONG-TERM CARE INSURANCE

DIVISION I

39.1(514G)	Purpose
39.2(514G)	Authority
39.3(514G)	Applicability and scope
39.4(514G)	Definitions
39.5(514G)	Policy definitions
39.6(514G)	Policy practices and provisions
39.7(514G)	Required disclosure provisions
39.8(514G)	Prohibition against postclaims underwriting
39.9(514D,514G)	Minimum standards for home health care benefits in long-term care insurance policies

39.10(514D,514G)	Requirement to offer inflation protection
39.11(514D,514G)	Requirements for application forms and replacement coverage
39.12(514G)	Reserve standards
39.13(514D)	Loss ratio
39.14(514G)	Filing requirement
39.15(514D,514G)	Standards for marketing
39.16(514D,514G)	Suitability
39.17(514G)	Prohibition against preexisting conditions and probationary periods in replacement policies or certificates
39.18(514G)	Standard format outline of coverage
39.19(514G)	Requirement to deliver shopper's guide
39.20(514G)	Policy summary and delivery of life insurance policies with long-term care riders
39.21(514G)	Reporting requirement for long-term care benefits funded through life insurance by acceleration of the death benefit
39.22(514G)	Unintentional lapse
39.23(514G)	Denial of claims
39.24(514G)	Incontestability period
39.25(514G)	Required disclosure of rating practices to consumers
39.26(514G)	Initial filing requirements
39.27(514G)	Reporting requirements
39.28(514G)	Premium rate schedule increases
39.29(514G)	Nonforfeiture
39.30(514G)	Standards for benefit triggers
39.31(514G)	Additional standards for benefit triggers for qualified long-term care insurance contracts
39.32(514G)	Penalties
39.33 to 39.40	Reserved

## DIVISION II

## INDEPENDENT REVIEW OF BENEFIT TRIGGER DETERMINATIONS

39.41(514G)	Purpose
39.42(514G)	Effective date
39.43(514G)	Definitions
39.44(514G)	Notice of benefit trigger determination and content
39.45(514G)	Notice of internal appeal decision and right to independent review
39.46(514G)	Independent review request
39.47(514G)	Certification process
39.48(514G)	Selection of independent review entity
39.49(514G)	Independent review process
39.50(514G)	Decision notification
39.51(514G)	Insurer information
39.52(514G)	Certification of independent review entity
39.53(514G)	Additional requirements
39.54(514G)	Toll-free telephone number
39.55(514G)	Insurance division application and reports
39.56 to 39.74	Reserved

## DIVISION III

## LONG-TERM CARE PARTNERSHIP PROGRAM

39.75(514H,83GA,HF723)	Purpose
39.76(514H,83GA,HF723)	Effective date
39.77(514H,83GA,HF723)	Definitions
39.78(514H,83GA,HF723)	Eligibility
39.79(514H,83GA,HF723)	Discontinuance of partnership program

- 39.80(514H,83GA,HF723) Required disclosures
- 39.81(514H,83GA,HF723) Form filings
- 39.82(514H,83GA,HF723) Exchanges
- 39.83(514H,83GA,HF723) Required policy terms and disclosures
- 39.84(514H,83GA,HF723) Standards for marketing and suitability
- 39.85(514H,83GA,HF723) Required reports

## CHAPTER 40 HEALTH MAINTENANCE ORGANIZATIONS

(Health and Insurance—Joint Rules)

- 40.1(514B) Definitions
- 40.2(514B) Application
- 40.3(514B) Inspection of evidence of coverage
- 40.4(514B) Governing body and enrollee representation
- 40.5(514B) Quality of care
- 40.6(514B) Change of name
- 40.7(514B) Change of ownership
- 40.8(514B) Termination of services
- 40.9(514B) Complaints
- 40.10(514B) Cancellation of enrollees
- 40.11(514B) Application for certificate of authority
- 40.12(514B) Net worth
- 40.13(514B) Fidelity bond
- 40.14(514B) Annual report
- 40.15(514B) Cash or asset management agreements
- 40.16 Reserved
- 40.17(514B) Reinsurance
- 40.18(514B) Provider contracts
- 40.19(514B) Producers' duties
- 40.20(514B) Emergency services
- 40.21(514B) Reimbursement
- 40.22(514B) Health maintenance organization requirements
- 40.23(514B) Disclosure requirements
- 40.24(514B) Provider access
- 40.25(514B) Electronic delivery of accident and health group insurance certificates

## CHAPTER 41 LIMITED SERVICE ORGANIZATIONS

- 41.1(514B) Definitions
- 41.2(514B) Application
- 41.3(514B) Inspection of evidence of coverage
- 41.4(514B) Governing body and enrollee representation
- 41.5(514B) Quality of care
- 41.6(514B) Change of name
- 41.7(514B) Change of ownership
- 41.8(514B) Complaints
- 41.9(514B) Cancellation of enrollees
- 41.10(514B) Application for certificate of authority
- 41.11(514B) Net equity and deposit requirements
- 41.12(514B) Fidelity bond
- 41.13(514B) Annual report
- 41.14(514B) Cash or asset management agreements

41.15(514B)	Reinsurance
41.16(514B)	Provider contracts
41.17(514B)	Producers' duties
41.18(514B)	Emergency services
41.19(514B)	Reimbursement
41.20(514B)	Limited service organization requirements
41.21(514B)	Disclosure requirements

#### CHAPTER 42

#### GENDER-BLENDED MINIMUM NONFORFEITURE STANDARDS FOR LIFE INSURANCE

42.1(508)	Purpose
42.2(508)	Definitions
42.3(508)	Use of gender-blended mortality tables
42.4(508)	Unfair discrimination
42.5(508)	Separability
42.6(508)	2001 CSO Mortality Table

#### CHAPTER 43

#### ANNUITY MORTALITY TABLES FOR USE IN DETERMINING RESERVE LIABILITIES FOR ANNUITIES

43.1(508)	Purpose
43.2(508)	Definitions
43.3(508)	Individual annuity or pure endowment contracts
43.4(508)	Group annuity or pure endowment contracts
43.5(508)	Application of the 1994 GAR Table
43.6(508)	Separability

#### CHAPTER 44

#### SMOKER/NONSMOKER MORTALITY TABLES FOR USE IN DETERMINING MINIMUM RESERVE LIABILITIES AND NONFORFEITURE BENEFITS

44.1(508)	Purpose
44.2(508)	Definitions
44.3(508)	Alternate tables
44.4(508)	Conditions
44.5(508)	Separability
44.6(508)	2001 CSO Mortality Table

#### *INSURANCE HOLDING COMPANY SYSTEMS*

#### CHAPTER 45

#### INSURANCE HOLDING COMPANY SYSTEMS

45.1(521A)	Purpose
45.2(521A)	Definitions
45.3(521A)	Subsidiaries of domestic insurers
45.4(521A)	Control acquisition of domestic insurer
45.5(521A)	Registration of insurers
45.6(521A)	Alternative and consolidated registrations
45.7(521A)	Exemptions
45.8(521A)	Disclaimers and termination of registration
45.9(521A)	Transactions subject to prior notice—notice filing
45.10(521A)	Extraordinary dividends and other distributions

CHAPTER 46  
MUTUAL HOLDING COMPANIES

46.1(521A)	Purpose
46.2(521A)	Definitions
46.3(521A)	Application—contents—process
46.4(521A)	Plan of reorganization
46.5(521A)	Duties of the commissioner
46.6(521A)	Regulation—compliance
46.7(521A)	Reorganization of domestic mutual insurer with mutual insurance holding company
46.8(521A)	Reorganization of foreign mutual insurer with mutual insurance holding company
46.9(521A)	Mergers of mutual insurance holding companies
46.10(521A)	Stock offerings
46.11(521A)	Regulation of holding company system
46.12(521A)	Reporting of stock ownership and transactions

CHAPTER 47  
VALUATION OF LIFE INSURANCE POLICIES

(Including New Select Mortality Factors)

47.1(508)	Purpose
47.2(508)	Application
47.3(508)	Definitions
47.4(508)	General calculation requirements for basic reserves and premium deficiency reserves
47.5(508)	Calculation of minimum valuation standard for policies with guaranteed nonlevel gross premiums or guaranteed nonlevel benefits (other than universal life policies)
47.6(508)	Calculation of minimum valuation standard for flexible premium and fixed premium universal life insurance policies that contain provisions resulting in the ability of a policyowner to keep a policy in force over a secondary guarantee period
47.7(508)	2001 CSO Mortality Table

*VIATICAL AND LIFE SETTLEMENTS*

CHAPTER 48  
VIATICAL AND LIFE SETTLEMENTS

48.1(508E)	Purpose and authority
48.2(508E)	Definitions
48.3(508E)	License requirements
48.4(508E)	Disclosure statements
48.5(508E)	Contract requirements
48.6(508E)	Filing of forms
48.7(508E)	Reporting requirements
48.8(508E)	Examination or investigations
48.9(508E)	Requirements and prohibitions
48.10(508E)	Penalties; injunctions; civil remedies; cease and desist
48.11(252J)	Suspension for failure to pay child support
48.12(261)	Suspension for failure to pay student loan
48.13(272D)	Suspension for failure to pay state debt
48.14(508E)	Severability

## CHAPTER 49

## FINANCIAL INSTRUMENTS USED IN HEDGING TRANSACTIONS

49.1(511)	Purpose
49.2(511)	Definitions
49.3(511)	Guidelines and internal control procedures
49.4(511)	Documentation requirements
49.5(511)	Trading requirements

*SECURITIES*

## CHAPTER 50

REGULATION OF SECURITIES OFFERINGS AND THOSE WHO ENGAGE  
IN THE SECURITIES BUSINESS

## DIVISION I

## DEFINITIONS AND ADMINISTRATION

50.1(502)	Definitions
50.2(502)	Cost of audit or inspection
50.3(502)	Interpretative opinions or no-action letters
50.4 to 50.9	Reserved

## DIVISION II

## REGISTRATION OF BROKER-DEALERS AND AGENTS

50.10(502)	Broker-dealer registrations, renewals, amendments, succession, and withdrawals
50.11(502)	Principals
50.12(502)	Agent and issuer registrations, renewals and amendments
50.13(502)	Agent continuing education requirements
50.14(502)	Broker-dealer record-keeping requirements
50.15(502)	Broker-dealer minimum financial requirements and financial reporting requirements
50.16(502)	Dishonest or unethical practices in the securities business
50.17(502)	Rules of conduct
50.18(502)	Limited registration of Canadian broker-dealers and agents
50.19(502)	Brokerage services by national and state banks
50.20(502)	Broker-dealers having contracts with national and state banks
50.21(502)	Brokerage services by credit unions, savings banks, and savings and loan institutions
50.22(502)	Broker-dealers having contracts with credit unions, savings banks, and savings and loan institutions
50.23 to 50.29	Reserved

## DIVISION III

REGISTRATION OF INVESTMENT ADVISERS,  
INVESTMENT ADVISER REPRESENTATIVES,  
AND FEDERAL COVERED INVESTMENT ADVISERS

50.30(502)	Electronic filing with designated entity
50.31(502)	Investment adviser applications and renewals
50.32(502)	Application for investment adviser representative registration
50.33(502)	Examination requirements
50.34(502)	Notice filing requirements for federal covered investment advisers
50.35(502)	Withdrawal of investment adviser registration
50.36(502)	Investment adviser brochure
50.37(502)	Cash solicitation
50.38(502)	Prohibited conduct in providing investment advice
50.39(502)	Custody of client funds or securities by investment advisers
50.40(502)	Minimum financial requirements for investment advisers

50.41(502)	Bonding requirements for investment advisers
50.42(502)	Record-keeping requirements for investment advisers
50.43(502)	Financial reporting requirements for investment advisers
50.44(502)	Solely incidental services by certain professionals
50.45(502)	Registration exemption for investment advisers to private funds
50.46(502)	Contents of investment advisory contract
50.47 to 50.49	Reserved

DIVISION IV  
RULES COVERING ALL REGISTERED PERSONS

50.50(502)	Internet advertising by broker-dealers, investment advisers, broker-dealer agents, investment adviser representatives, and federal covered investment advisers
50.51(502)	Consent to service
50.52(252J)	Denial, suspension or revocation of agent or investment adviser representative registration for failure to pay child support
50.53(261)	Denial, suspension or revocation of agent or investment adviser representative registration for failure to pay debts owed to or collected by the college student aid commission
50.54(272D)	Denial, suspension or revocation of agent or investment adviser representative registration for failure to pay state debt
50.55(502)	Use of senior-specific certifications and professional designations
50.56 to 50.59	Reserved

DIVISION V  
REGISTRATION OF SECURITIES

50.60(502)	Notice filings for investment company securities offerings
50.61(502)	Registration of small corporate offerings
50.62(502)	Streamlined registration for certain equity securities
50.63(502)	Registration of multijurisdictional offerings
50.64(502)	Form of financial statements
50.65(502)	Reports contingent to registration by qualification
50.66(502)	NASAA guidelines and statements of policy
50.67(502)	Amendments to registration by qualification
50.68(502)	Delivery of prospectus
50.69(502)	Advertisements
50.70 to 50.79	Reserved

DIVISION VI  
EXEMPTIONS

50.80(502)	Uniform limited offering exemption
50.81(502)	Notice filings for Rule 506 offerings
50.82(502)	Notice filings for agricultural cooperative associations
50.83(502)	Unsolicited order exemption
50.84(502)	Solicitation of interest exemption
50.85(502)	Internet offers exemption
50.86(502)	Denial, suspension, revocation, condition, or limitation of limited offering transaction exemption
50.87(502)	Nonprofit securities exemption
50.88(502)	Transactions with specified investors
50.89(502)	Designated securities manuals
50.90 to 50.99	Reserved

DIVISION VII  
FRAUD AND OTHER PROHIBITED CONDUCT

50.100(502)	Fraudulent practices
50.101(502)	Rescission offers
50.102(502)	Fraudulent, deceptive or manipulative act, practice, or course of business in providing investment advice
50.103(502)	Investment advisory contracts
50.104 to 50.109	Reserved

DIVISION VIII  
VIATICAL SETTLEMENT INVESTMENT CONTRACTS

50.110(502)	Application by viatical settlement investment contract issuers and registration of agents to sell viatical settlement investment contracts
50.111(502)	Risk disclosure
50.112(502)	Advertising of viatical settlement investment contracts
50.113(502)	Duty to disclose

CHAPTERS 51 to 53  
Reserved

CHAPTER 54  
RESIDENTIAL SERVICE CONTRACTS

54.1(523C)	Purpose
54.2(523C)	Definitions
54.3(523C)	Title
54.4(523C)	Scope
54.5(523C)	Application of insurance laws
54.6(523C)	Exemptions
54.7 to 54.9	Reserved
54.10(523C)	Administration
54.11(523C)	Misrepresentations of government approval
54.12(523C)	Public access to hearings
54.13(523C)	Public access to records
54.14(523C)	Procedure for public complaints
54.15(523C)	Fees
54.16(523C)	Forms
54.17 to 54.19	Reserved
54.20(523C)	Service company licenses
54.21(523C)	Suspension or revocation of license
54.22(523C)	Licenses not transferable
54.23 to 54.29	Reserved
54.30(523C)	Forms of contracts
54.31 to 54.39	Reserved
54.40(523C)	Cessation of business—records
54.41(523C)	Records
54.42(523C)	Annual reports
54.43 to 54.49	Reserved
54.50(523C)	Prohibited acts or practices
54.51(523C)	Orders
54.52(523C)	Investigations and subpoenas
54.53(523C)	Audits

CHAPTER 55  
LICENSING OF PUBLIC ADJUSTERS

- 55.1(82GA, HF499) Purpose
- 55.2(82GA, HF499) Definitions
- 55.3(82GA, HF499) License required to operate as public adjuster
- 55.4(82GA, HF499) Application for license
- 55.5(82GA, HF499) Issuance of resident license
- 55.6(82GA, HF499) Public adjuster examination
- 55.7(82GA, HF499) Exemptions from examination
- 55.8(82GA, HF499) Nonresident license reciprocity
- 55.9(82GA, HF499) Terms of licensure
- 55.10(82GA, HF499) Evidence of financial responsibility
- 55.11(82GA, HF499) Continuing education
- 55.12(82GA, HF499) License denial, nonrenewal or revocation
- 55.13(82GA, HF499) Reinstatement or reissuance of a license after suspension, revocation or forfeiture in connection with disciplinary matters; and forfeiture in lieu of compliance
- 55.14(82GA, HF499) Contract between public adjuster and insured
- 55.15(82GA, HF499) Escrow accounts
- 55.16(82GA, HF499) Record retention
- 55.17(82GA, HF499) Standards of conduct of public adjuster
- 55.18(82GA, HF499) Public adjuster fees
- 55.19(82GA, HF499) Penalties
- 55.20(82GA, HF499) Fees
- 55.21(82GA, HF499) Severability

CHAPTER 56  
WORKERS' COMPENSATION GROUP SELF-INSURANCE

- 56.1(87,505) General provisions
- 56.2(87,505) Definitions
- 56.3(87,505) Requirements for self-insurance
- 56.4 Reserved
- 56.5(87,505) Excess insurance
- 56.6(87,505) Rates and reporting of rates
- 56.7(87,505) Special provisions
- 56.8(87,505) Certificate of approval; termination
- 56.9(87,505) Examinations
- 56.10(87,505) Board of trustees—membership, powers, duties, and prohibitions
- 56.11(87,505) Association membership; termination; liability
- 56.12(87,505) Requirements of sales agents
- 56.13(87,505) Requirements for continued approval
- 56.14(87,505) Misrepresentation prohibited
- 56.15(87,505) Investments
- 56.16(87,505) Refunds
- 56.17(87,505) Premium payment; reserves
- 56.18(87,505) Deficits and insolvencies
- 56.19(87,505) Grounds for nonrenewal or revocation of a certificate of relief from insurance
- 56.20(87,505) Hearing and appeal
- 56.21(87,505) Existing approved self-insurers
- 56.22(87,505) Severability clause

## CHAPTER 57

## WORKERS' COMPENSATION SELF-INSURANCE FOR INDIVIDUAL EMPLOYERS

57.1(87,505)	General provisions
57.2(87,505)	Definitions
57.3(87,505)	Requirements for self-insurance
57.4(87,505)	Additional security requirements
57.5(87,505)	Application for an individual self-insurer
57.6	Reserved
57.7(87,505)	Excess insurance
57.8(87,505)	Insolvency
57.9(87,505)	Renewals
57.10(87,505)	Periodic examination
57.11(87,505)	Grounds for nonrenewal or revocation of a certificate of relief from insurance
57.12(87,505)	Hearing and appeal
57.13(87,505)	Existing approved self-insurers
57.14(87,505)	Severability clause

## CHAPTER 58

## THIRD-PARTY ADMINISTRATORS

58.1(510)	Purpose
58.2(510)	Definitions
58.3(505,510)	Registration required
58.4(510)	Third-party administrator duties
58.5(510)	Renewal procedure
58.6(505,510)	Responsibilities of the insurer
58.7(505,510)	Written agreement
58.8(510)	Compensation to the third-party administrator
58.9(510)	Disclosure of charges and fees
58.10(510)	Delivery of materials to covered individuals
58.11(510)	Annual report and fee
58.12(510)	Change of information
58.13(510)	Inquiry by commissioner
58.14(510)	Complaints
58.15(510)	Periodic examination
58.16(510)	Grounds for denial, nonrenewal, suspension or revocation of certificate of registration
58.17(510)	Confidential information
58.18(510)	Fees
58.19(510)	Severability clause
58.20(510)	Compliance date

## CHAPTER 59

## PHARMACY BENEFITS MANAGERS

59.1(510B)	Purpose
59.2(510B)	Definitions
59.3(510B)	Timely payment of pharmacy claims
59.4(510B)	Study
59.5(510B)	Complaints
59.6(510B)	Auditing practices
59.7(510B)	Termination of pharmacy contracts

CHAPTER 60  
WORKERS' COMPENSATION INSURANCE RATE FILING PROCEDURES

60.1(515A)	Purpose
60.2(515A)	Definitions, scope, authority
60.3(515A)	General filing requirements
60.4(515A)	Rate or manual rule filing
60.5(515A)	Violation and penalties
60.6(515A)	Severability
60.7(515A)	Effective date

CHAPTERS 61 to 69  
Reserved

*MANAGED HEALTH CARE*

CHAPTER 70  
UTILIZATION REVIEW

70.1(505,514F)	Purpose
70.2(505,514F)	Definitions
70.3(505,514F)	Application
70.4(505,514F)	Standards
70.5(505,514F)	Retroactive application
70.6(505,514F)	Variances allowed
70.7(505,514F)	Confidentiality
70.8(76GA,ch1202)	Utilization review of postdelivery benefits and care
70.9(505,507B,514F)	Enforcement
70.10(514F)	Credentialing—retrospective payment

*HEALTH BENEFIT PLANS*

CHAPTER 71  
SMALL GROUP HEALTH BENEFIT PLANS

71.1(513B)	Purpose
71.2(513B)	Definitions
71.3(513B)	Applicability and scope
71.4(513B)	Establishment of classes of business
71.5(513B)	Transition for assumptions of business from another carrier
71.6(513B)	Restrictions relating to premium rates
71.7(513B)	Requirement to insure entire groups
71.8(513B)	Case characteristics
71.9(513B)	Application to reenter state
71.10(513B)	Creditable coverage
71.11(513B)	Rules related to fair marketing
71.12(513B)	Status of carriers as small employer carriers
71.13(513B)	Restoration of coverage
71.14(513B)	Basic health benefit plan and standard health plan policy forms
71.15(513B)	Methods of counting creditable coverage
71.16(513B)	Certificates of creditable coverage
71.17(513B)	Notification requirements
71.18(513B)	Special enrollments
71.19(513B)	Disclosure requirements
71.20(514C)	Treatment options
71.21(514C)	Emergency services
71.22(514C)	Provider access

71.23(513B)	Reconstructive surgery
71.24(514C)	Contraceptive coverage
71.25(513B)	Suspension of the small employer health reinsurance program
71.26(513B)	Uniform health insurance application form

## CHAPTER 72

## LONG-TERM CARE ASSET PRESERVATION PROGRAM

72.1(249G)	Purpose
72.2(249G)	Applicability and scope
72.3(249G)	Definitions
72.4(249G)	Qualification of long-term care insurance policies and certificates
72.5(249G)	Standards for marketing
72.6(249G)	Minimum benefit standards for qualifying policies and certificates
72.7(249G)	Required policy and certificate provisions
72.8(249G)	Prohibited provisions in certified policies or certificates
72.9(249G)	Reporting requirements
72.10(249G)	Maintaining auditing information
72.11(249G)	Reporting on asset protection
72.12(249G)	Preparing a service summary
72.13(249G)	Plan of action
72.14(249G)	Auditing and correcting deficiencies in issuer record keeping
72.15(249G)	Separability

## CHAPTER 73

## HEALTH INSURANCE PURCHASING COOPERATIVES

73.1(75GA,ch158)	Purpose
73.2(75GA,ch158)	Applicability and scope
73.3(75GA,ch158)	Definitions
73.4(75GA,ch158)	Division duties—application—filing requirements—license—audits and examinations
73.5(75GA,ch158)	Fidelity bond—letter of credit
73.6(75GA,ch158)	Annual report
73.7(75GA,ch158)	Business plan
73.8(75GA,ch158)	Participants
73.9(75GA,ch158)	Health insurance purchasing cooperative—product offerings—exemptions
73.10(75GA,ch158)	Insurance risk
73.11(75GA,ch158)	Rates
73.12(75GA,ch158)	Election—disclosure and confidentiality
73.13(75GA,ch158)	Structure—merger and consolidation
73.14(75GA,ch158)	Conflict of interest
73.15(75GA,ch158)	Nondiscrimination and retaliatory protections
73.16(75GA,ch158)	Annual health insurance or health care benefits plan selection
73.17(75GA,ch158)	License subject to conditions—waivers
73.18(75GA,ch158)	Procedures
73.19(75GA,ch158)	Data collection—quality evaluation
73.20(75GA,ch158)	Examination—costs
73.21(75GA,ch158)	Trade practices
73.22(75GA,ch158)	Grounds for denial, nonrenewal, suspension or revocation of certificate
73.23(75GA,ch158)	Hearing and appeal
73.24(75GA,ch158)	Solvency

CHAPTER 74  
HEALTH CARE ACCESS

74.1(505)	Purpose
74.2(505)	Applicability and scope
74.3(505)	Definitions
74.4(505)	Access to health care or health insurance for an employee
74.5(505)	Employer participation
74.6(505)	Violation of chapter

CHAPTER 75  
IOWA INDIVIDUAL HEALTH BENEFIT PLANS

75.1(513C)	Purpose
75.2(513C)	Definitions
75.3(513C)	Applicability and scope
75.4(513C)	Establishment of blocks of business
75.5(513C)	Transition for assumptions of business from another carrier or ODS
75.6(513C)	Restrictions relating to premium rates
75.7(513C)	Availability of coverage
75.8(513C)	Disclosure of information
75.9(513C)	Standards to ensure fair marketing
75.10(513C)	Basic health benefit plan and standard health benefit plan policy forms
75.11(513C)	Maternity benefit rider
75.12(513C)	Disclosure requirements
75.13(514C)	Treatment options
75.14(514C)	Emergency services
75.15(514C)	Provider access
75.16(514C)	Diabetic coverage
75.17(513C)	Reconstructive surgery
75.18(514C)	Contraceptive coverage

CHAPTER 76  
EXTERNAL REVIEW

76.1(514J)	Purpose
76.2(514J)	Applicable law and definitions
76.3(514J)	Disclosure requirements
76.4(514J)	External review request
76.5(514J)	Communication between covered person, health carrier, independent review organization and the commissioner
76.6(514J)	Assignment of independent review organization by the commissioner
76.7(514J)	Decision notification
76.8(514J)	Health carrier information
76.9(514J)	Certification of independent review organization
76.10(514J)	Fees charged by independent review organizations
76.11(514J)	Penalties

CHAPTER 77  
MULTIPLE EMPLOYER WELFARE ARRANGEMENTS

77.1(507A)	Certificate of registration
77.2(507A)	Application for certificate of registration
77.3(507A)	Financial requirements
77.4(507A)	Policy or contract
77.5(507A)	Disclosure
77.6(507A)	Filing fee

77.7(507A)	Agreements and management contracts
77.8(507A)	Examination
77.9(507A)	Trade practices
77.10(507A)	Insolvency
77.11(507A)	Suspension or revocation of certificate

## CHAPTER 78

## UNIFORM PRESCRIPTION DRUG INFORMATION CARD

78.1(514L)	Purpose
78.2(514L)	Definitions
78.3(514L)	Implementation

## CHAPTER 79

Reserved

*INSURANCE COVERAGE FOR  
PEDIATRIC PREVENTIVE SERVICES*

## CHAPTER 80

## WELL-CHILD CARE

80.1(505,514H)	Purpose
80.2(505,514H)	Applicability and scope
80.3(505,514H)	Effective date
80.4(505,514H)	Policy definitions
80.5(505,514H)	Benefit plan

## CHAPTER 81

## POSTDELIVERY BENEFITS AND CARE

81.1(514C)	Purpose
81.2(514C)	Applicability and scope
81.3(514C)	Postdelivery benefits

## CHAPTERS 82 to 84

Reserved

## CHAPTER 85

## REGULATION OF NAVIGATORS

85.1(505,522D)	Purpose and authority
85.2(505,522D)	Definitions
85.3(505,522D)	Requirement to hold a license
85.4(505,522D)	Issuance of license
85.5(505,522D)	License renewal
85.6(505,522D)	License reinstatement
85.7(505,522D)	Reinstatement or reissuance of a license after suspension, revocation or forfeiture in connection with disciplinary matters; and forfeiture in lieu of compliance
85.8(505,522D)	Change in name, address or state of residence
85.9(505,522D)	Licensing of a business entity
85.10(505,522D)	Initial training of navigators
85.11(505,522D)	Continuing education requirements for navigators
85.12(505,522D)	Administration of examinations
85.13(505,522D)	Fees
85.14(505,522D)	Evidence of financial responsibility
85.15(505,522D)	Practices
85.16(505,522D)	Severability

CHAPTERS 86 to 89  
Reserved

CHAPTER 90

FINANCIAL AND HEALTH INFORMATION REGULATION

- 90.1(505) Purpose and scope  
90.2(505) Definitions

DIVISION I  
RULES FOR FINANCIAL INFORMATION

- 90.3(505) Initial privacy notice to consumers required  
90.4(505) Annual privacy notice to customers required  
90.5(505) Information to be included in privacy notices  
90.6(505) Form of opt-out notice to consumers and opt-out methods  
90.7(505) Revised privacy notices  
90.8(505) Delivery of notice  
90.9(505) Limits on disclosure of nonpublic personal financial information to nonaffiliated third parties  
90.10(505) Limits on redisclosure and reuse of nonpublic personal financial information  
90.11(505) Limits on sharing account number information for marketing purposes  
90.12(505) Exception to opt-out requirements for disclosure of nonpublic personal financial information for service providers and joint marketing  
90.13(505) Exceptions to notice and opt-out requirements for disclosure of nonpublic personal financial information for processing and servicing transactions  
90.14(505) Other exceptions to notice and opt-out requirements for disclosure of nonpublic personal financial information  
90.15(505) Notice through a Web site  
90.16(505) Licensee exception to notice requirement

DIVISION II  
RULES FOR HEALTH INFORMATION

- 90.17(505) Disclosure of nonpublic personal health information  
90.18(505) Authorizations  
90.19(505) Delivery of authorization request  
90.20(505) Relationship to federal rules  
90.21(505) Relationship to state laws  
90.22(505) Protection of Fair Credit Reporting Act  
90.23(505) Nondiscrimination  
90.24(505) Severability  
90.25(505) Penalties  
90.26(505) Effective dates  
90.27 to 90.36 Reserved

DIVISION III  
SAFEGUARDING CUSTOMER INFORMATION

- 90.37(505) Information security program  
90.38(505) Examples of methods of development and implementation  
90.39(505) Penalties  
90.40(505) Effective date

CHAPTER 91  
2001 CSO MORTALITY TABLE

- 91.1(508) Purpose  
91.2(508) Definitions  
91.3(508) 2001 CSO Mortality Table

91.4(508)	Conditions
91.5(508)	Applicability of the 2001 CSO Mortality Table to 191—Chapter 47, Valuation of Life Insurance Policies
91.6(508)	Gender-blended table
91.7(508)	Separability

CHAPTER 92  
UNIVERSAL LIFE INSURANCE

92.1(508)	Purpose and authority
92.2(508)	Definitions
92.3(508)	Scope
92.4(508)	Valuation
92.5(508)	Nonforfeiture
92.6(508)	Mandatory policy provisions
92.7(508)	Disclosure requirements
92.8(508)	Periodic disclosure to policyowner
92.9(508)	Interest-indexed universal life insurance policies
92.10(508)	Applicability

CHAPTER 93  
CONDUIT DERIVATIVE TRANSACTIONS

93.1(511,521A)	Purposes
93.2(511,521A)	Definitions
93.3(511,521A)	Provisions not applicable
93.4(511,521A)	Standards for conduit derivative transactions
93.5(511,521A)	Internal controls
93.6(511,521A)	Reporting requirements for conduit derivative transactions
93.7(511,521A)	Conduit ownership
93.8(511,521A)	Exemption from applicability

CHAPTER 94  
PREFERRED MORTALITY TABLES FOR USE  
IN DETERMINING MINIMUM RESERVE LIABILITIES

94.1(508)	Purpose
94.2(508)	Definitions
94.3(508)	2001 CSO Preferred Class Structure Mortality Table
94.4(508)	Conditions
94.5(508)	Separability

CHAPTER 95  
DETERMINING RESERVE LIABILITIES FOR PRENEED LIFE INSURANCE

95.1(508)	Authority
95.2(508)	Scope
95.3(508)	Purpose
95.4(508)	Definitions
95.5(508)	Minimum valuation mortality standards
95.6(508)	Minimum valuation interest rate standards
95.7(508)	Minimum valuation method standards
95.8(508)	Transition rules
95.9(508)	Effective date

## CHAPTER 96

## SYNTHETIC GUARANTEED INVESTMENT CONTRACTS

96.1(505,508)	Authority
96.2(505,508)	Purpose
96.3(505,508)	Scope and application
96.4(505,508)	Definitions
96.5(505,508)	Financial requirements and plan of operation
96.6(505,508)	Required contract provisions and filing requirements
96.7(505,508)	Investment management of the segregated portfolio
96.8(505,508)	Purchase of annuities
96.9(505,508)	Unilateral contract terminations
96.10(505,508)	Reserves
96.11(505,508)	Severability
96.12(505,508)	Effective date

## CHAPTER 97

ACCOUNTING FOR CERTAIN DERIVATIVE INSTRUMENTS USED TO HEDGE  
THE GROWTH IN INTEREST CREDITED FOR INDEXED INSURANCE PRODUCTS  
AND ACCOUNTING FOR THE INDEXED INSURANCE PRODUCTS RESERVE

97.1(508)	Authority
97.2(508)	Purpose
97.3(508)	Definitions
97.4(508)	Asset accounting
97.5(508)	Indexed annuity product reserve calculation methodology
97.6(508)	Indexed life product reserve calculation methodology
97.7(508)	Other requirements

## CHAPTER 98

## ANNUAL FINANCIAL REPORTING REQUIREMENTS

98.1(505)	Authority
98.2(505)	Purpose
98.3(505)	Definitions
98.4(505)	General requirements related to filing and extensions for filing of annual audited financial reports and audit committee appointment
98.5(505)	Contents of annual audited financial report
98.6(505)	Designation of independent certified public accountant
98.7(505)	Qualifications of independent certified public accountant
98.8(505)	Consolidated or combined audits
98.9(505)	Scope of audit and report of independent certified public accountant
98.10(505)	Notification of adverse financial condition
98.11(505)	Communication of Internal Control Related Matters Noted in an Audit
98.12(505)	Definition, availability and maintenance of independent certified public accountants' work papers
98.13(505)	Requirements for audit committees
98.14(505)	Conduct of insurer in connection with the preparation of required reports and documents
98.15(505)	Management's Report of Internal Control Over Financial Reporting
98.16(505)	Exemptions
98.17(505)	Letter to insurer with accountant's qualifications
98.18(505)	Canadian and British companies
98.19(505)	Severability provision
98.20(505)	Effective date

## CHAPTER 99

## LIMITED PURPOSE SUBSIDIARY LIFE INSURANCE COMPANIES

99.1(505,508)	Authority
99.2(505,508)	Purpose
99.3(505,508)	Definitions
99.4(505,508)	Formation of LPS
99.5(505,508)	Certificate of authority
99.6(505,508)	Capital and surplus
99.7(505,508)	Plan of operation
99.8(505,508)	Dividends and distributions
99.9(505,508)	Reports and notifications
99.10(505,508)	Material transactions
99.11(505,508)	Investments
99.12(508)	Securities
99.13(505,508)	Permitted reinsurance
99.14(505,508)	Certification of actuarial officer
99.15(505,508)	Effective date

*REGULATED INDUSTRIES*

## SALES OF CEMETERY MERCHANDISE, FUNERAL MERCHANDISE AND FUNERAL SERVICES

## CHAPTER 100

## GENERAL PROVISIONS

100.1(523A)	Purpose
100.2(523A)	Definitions
100.3(523A)	Contact and correspondence
100.4(523A)	Fees

## CHAPTER 101

## TRUST DEPOSITS AND TRUST FUNDS

101.1(523A)	Trust income withdrawals
101.2(523A)	Amount of trust income withdrawn
101.3(523A)	Allocation of trust income to purchasers' accounts
101.4(523A)	Credit for trust income withdrawn
101.5(523A)	Time period during which trust income may be withdrawn
101.6(523A)	Application of contract law
101.7(523A)	Consumer price index adjustment
101.8(523A)	Cancellation refunds

## CHAPTER 102

## WAREHOUSED MERCHANDISE

102.1(523A)	Funeral and cemetery merchandise delivered to the purchaser or warehoused
102.2(523A)	Storage facilities

## CHAPTER 103

## LICENSING OF PRENEED SELLERS AND SALES AGENTS

103.1(523A)	Requirement for a preneed seller license or a sales agent license
103.2(523A)	Application and licensing of preneed seller or sales agent
103.3(523A)	Change of ownership or sale of business of preneed seller
103.4(523A)	License renewal
103.5(523A)	Denial of license applications or of applications for renewal
103.6(523A)	Reinstatement or reissuance of a license after suspension, revocation or forfeiture in connection with disciplinary matters; and forfeiture in lieu of compliance

- 103.7(252J) Suspension for failure to pay child support  
 103.8(261) Suspension for failure to pay student loan

## CHAPTER 104

## CONTINUING EDUCATION FOR SALES AGENTS

- 104.1(523A) Continuing education requirements  
 104.2(523A) Acceptable areas of continuing education  
 104.3(523A) Academic coursework  
 104.4(523A) Effective date  
 104.5(523A) Compliance period  
 104.6(523A) Denial of sales agent license renewal application  
 104.7(523A) Disqualification and replacement of credits  
 104.8(523A) Current mailing address  
 104.9(523A) Proof of completion of continuing education requirements  
 104.10(523A) Standards for continuing education activities  
 104.11(523A) Qualifications of presenters and proof of attendance  
 104.12(523A) Reviews  
 104.13(523A) Exemption

## CHAPTER 105

## STANDARDS OF CONDUCT AND PROHIBITED PRACTICES

- 105.1(523A) Purpose  
 105.2(523A) Numbering purchase agreements  
 105.3(523A) Records maintenance  
 105.4(523A) Annual reports  
 105.5(523A) Fidelity bond or insurance  
 105.6(523A) Grounds for discipline  
 105.7(523A) Prohibition on sales activities and practices without a license or without an appointment

## CHAPTER 106

## DISCIPLINARY PROCEDURES

- 106.1(523A) Investigations  
 106.2(17A,523A) Penalties  
 106.3(17A,523A) Administrative procedures

## CHAPTERS 107 to 109

Reserved

## CHAPTER 110

STANDARDS AND COMMISSIONER'S AUTHORITY FOR COMPANIES  
 DEEMED TO BE IN HAZARDOUS FINANCIAL CONDITION

- 110.1(505) Authority  
 110.2(505) Purpose  
 110.3(505) Definition  
 110.4(505) Standards  
 110.5(505) Commissioner's authority  
 110.6(505) Judicial review  
 110.7(505) Separability  
 110.8(505) Effective date



*SECURITIES*  
CHAPTER 50  
REGULATION OF SECURITIES OFFERINGS AND THOSE WHO ENGAGE  
IN THE SECURITIES BUSINESS

[Appeared as Ch 17, 1973 IDR]  
[Prior to 10/22/86, Insurance Department[510]]

DIVISION I  
DEFINITIONS AND ADMINISTRATION

**191—50.1(502) Definitions.** For the purposes of this chapter, the definitions in Iowa Code chapter 502 and the following definitions shall apply unless the context otherwise requires:

“*Act*” means Iowa Code chapter 502, the Iowa Uniform Securities Act (Blue Sky Law).

“*Administrator*” means the commissioner of insurance or the deputy administrator appointed under Iowa Code section 502.601.

“*CCH NASAA Reports*” means the official statements of policy of the North American Securities Administrators Association, Inc., printed by Commerce Clearing House, the official reporter for NASAA.

“*CRD*” means the Central Registration Depository.

“*CSRU*” means the Iowa child support recovery unit.

“*FDIC*” means the Federal Deposit Insurance Corporation.

“*FINRA*” means the Financial Industry Regulatory Authority.

“*Form ADV*” means Uniform Application for Investment Adviser Registration.

“*Form ADV-E*” means the Certificate of Accounting of Client Securities and Funds in the Possession or Custody of an Investment Adviser.

“*Form ADV-H*” means Notice of Hardship Application for Investment Adviser Registration.

“*Form ADV-W*” means Notice of Withdrawal from Registration as Investment Adviser.

“*Form BD*” means Uniform Application for Broker-Dealer Registration.

“*Form BDW*” means Uniform Request for Broker-Dealer Withdrawal.

“*Form ICP*” means Agricultural Cooperative Notice of Sales of Notes or Evidences of Indebtedness.

“*Form D*” means Notice of Sale of Securities Pursuant to Regulation D, Section 4(6), and/or Uniform Limited Offering Exemption, and includes the Appendix.

“*Form F-7*” means Registration Statement Under the Securities Act of 1933, for registration of securities of certain Canadian issuers offered for cash upon the exercise of rights granted to existing security holders.

“*Form F-8*” means Registration Statement Under the Securities Act of 1933, for registration of securities of certain Canadian issuers to be issued in exchange offers or a business combination.

“*Form F-9*” means Registration Statement Under the Securities Act of 1933, for registration of certain investment grade debt or investment grade preferred securities of certain Canadian issuers.

“*Form F-10*” means Registration Statement Under the Securities Act of 1933, for registration of securities of certain Canadian issuers.

“*Form NF*” means Uniform Investment Company Notice Filing.

“*Form S-1*” means Registration Statement Under the Securities Act of 1933, for registration of securities for which no other form is authorized or prescribed.

“*Form SB-2*” means Registration Statement Under the Securities Act of 1933, for registration of securities to be sold to the public by small business issuers.

“*Form U-1*” means Uniform Application to Register Securities.

“*Form U-2*” means Uniform Consent to Service of Process.

“*Form U-2A*” means Uniform Corporate Resolution.

“*Form U-4*” means Uniform Application for Securities Industry Registration or Transfer.

“*Form U-5*” means Uniform Termination Notice for Securities Industry Registration.

“*Form U-6*” means Uniform Disciplinary Action Reporting Form.

“*Form U-7*” means Small Corporate Offering Registration Form.

“*Form USR-1*” means Investment Company Report of Sales.

“*Gift*” means a rendering of anything of value in return for which legal consideration of equal or greater value is not given and received.

“*IARD*” means the Investment Advisory Registration Depository.

“*Immediate family*” includes parent, mother-in-law, father-in-law, spouse, former spouse, brother, sister, brother-in-law, sister-in-law, son-in-law, daughter-in-law, child and stepchild. In addition, “immediate family” includes any other person who is supported, directly or indirectly, to a material extent by an agent.

“*Investment contract*” as used in Iowa Code section 502.102(28) includes:

1. Any investment in a common enterprise with the expectation of profit to be derived through the essential managerial efforts of someone other than the investor.

(1) “Common enterprise” in this definition means an enterprise in which the fortunes of the investor are tied to the efficacy of the efforts and successes of those seeking the investment or of a third party.

(2) “Profit” in this definition includes income or a return on the investment, including a fixed rate of return, dividends, other periodic payments, or the increased value of the investment; or

2. Any investment by which an offeree furnishes initial value to an offerer, and a portion of this initial value is subjected to the risks of the enterprise, and the furnishing of the initial value is induced by the offerer’s promises or representations which give rise to a reasonable understanding that a valuable benefit of some kind over and above the initial value will accrue to the offeree as a result of the operation of the enterprise, and the offeree does not exercise practical and actual control over the managerial decisions of the enterprise.

“*Loan*” means an agreement to advance property, including but not limited to money, in return for the promise that payment will be made for use of the property.

“*NASAA*” means the North American Securities Administrators Association, Inc.

“*NASDAQ*” means the NASDAQ Stock Market.

“*NCUA*” means the National Credit Union Association.

“*NSMIA*” means the National Securities Markets Improvement Act of 1996, Public Law 104-290.

“*NYSE*” means the New York Stock Exchange.

“*OTC*” means over the counter.

“*PCAOB*” means the Public Company Accounting Oversight Board.

“*SAI*” means Statement of Additional Information.

“*SEC*” means the United States Securities and Exchange Commission as established pursuant to 15 U.S.C. Section 78(d).

“*SOIF*” means Solicitation of Interest Form.

This rule is intended to implement Iowa Code section 502.605(1).

[ARC 9169B, IAB 10/20/10, effective 11/24/10; ARC 1076C, IAB 10/2/13, effective 11/6/13]

### **191—50.2(502) Cost of audit or inspection.**

**50.2(1)** A broker-dealer or investment adviser may be assessed the actual and necessary costs of travel, lodging, and other expenses directly attributable to an audit or inspection made pursuant to Iowa Code section 502.411(4). The assessment of costs of travel, lodging, and other expenses, if any, shall be determined in accordance with the department of administrative services (DAS) state accounting enterprise Accounting Policy and Procedures Manual in effect at the time of the audit or inspection.

**50.2(2)** If costs are assessed under subrule 50.2(1), the administrator may, upon completion of the examination, or at such regular intervals prior to completion as the administrator determines, prepare an account of the costs incurred in performing and preparing the report of the examination which shall be charged to and paid by the broker-dealer or investment adviser examined.

**50.2(3)** The administrator shall notify the broker-dealer or investment adviser of the expenses attributable to the audit or inspection as soon as practicable.

**50.2(4)** Assessments collected pursuant to this rule shall be paid to the administrator and shall be deposited as provided in Iowa Code section 505.7.

This rule is intended to implement Iowa Code section 502.411(4).  
[ARC 1076C, IAB 10/2/13, effective 11/6/13]

**191—50.3(502) Interpretative opinions or no-action letters.** Interested persons may request the administrator to issue an interpretative opinion pursuant to Iowa Code section 502.605(4). These requests will be answered by means of a no-action letter. Requests for confirmation of the availability of an exemption shall be answered in the same manner. The following procedure is recommended for the submission of such requests:

**50.3(1)** The request should be in writing and include the factual situation involved, a citation to the applicable part of the rule or statute, and the question sought to be answered. Any disclosure or informational materials which pertain to the issue should also be filed.

**50.3(2)** The administrator, or any person delegated under Iowa Code section 502.601(1), may respond to the request by determining to take or not to take a no-action position or by declining to reach a determination due to insufficient facts, conflicting case or administrative law or such other reasons as the administrator's discretionary power allows.

**50.3(3)** All no-action determinations shall be based upon the representations made by the requesting party in the letter and information filed, since any different facts or conditions might require a different conclusion. The no-action letter shall express the division's position on enforcement action only and shall not purport to express any legal conclusion on the questions presented. No determination shall take a position on whether or not any disclosure materials satisfactorily comply with the antifraud and civil liability sections of the Act.

**50.3(4)** A no-action determination issued under this rule may be provided to interested persons for a filing fee of \$100.

This rule is intended to implement Iowa Code section 502.605(4).

**191—50.4 to 50.9** Reserved.

DIVISION II  
REGISTRATION OF BROKER-DEALERS AND AGENTS

**191—50.10(502) Broker-dealer registrations, renewals, amendments, succession, and withdrawals.**

**50.10(1)** An applicant for an initial registration to conduct business as a broker-dealer must:

*a.* File a current Form BD. If the applicant is a member of FINRA, Form BD shall be filed with CRD. If the applicant is not a member of FINRA, Form BD shall be signed and notarized and filed with the administrator; and

*b.* Pay a \$200 filing fee. If the applicant is a member of FINRA, the fee shall be remitted to the CRD. If the applicant is not a member of FINRA, the fee shall be remitted to the administrator.

**50.10(2)** No application for initial registration will be deemed complete for purposes of Iowa Code section 502.406(3) until the applicant has been approved as a member of FINRA.

**50.10(3)** An applicant that is a member of FINRA and that seeks renewal of a broker-dealer registration shall comply with the renewal time frames established by FINRA for renewal on the CRD system and shall:

*a.* File with CRD an updated Form BD;

*b.* Pay to the CRD a \$200 renewal filing fee.

**50.10(4)** An applicant that is not a member of FINRA and that seeks renewal of a broker-dealer registration shall by November 30 of each year:

*a.* File with the administrator an updated Form BD, manually signed and notarized;

*b.* File with the administrator the renewal applicant's most recent audited financial statements if they were not previously submitted to the administrator pursuant to subrule 50.10(1);

*c.* Pay a \$200 renewal filing fee, which shall be remitted to the administrator.

**50.10(5)** Failure to comply with the requirements of subrule 50.10(3) or 50.10(4) shall be deemed a request for withdrawal of the broker-dealer registration, and the registration will be terminated as of December 31 of the renewal year.

**50.10(6)** A registered broker-dealer that is a FINRA member shall submit a withdrawal request by filing an accurate and complete Form BDW with CRD. A registered broker-dealer that is not a FINRA member shall submit a withdrawal request by filing an accurate and complete Form BDW with the administrator.

**50.10(7)** For purposes of Iowa Code section 502.406(2), a correcting amendment to the information or a record contained in either an initial or renewal application shall be considered to be filed “promptly” with the administrator if filed within 30 days of the event necessitating the correcting amendment.

**50.10(8)** Succession and change in registration.

*a.* In the case of an organizational change, including a change in the state of incorporation or form of organization, not involving a material change in financial condition or management, a broker-dealer shall file all applicable amendments to Form BD.

*b.* In the case of an organizational change, including a change in the state of incorporation or form of organization, involving a material change in financial condition or management, a broker-dealer shall file a new application for registration pursuant to subrule 50.10(1). The filing must include the fee pursuant to paragraph 50.10(1) “c” and registration fees for all Iowa-registered agents.

*c.* In the case of a change in name, a broker-dealer shall file all applicable amendments to Form BD.

**50.10(9)** Upon the administrator’s oral or written request, a broker-dealer shall provide to the administrator the broker-dealer’s most recent financial reports, audited or unaudited, within two business days of the request. A broker-dealer may utilize express mail delivery or transmission via electronic means to comply with a request pursuant to this subrule. Financial reports not received by the filing deadline are subject to a late fee of \$50 per day beyond the filing deadline, not to exceed an aggregate penalty of \$500. Imposition of the late fee is not a reportable event. In the event of the broker-dealer’s continued noncompliance, the administrator may also pursue sanctions authorized by Iowa Code section 502.412.

This rule is intended to implement Iowa Code section 502.411(2).  
[ARC 9169B, IAB 10/20/10, effective 11/24/10]

**191—50.11(502) Principals.** Every registered broker-dealer shall have at least two officers or partners registered with FINRA as principals, appropriate to the function(s) to be performed.

This rule is intended to implement Iowa Code section 502.406.  
[ARC 9169B, IAB 10/20/10, effective 11/24/10]

**191—50.12(502) Agent and issuer registrations, renewals and amendments.**

**50.12(1)** Agent registration. Every applicant for registration as an agent of a broker-dealer shall:

*a.* Pass the Uniform Securities Agent State Law Examination (Series 63) or the Uniform Combined State Law Examination (Series 66);

*b.* Pass the appropriate qualifying examination administered by the Financial Industry National Regulatory Authority (FINRA). In the event that an applicant for registration as an agent has received a waiver by FINRA of a FINRA examination otherwise required by this paragraph, the FINRA waiver will be accepted in lieu of the examination requirement;

*c.* File an accurate and complete Form U-4 with CRD; and

*d.* Pay a \$40 filing fee to FINRA if applying for registration as an agent of a FINRA member broker-dealer, or to the administrator if applying for registration as an agent of a non-FINRA member broker-dealer.

**50.12(2)** Any individual who is out of the business of effecting transactions in securities for less than two years from the date of filing an application and who has previously passed an examination required in subrule 50.12(1) shall not be required to retake the examination to be eligible to be relicensed upon application.

**50.12(3)** Renewals, amendments, and withdrawal requests.

*a.* A registered agent of a FINRA member broker-dealer shall submit all renewals, renewal fees, amendments to Form U-4, and withdrawal requests to CRD. A withdrawal request shall be made by filing an accurate and complete Form U-5 with CRD.

*b.* A registered agent of a non-FINRA member broker-dealer shall submit all renewals, renewal fees, amendments to Form U-4, and withdrawal requests to the administrator. A withdrawal request shall be made by filing an accurate and complete Form U-5 with the administrator.

**50.12(4)** An issuer seeking to employ persons as agents of the issuer within the meaning of Iowa Code section 502.102(2) must apply in writing to the administrator for such authority. The application shall include:

- a.* A statement of the issuer's intent to employ agents for the sale of its securities;
- b.* The name, address, social security number, and proof of satisfaction of subrule 50.12(1) for each agent;
- c.* A complete description of the subject securities;
- d.* A complete and accurate Form U-4; and
- e.* A \$40 filing fee.

This rule is intended to implement Iowa Code section 502.406.

[ARC 9169B, IAB 10/20/10, effective 11/24/10; ARC 1076C, IAB 10/2/13, effective 11/6/13]

**191—50.13(502) Agent continuing education requirements.** Every registered agent shall comply with all applicable continuing education requirements adopted by FINRA, NYSE, or any other self-regulatory agency. Failure to comply with any such requirements may be a basis for discipline pursuant to Iowa Code section 502.412(4) "n."

This rule is intended to implement Iowa Code section 502.411(8).

[ARC 9169B, IAB 10/20/10, effective 11/24/10]

**191—50.14(502) Broker-dealer record-keeping requirements.**

**50.14(1)** Unless otherwise provided by an SEC order, each broker-dealer registered or required to be registered under the Act shall make, maintain and preserve books and records in compliance with SEC Rules 17a-3 (17 CFR 240.17a-3), 17a-4 (17 CFR 240.17a-4), 15c2-6 (17 CFR 240.15c2-6) and 15c2-11 (17 CFR 240.15c2-11).

**50.14(2)** To the extent that the SEC amends the above-referenced rules, broker-dealers complying with such rules as amended shall not be subject to enforcement action by the administrator for violating this rule to the extent that the violation results solely from the broker-dealer's compliance with the amended rule.

This rule is intended to implement Iowa Code section 502.411(3).

**191—50.15(502) Broker-dealer minimum financial requirements and financial reporting requirements.**

**50.15(1)** Each broker-dealer registered or required to be registered under the Act shall comply with SEC Rules 15c3-1 (17 CFR 240.15c3-1), 15c3-2 (17 CFR 240.15c3-2), and 15c3-3 (17 CFR 240.15c3-3).

**50.15(2)** Each broker-dealer registered or required to be registered under the Act shall comply with SEC Rule 17a-11 (17 CFR 240.17a-11) and shall file with the administrator copies of notices of financial deficiencies, as required under SEC Rule 17a-11 (17 CFR 240.17a-11).

**50.15(3)** To the extent that the SEC amends the above-referenced rules, broker-dealers complying with such rules as amended shall not be subject to enforcement action by the administrator for violations resulting solely from the broker-dealer's compliance with the amended rules.

This rule is intended to implement Iowa Code section 502.411(2).

**191—50.16(502) Dishonest or unethical practices in the securities business.**

**50.16(1)** Dishonest or unethical business practices by any person in the securities business, other than an agent, investment adviser, investment adviser representative, or federal covered investment adviser, as prohibited pursuant to Iowa Code section 502.412(4) "m" include, but are not limited to, the following:

- a.* Engaging in any unreasonable and unjustifiable delay in delivering securities purchased by any customers or paying, upon request, free credit balances reflecting completed transactions of any customers;
- b.* Inducing in a customer's account trading which is excessive in size or frequency relative to the financial resources and character of the account;
- c.* Suitability:
  - (1) Failing to use reasonable diligence, in regard to the opening and maintenance of every account, to know and retain the essential facts concerning every customer and concerning the authority of each person acting on behalf of such customer;
  - (2) Recommending a transaction or investment strategy involving a security or securities without a reasonable basis to believe that the transaction or investment strategy is suitable for the customer, based on the information obtained through the reasonable diligence of the member or associated person to ascertain the customer's investment profile. A customer's investment profile includes, but is not limited to, the customer's age, other investments, financial situation and needs, tax status, investment objectives, investment experience, investment time horizon, liquidity needs, risk tolerance, and any other information the customer may disclose to the broker-dealer or agent in connection with such recommendation;
- d.* Executing a transaction on behalf of a customer without authorization;
- e.* Exercising any discretionary power in effecting a transaction for a customer's account without first obtaining written discretionary authority from the customer, unless the discretionary power relates solely to the time or price for executing the orders;
- f.* Executing any transaction in a margin account without securing from the customer a properly executed written margin agreement prior to the initial transaction in the account;
- g.* Failing to segregate customers' free securities or securities held in safekeeping;
- h.* Hypothecating a customer's securities without having a lien on them unless the broker-dealer secures from the customer a properly executed written consent promptly after the initial transaction, except as otherwise permitted by SEC rules;
- i.* Entering into a transaction with or for a customer at a price not reasonably related to the current market price of the security or receiving an unreasonable commission or profit;
- j.* Failing to furnish on or before the transaction confirmation date a final prospectus, or, if a final prospectus is not available, a preliminary prospectus together with additional documents which include all information that would be set forth in the final prospectus, to a customer purchasing securities in an offering registered pursuant to Iowa Code section 502.303 or 502.304 or that is subject to a notice filing made pursuant to Iowa Code section 502.302. If the offering is not registered, the broker-dealer shall furnish those disclosure documents that are customarily available;
- k.* Charging unreasonable and inequitable fees for services performed, including miscellaneous services such as collecting moneys due for principal, dividends or interest, exchange or transfer of securities, appraisals, safekeeping, custody of securities or other services regarding the securities business;
- l.* Offering to buy from or sell to any person any security at a stated price unless the broker-dealer is prepared to purchase or sell the security at the stated price and under the conditions as stated at the time of the offer to buy or sell the security;
- m.* Representing that a security is being offered to a customer "at the market" or a price relevant to the market price unless the broker-dealer knows or has reasonable grounds to believe that a market for the security exists other than that made, created or controlled by the broker-dealer, or by any person for whom the broker-dealer is acting or with whom the broker-dealer is associated in the distribution, or any person controlled by, controlling or under common control with such broker-dealer;
- n.* Effecting any transaction in, or inducing the purchase or sale of, any security by any manipulative, deceptive or fraudulent device, practice, plan, program, design or contrivance, including but not limited to:
  - (1) Effecting any transaction in a security involving no change in the beneficial ownership thereof;

(2) Entertaining an order for the purchase or sale of any security knowing that an order or orders of substantially the same size have been or will be entered by or for the same or different parties at substantially the same time and price for the purpose of creating a false or misleading appearance of active trading in the security or a false or misleading appearance regarding the market for the security. Nothing in this subparagraph shall prohibit a broker-dealer from entering bona fide agency cross transactions for the broker-dealer's customers;

(3) Effecting, alone or with one or more persons, a series of transactions in any security which creates actual or apparent active trading in a security or raising or depressing the price of the security for the purpose of inducing the purchase or sale of the security by others;

*o.* Guaranteeing a customer against loss in any securities account of the customer carried by the broker-dealer or in any securities transaction effected by the broker-dealer with or for the customer;

*p.* Publishing or circulating, or causing to be published or circulated, any notice, circular, advertisement, newspaper article, investment service, or communication of any kind purporting to report any transaction as a purchase or sale of any security unless the broker-dealer believes that the transaction was a bona fide purchase or sale of such security, or purporting to quote the bid price or asked price for any security unless the broker-dealer believes that the quotation represents a bona fide bid for or offer of such security;

*q.* Using any advertising or sales presentation in a deceptive or misleading fashion including but not limited to a distribution of any nonfactual data, material or presentation based on conjecture, unfounded or unrealistic claims or assertions in any brochure or flyer, or display by words, pictures, graphs or other medium designed to supplement, detract from, supersede or defeat the purpose or effect of any prospectus or disclosure;

*r.* Failing to disclose that the broker-dealer is controlled by, controlling, affiliated with or under common control of the issuer of any security before entering into any contract with or for a customer for the purchase or sale of the security. The existence of any control or affiliation shall be disclosed to the customer in writing prior to completion of the transaction;

*s.* Failing to make a bona fide public offering of all of the securities allotted to a broker-dealer for distribution, whether the securities were acquired by the broker-dealer as an underwriter, as a selling group member, or from a member participating in the distribution as an underwriter or selling group member;

*t.* Failing or refusing to furnish a customer, upon reasonable request, information to which the customer is entitled or to respond to a formal written request or complaint from the customer;

*u.* Failing or refusing to provide information requested in writing by the administrator within 14 days or a later time as prescribed by the administrator;

*v.* Extending credit to a customer in violation of the Securities Exchange Act of 1934 or the regulations of the Federal Reserve Board;

*w.* Engaging in acts or practices enumerated in rule 191—50.100(502);

*x.* Failing in the solicitation of a sale or purchase of an OTC non-NASDAQ security to promptly provide, upon the customer's request, the most current prospectus, the most recent periodic report filed pursuant to Section 13 of the Securities Exchange Act of 1934, or any other available research reports;

*y.* Marking any order tickets or confirmations as unsolicited when the transaction is solicited;

*z.* Failing to provide each customer, on no greater than a quarterly basis, a statement of account that, for all OTC non-NASDAQ equity securities in the account for which the firm has been a market maker during the reportable period, contains a value for each security based on the closing market bid on a date certain for any month in which activity has occurred in a customer's account;

*aa.* Failing to comply with any applicable provision of the FINRA Conduct Rules or any applicable fair practice or ethical standard promulgated by the SEC or by a self-regulatory organization approved by the SEC; and

*bb.* Engaging in or aiding in "boiler-room" operations or high-pressure tactics in connection with the promotion of speculative offerings or "hot issues" by means of an intensive telephone campaign or unsolicited calls to persons not known by, nor having an account with, the agent or broker-dealer

represented by the agent, where the prospective purchaser is encouraged to make a hasty decision to buy, irrespective of the purchaser's investment needs and objectives.

**50.16(2)** Dishonest or unethical practices by an agent in the securities business as prohibited pursuant to Iowa Code section 502.412(4) "m" include, but are not limited to, the following:

*a.* Lending money or securities to or borrowing money or securities from a customer or acting as a custodian for money, securities, or an executed stock power of a customer unless the customer is a member of the agent's immediate family and the act or practice is approved in advance by the agent's supervisory personnel;

*b.* Effecting securities transactions not recorded on the regular books or records of the broker-dealer the agent represents unless the transactions are authorized in writing by the broker-dealer prior to executing the transaction;

*c.* Establishing or maintaining an account containing fictitious information for the purpose of executing transactions otherwise prohibited;

*d.* Sharing, directly or indirectly, in profits or losses in any customer account without the written authorization of the customer and the broker-dealer the agent represents;

*e.* Dividing or otherwise splitting the agent's commissions, profits, or other compensation from the purchase or sale of securities with any person who is not registered as an agent for the same broker-dealer or for a broker-dealer under direct or indirect common control;

*f.* Soliciting or accepting a gift, directly or indirectly, from an unrelated customer that in the aggregate exceeds \$250 in a calendar year. A gift accepted by an immediate family member from an unrelated customer shall be included in the aggregate limit. An agent shall not solicit or accept from a customer a gift transferred through a relative or third party to the agent's benefit that would have the effect of evading this paragraph;

*g.* Soliciting or accepting being named as a beneficiary, executor, or trustee in a will or trust of an unrelated customer;

*h.* Evading or otherwise negating the requirements of paragraph 50.16(2) "a," "f" or "g" by terminating the customer relationship for the purpose of soliciting or accepting a loan or gift or being named as a beneficiary, executor or trustee in a will or trust that the agent is otherwise not permitted to solicit or accept. An agent is not in violation of this paragraph if the agent has made a bona fide termination of the customer relationship and conducted no securities-related business or other business for a period of three years with the customer;

*i.* Engaging in conduct specified in subrule 50.16(1), paragraphs "b" to "f," "i," "j," "n" to "q," "u," and "w" to "aa";

*j.* Engaging in conduct deemed dishonest or unethical in rule 191—50.55(502); and

*k.* Employing any method or tactic which uses undue pressure, force, fright, or threat, whether explicit or implied, to solicit the purchase or sale of securities, or committing any act which shows that the agent has exerted undue influence over a person.

This rule is intended to implement Iowa Code section 502.412(4) "m."  
[ARC 9169B, IAB 10/20/10, effective 11/24/10; ARC 1076C, IAB 10/2/13, effective 11/6/13]

### **191—50.17(502) Rules of conduct.**

**50.17(1)** Each broker-dealer, after executing and before completing each transaction with its customer, shall give or send the customer a written confirmation. A broker-dealer not registered pursuant to the Securities Exchange Act of 1934 shall provide a written confirmation including, at a minimum:

*a.* A description of the security purchased or sold, the date of the transaction, the price at which the security was purchased or sold and any commission charged;

*b.* A statement as to whether the broker-dealer was acting for its own account, as the agent for the customer, as the agent for some other person, or as the agent for both the customer and some other person;

*c.* When the broker-dealer is acting as an agent for the customer, the name of the person from whom the security was purchased or to whom it was sold or the fact that such information will be furnished upon the customer's request.

**50.17(2)** A broker-dealer registered pursuant to the Securities Exchange Act of 1934 shall comply with all requirements of the Securities Exchange Act of 1934 and its implementing rules regarding written confirmations.

**50.17(3)** Each broker-dealer shall establish written supervisory procedures and a system for applying those procedures which may reasonably be expected to prevent and detect any violations of Iowa Code chapter 502, its implementing rules, and any orders issued pursuant to it. Each broker-dealer shall designate and qualify a number of supervisory employees reasonable in relation to the number of its registered agents, offices, and transactions in Iowa.

**50.17(4)** Each broker-dealer whose principal office is located in Iowa shall have at least one partner, officer or registered agent employed on a full-time basis at its principal office.

This rule is intended to implement Iowa Code sections 502.411(3) and 502.412(4) "i."

**191—50.18(502) Limited registration of Canadian broker-dealers and agents.**

**50.18(1)** A Canadian broker-dealer may register under this rule if the broker-dealer:

*a.* Files with the administrator an application in the form required by the jurisdiction in which the broker-dealer has its principal office;

*b.* Files with the administrator a consent to service of process on Form U-2;

*c.* Is registered as a broker-dealer and is in good standing in the jurisdiction from which the broker-dealer is effecting transactions into Iowa and files with the administrator satisfactory evidence thereof;

*d.* Is a member of a self-regulatory organization or stock exchange in Canada; and

*e.* Pays a \$200 filing fee.

**50.18(2)** An agent representing a Canadian broker-dealer registered under this rule in effecting transactions in securities in Iowa may register under this rule if the agent:

*a.* Files with the administrator an application in the form required by the jurisdiction in which the broker-dealer has its principal office;

*b.* Files with the administrator a consent to service of process;

*c.* Is registered and is in good standing in the jurisdiction from which the agent is effecting transactions into Iowa and files with the administrator satisfactory evidence thereof; and

*d.* Pays a \$40 filing fee.

**50.18(3)** A Canadian broker-dealer that is resident in Canada and has no office or other physical presence in Iowa may, provided that the broker-dealer is registered under this rule, effect transactions in Iowa:

*a.* With or for a person from Canada temporarily residing in Iowa with whom the Canadian broker-dealer had a bona fide broker-dealer-client relationship before the person entered the United States;

*b.* With or for a person from Canada currently residing in Iowa whose transactions are in a self-directed, tax-advantaged retirement plan in Canada of which the person is the holder or contributor; or

*c.* With or through:

(1) The issuers of the securities involved in the transactions;

(2) Other registered broker-dealers;

(3) Banks, savings institutions, trust companies, insurance companies, or investment companies as the term is defined in the Investment Company Act of 1940;

(4) Pension or profit-sharing trusts; or

(5) Other financial institutions or institutional investors, whether acting on their own behalf or as trustees.

**50.18(4)** An agent registered pursuant to subrule 50.18(2) representing a Canadian broker-dealer registered pursuant to subrule 50.18(1) may effect all securities transactions that the broker-dealer is authorized by subrule 50.18(3) to effect.

**50.18(5)** If no denial order is in effect and no proceeding is pending pursuant to Iowa Code section 502.304, a registration filed pursuant to this rule becomes effective on the forty-fifth day after an application is filed, unless otherwise provided by order of the administrator.

**50.18(6)** A Canadian broker-dealer registered under this rule shall:

*a.* Maintain provincial or territorial registration and membership in a self-regulatory organization or stock exchange and remain in good standing in each;

*b.* Provide, upon the administrator's request, all books and records relating to its business in Iowa as a broker-dealer;

*c.* Promptly inform the administrator of any criminal action taken against the broker-dealer or of any finding or sanction imposed on the broker-dealer as a result of a self-regulatory or other regulatory action involving fraud, theft, deceit, misrepresentation, or like conduct; and

*d.* Disclose in writing to each of the broker-dealer's clients in Iowa that the broker-dealer and its agents are not subject to the full regulatory requirements of the Act.

**50.18(7)** An agent of a Canadian broker-dealer registered under this rule shall:

*a.* Maintain the agent's provincial or territorial registration and remain in good standing; and

*b.* Promptly inform the administrator of any criminal action taken against the agent or of any finding or sanction imposed on the agent as a result of a self-regulatory or other regulatory action involving fraud, theft, deceit, misrepresentation, or like conduct.

**50.18(8)** Renewal applications for Canadian broker-dealers and agents under this rule must be filed before December 1 each year and may be made by filing with the administrator the most recent renewal application, if any, filed in the jurisdiction in which the broker-dealer has its principal office or, if no such renewal application is required, the most recent application filed pursuant to paragraph 50.18(1) "a" or 50.18(2) "a."

**50.18(9)** Every applicant for registration or renewal registration pursuant to this rule shall pay the applicable fee for broker-dealers and agents as set forth in Iowa Code section 502.410.

**50.18(10)** A Canadian broker-dealer or agent registered under this rule and in compliance with paragraph 50.18(3) "c" is exempt from all the requirements of the Act, except for the antifraud sections and the requirements set out in this rule.

**50.18(11)** All transactions in securities effected between Canadian broker-dealers or agents registered under this rule and Canadian persons meeting the requirements of paragraph 50.18(3) "a" or "b" are exempt from Iowa Code sections 502.301 and 502.504.

This rule is intended to implement Iowa Code section 502.401(4).

[ARC 9169B, IAB 10/20/10, effective 11/24/10]

#### **191—50.19(502) Brokerage services by national and state banks.**

**50.19(1)** A bank may, without registering as a broker-dealer, effect:

*a.* Transactions pursuant to Iowa Code section 502.102(4) "c"; or

*b.* Transactions permitted by order of the administrator.

**50.19(2)** A bank that has entered into a contract with an Iowa-registered broker-dealer may provide the following ministerial securities services without registering as a broker-dealer:

*a.* Provide bank customers and the public with a telephone number of the broker-dealer and provide telephone facilities on bank premises for customers and members of the public to use in contacting the broker-dealer;

*b.* Distribute literature to bank customers and members of the public about particular services provided by the broker-dealer, subject to the requirements of subrule 50.19(4);

*c.* Provide broker-dealer account applications to bank customers and members of the public and provide assistance in completing the forms. The disclosures required pursuant to subrule 50.19(4), in the form prescribed by subrule 50.19(5), shall be included on either the account application or an attachment to the application. If the disclosures are provided on an attachment to the application, both the application

and attachment must be signed by the applicant. The bank may mail the completed account applications to a broker-dealer;

*d.* Assist bank customers wishing to transfer funds into and out of their bank accounts for securities transactions; and

*e.* Provide mailers to bank customers and members of the public and assist them in transmitting securities and securities documents to the broker-dealer.

**50.19(3)** A bank that has entered into a contract with an Iowa-registered broker-dealer may attempt to effect and effect securities transactions without registering as a broker-dealer if all of the following requirements are met:

*a.* Any bank employee who attempts to effect and effects securities transactions is a registered agent of the broker-dealer and:

- (1) Has passed an acceptable subject matter examination pursuant to paragraph 50.12(1)“*a*”;
- (2) Has passed the FINRA Series 63 or Series 66 examination;
- (3) Is registered with FINRA; and
- (4) Is registered as an agent of the broker-dealer pursuant to rule 191—50.12(502).

*b.* If the broker-dealer provides securities services in an area of public access on the bank premises in which banking services are not provided, the bank requires that the broker-dealer clearly distinguish the area in which securities services are provided. If securities services and banking services are provided in the same public area on the bank premises, there shall be a sign clearly identifying the broker-dealer providing the securities services.

*c.* The bank receives only the following types of compensation from the broker-dealer:

(1) Transaction-related compensation, subject to the restrictions provided by paragraph 50.19(7)“*b*”;

(2) An administrative fee;

(3) Payments for compensation of employees jointly employed by the bank and the broker-dealer;

and

(4) Lease payments.

**50.19(4)** A bank attempting to effect and effecting securities transactions pursuant to a contract with an Iowa-registered broker-dealer may distribute advertisements or promotional materials without registering as a broker-dealer if the advertisements or promotional materials clearly and prominently:

*a.* Identify the broker-dealer;

*b.* State in bold typeface that securities transactions and related earnings or profits are not insured by the FDIC;

*c.* State that the securities offered by the broker-dealer are not guaranteed by, nor are they obligations of, the bank; and

*d.* State that the bank and the broker-dealer are separate organizations.

**50.19(5)** The following or a similar statement printed in bold typeface and capital letters shall satisfy the disclosure requirements of subrule 50.19(4): [NAME OF BROKER-DEALER] IS NOT A BANK, AND SECURITIES OFFERED BY [NAME OF BROKER-DEALER] ARE NOT BACKED OR GUARANTEED BY ANY BANK NOR ARE THEY INSURED BY THE FDIC.

**50.19(6)** The disclosure requirements of subrule 50.19(4) shall not apply to radio or television advertisements not exceeding 30 seconds in length.

**50.19(7)** A bank shall not engage in the following securities activities:

*a.* Distribute prospectuses to bank customers or to members of the public regarding securities unless done so:

(1) In the exercise of trust functions permitted to banks;

(2) Pursuant to registration as a broker-dealer; or

(3) In the performance of securities activities as permitted by subrule 50.19(1), 50.19(2), or 50.19(3);

*b.* Allow registered joint bank and broker-dealer employees to split commissions or other transaction-related remuneration received from customers with unregistered bank employees;

*c.* Transmit account statements, confirmations, or other broker-dealer communications to bank customers or members of the public unless the communications contain a disclosure statement as required by subrule 50.19(4);

*d.* Permit bank employees who are not registered securities agents of the broker-dealer to receive or transmit orders to the broker-dealer from customers or the public, except as permitted by subrule 50.19(1); and

*e.* Permit bank employees who are not registered agents of the broker-dealer to perform securities functions directly involving customer contact, except as provided in subrules 50.19(1) and 50.19(2).

This rule is intended to implement Iowa Code sections 502.102(4) “c” and 502.401.  
[ARC 9169B, IAB 10/20/10, effective 11/24/10]

**191—50.20(502) Broker-dealers having contracts with national and state banks.**

**50.20(1)** A broker-dealer engaging in securities activities with banks as permitted by subrules 50.19(2) and 50.19(3) shall maintain for three years and make available to the administrator upon request the following records:

*a.* Copies of all advertisements and promotional literature disseminated by the bank and broker-dealer regarding securities services and products offered by the broker-dealer to bank customers and the public;

*b.* Copies of each contract executed between the bank and the broker-dealer which propose to sell securities to bank customers or the public;

*c.* Copies of new account forms to be completed by bank customers or members of the public who open an account with the broker-dealer;

*d.* A list of every bank employee who is a registered securities agent of the broker-dealer and the employee’s social security number and CRD number; and

*e.* Copies of compliance and procedures manuals regarding the securities activities of the bank.

**50.20(2)** In addition to any responsibilities assumed pursuant to subrule 50.69(5), a broker-dealer engaging in securities transactions pursuant to a contract with a bank as permitted by subrules 50.19(2) and 50.19(3) shall not allow a person who is not an Iowa-registered securities agent of the broker-dealer to use the broker-dealer name, logo, or trademark on business cards or letterheads.

This rule is intended to implement Iowa Code sections 502.102(4) “c” and 502.401.

**191—50.21(502) Brokerage services by credit unions, savings banks, and savings and loan institutions.**

**50.21(1)** A credit union, savings bank, or savings and loan institution may, without registering as a broker-dealer, effect:

*a.* Transactions pursuant to Iowa Code section 502.102(4) “c”; and

*b.* Transactions permitted by order of the administrator.

**50.21(2)** A credit union, savings bank, or savings and loan institution that has entered into a contract with an Iowa-registered broker-dealer may provide the following ministerial securities services without registering as a broker-dealer:

*a.* Provide customers and the public with a telephone number of the broker-dealer and provide telephone facilities on its premises for customers and members of the public to use in contacting the broker-dealer;

*b.* Distribute literature to its customers and members of the public about particular services provided by the broker-dealer, subject to the requirements of subrule 50.21(4);

*c.* Provide broker-dealer account applications to its customers and members of the public and provide assistance in completing the forms. The disclosures required pursuant to subrule 50.21(4) shall be included on either the account application or an attachment to the application. If the disclosures are provided on an attachment to the application, both the application and attachment must be signed by the applicant. The credit union, savings bank, or savings and loan institution may mail the completed account applications to a broker-dealer;

*d.* Assist its customers wishing to transfer funds into and out of their accounts for securities transactions; and

*e.* Provide mailers to its customers and members of the public and assist them in transmitting securities and securities documents to the broker-dealer.

**50.21(3)** A credit union, savings bank, or savings and loan institution that has entered into a contract with an Iowa-registered broker-dealer may attempt to effect and effect securities transactions without registering as a broker-dealer if all of the following requirements are met:

*a.* Any credit union, savings bank, or savings and loan institution employee who attempts to effect and effects securities transactions is a registered agent of the broker-dealer and:

- (1) Has passed an acceptable subject matter examination pursuant to paragraph 50.12(1)“*a*”;
- (2) Has passed the FINRA Series 63 or Series 66 examination;
- (3) Is registered with FINRA; and
- (4) Is registered as an agent of the broker-dealer pursuant to rule 191—50.12(502).

*b.* If the broker-dealer provides securities services in an area of public access on the credit union, savings bank, or savings and loan institution premises in which credit union, savings bank, or savings and loan institution services are not provided, the credit union, savings bank, or savings and loan institution requires that the broker-dealer clearly distinguish the area in which securities services are provided. If securities services and credit union, savings bank, or savings and loan institution services are provided in the same public area on the bank premises, there shall be a sign clearly identifying the broker-dealer providing the securities services.

*c.* The credit union, savings bank, or savings and loan institution receives only the following types of compensation from the broker-dealer:

- (1) Transaction-related compensation, subject to the restrictions provided by paragraph 50.19(7)“*b*”;
- (2) An administrative fee;
- (3) Payments for compensation of employees jointly employed by the credit union, savings bank, or savings and loan institution and the broker-dealer; and
- (4) Lease payments.

**50.21(4)** Credit unions, savings banks, and savings and loan institutions attempting to effect and effecting securities transactions under contracts with Iowa-registered broker-dealers may distribute advertisements or promotional materials without registering as broker-dealers if the advertisements or promotional materials clearly and prominently:

*a.* Identify the broker-dealer.

*b.* Disclose in bold print that securities transactions and related earnings or profits are not insured by:

- (1) The FDIC, in the case of savings banks and savings and loan institutions, or
- (2) The NCUA, in the case of credit unions.

*c.* Disclose that securities offered by the broker-dealer are not guaranteed by, nor are they obligations of, the credit union, savings bank, or savings and loan institution.

*d.* Disclose that the credit union, savings bank, or savings and loan institution and the broker-dealer are separate organizations.

**50.21(5)** The following or a similar statement in bold print and capital letters will satisfy the disclosure requirements of subrule 50.21(4): [NAME OF BROKER-DEALER] IS NOT A [SAVINGS BANK, SAVINGS AND LOAN INSTITUTION, OR CREDIT UNION], AND SECURITIES OFFERED BY [NAME OF BROKER-DEALER] ARE NOT BACKED OR GUARANTEED BY ANY [SAVINGS BANK, SAVINGS AND LOAN INSTITUTION, OR CREDIT UNION] NOR ARE THEY INSURED BY THE [FDIC OR NCUA].

**50.21(6)** The disclosure requirements of subrule 50.21(4) shall not apply to radio or television advertisements not exceeding 30 seconds in length.

**50.21(7)** Credit unions, savings banks, and savings and loan institutions shall not:

- a.* Distribute prospectuses for securities to customers or to members of the public except:
- (1) In the exercise of trust functions permitted to them;
  - (2) Pursuant to registration as a broker-dealer; or

- (3) In the performance of securities activities as permitted by subrules 50.21(1) to 50.21(3); or  
 b. Engage in any of the activities proscribed if performed by an unregistered bank by paragraphs 50.19(7) “b” to “e.”

This rule is intended to implement Iowa Code sections 502.102(4) “c” and 502.401.  
 [ARC 9169B, IAB 10/20/10, effective 11/24/10]

**191—50.22(502) Broker-dealers having contracts with credit unions, savings banks, and savings and loan institutions.**

**50.22(1)** A broker-dealer engaging in securities activities with credit unions, savings banks, or savings and loan institutions as permitted by subrules 50.21(2) and 50.21(3) shall maintain for three years and make available to the administrator upon request the following records:

- a. Copies of all advertisements and promotional literature disseminated by the credit union, savings bank, or savings and loan institution and the broker-dealer regarding securities services and products offered by the broker-dealer to credit union, savings bank, or savings and loan institution customers and the public;
- b. Copies of each contract executed between the credit union, savings bank, or savings and loan institution and the broker-dealer which proposes to sell securities to credit union, savings bank, or savings and loan institution customers or the public;
- c. Copies of new account forms to be completed by credit union, savings bank, or savings and loan institution customers or members of the public who open an account with the broker-dealer;
- d. A list of every credit union, savings bank, or savings and loan institution employee who is a registered securities agent of the broker-dealer and the employee’s social security number and CRD number; and
- e. Copies of compliance and procedures manuals regarding the securities activities of the credit union, savings bank, or savings and loan institution.

**50.22(2)** In addition to any responsibilities assumed pursuant to subrule 50.69(5), a broker-dealer engaging in securities transactions pursuant to a contract with a credit union, savings bank, or savings and loan institution as permitted by subrules 50.21(2) and 50.21(3) shall not allow a person who is not an Iowa-registered securities agent of the broker-dealer to use the broker-dealer name, logo, or trademark on business cards or letterheads.

This rule is intended to implement Iowa Code sections 502.102(4) “c” and 502.401.

**191—50.23 to 50.29** Reserved.

DIVISION III  
 REGISTRATION OF INVESTMENT ADVISERS,  
 INVESTMENT ADVISER REPRESENTATIVES,  
 AND FEDERAL COVERED INVESTMENT ADVISERS

**191—50.30(502) Electronic filing with designated entity.**

**50.30(1) Designation.** Pursuant to Iowa Code sections 502.406 and 502.608(3) “a,” the administrator designates the IARD operated by FINRA to receive and store filings and collect related fees from investment advisers on behalf of the administrator.

**50.30(2) Use of IARD.** Unless otherwise provided, all investment adviser applications, amendments, reports, notices, related filings and fees required to be filed with the administrator pursuant to the rules promulgated under the Act shall be filed electronically with and transmitted to IARD. The following additional conditions relate to such electronic filings:

- a. *Electronic signature.* When a signature or signatures are required by the particular instructions of any filing to be made through IARD, a duly authorized signatory of the applicant, as required, shall affix the duly authorized signatory’s electronic signature to the filing by typing the duly authorized signatory’s name in the appropriate fields and submitting the filing to IARD. Submission of a filing in this manner shall constitute irrefutable evidence of legal signature by any individuals whose names are typed on the filing.

*b. When filed.* Solely for purposes of a filing made through IARD, a document is considered filed with the administrator when all fees are received and the filing is accepted by IARD on behalf of the state.

This rule is intended to implement Iowa Code sections 502.102(8), 502.406 and 502.608(3) “a.” [ARC 9169B, IAB 10/20/10, effective 11/24/10]

### **191—50.31(502) Investment adviser applications and renewals.**

**50.31(1) *Investment adviser applications—required filings.*** The application for initial registration as an investment adviser shall be made by:

- a.* Filing Form ADV Parts 1 and 2 with IARD; and
- b.* Remitting the \$100 filing fee to IARD pursuant to Iowa Code section 502.410(3).

**50.31(2) *Investment adviser applications—discretionary filings.*** The administrator may require that an application for initial registration also include the following:

- a.* Financial statements as set forth in paragraph 50.42(1) “f” including, but not limited to, a copy of the balance sheet for the last fiscal year and, if the balance sheet is prepared as of a date more than 45 days from the date of the filing of the application, an unaudited balance sheet prepared in accordance with subrule 50.40(7);
- b.* A copy of the surety bond required pursuant to rule 191—50.41(502), if any; and
- c.* Any other information necessary for determining whether registration is appropriate.

**50.31(3) *Investment adviser renewals—required filings.*** Annual renewals by investment advisers shall be made by:

- a.* Filing an annual renewal registration with IARD; and
- b.* Remitting the \$100 filing fee to IARD as required pursuant to Iowa Code section 502.410(3).

**50.31(4) *Investment adviser renewals—discretionary filings.*** The administrator may require the filing of a copy of the surety bond, if any, required pursuant to rule 191—50.41(502).

**50.31(5) *Completion of filing.*** An application for initial or renewal registration is considered filed for the purposes of Iowa Code section 502.406 when the required fee and all required submissions have been received by IARD and the administrator.

**50.31(6) *Updates and amendments.*** The investment adviser is under a continuing obligation to update information provided on Form ADV as follows:

- a.* An updated Form ADV must be filed with IARD within 90 days of the end of the investment adviser’s fiscal year; and
- b.* Any amendment to Form ADV must be filed with IARD within 30 days of the event causing the required amendment.

**50.31(7) *Succession and change in registration.***

*a.* In the case of an organizational change, including a change in the state of incorporation or form of organization, not involving a material change in financial condition or management, an investment adviser shall file all applicable amendments to Form ADV.

*b.* In the case of an organizational change, including a change in the state of incorporation or form of organization, involving a material change in financial condition or management, an investment adviser must file a new application for registration pursuant to subrule 50.31(1). The filing must include the fee pursuant to paragraph 50.31(1) “b” and registration fees for all Iowa-registered investment adviser representatives.

*c.* In the case of a change in name, an investment adviser shall file all applicable amendments to Form ADV.

This rule is intended to implement Iowa Code sections 502.102(8) and 502.406. [ARC 1076C, IAB 10/2/13, effective 11/6/13]

### **191—50.32(502) Application for investment adviser representative registration.**

**50.32(1) *Designation.*** Pursuant to Iowa Code sections 502.406 and 502.608(3) “a,” the administrator designates the CRD operated by FINRA to receive and store filings and collect related fees from investment adviser representatives on behalf of the administrator.

**50.32(2) Initial application.** The application for initial registration as an investment adviser representative made pursuant to Iowa Code section 502.406(1) shall be made by filing Form U-4 with the CRD. The following shall be submitted to the CRD with the application:

- a. Proof of compliance by the investment adviser representative with the examination requirements of rule 191—50.33(502); and
- b. If applicable, the \$30 fee required pursuant to Iowa Code section 502.410(4).

**50.32(3) Annual renewal.** Annual renewals by investment adviser representatives shall be made by:

- a. Filing an annual renewal registration with CRD; and
- b. If applicable, remitting the \$30 filing fee to CRD as required pursuant to Iowa Code section 502.410(4).

**50.32(4) Completion of filing.** An application for initial or renewal registration is considered filed for the purposes of Iowa Code section 502.406 when the required fee and all required submissions have been received by the CRD.

**50.32(5) Updates, amendments, withdrawals and terminations.** The investment adviser representative is under a continuing obligation to update information provided on Form U-4 as follows:

- a. Any amendment to information provided on Form U-4 must be filed with CRD within 30 days of the event causing the required amendment; and
- b. A withdrawal request or termination must be filed with CRD within 30 days of the event causing the necessity of a withdrawal request or termination. A withdrawal request shall be made by filing an accurate and complete Form U-5 with CRD.

This rule is intended to implement Iowa Code sections 502.102(8) and 502.406.  
[ARC 9169B, IAB 10/20/10, effective 11/24/10]

#### **191—50.33(502) Examination requirements.**

**50.33(1)** Except as exempted by subrule 50.33(2), a person applying to be registered as an investment adviser representative shall provide the administrator with proof that the person has obtained a passing score on one of the following examinations:

- a. The Series 65 examination as implemented January 1, 2000; or
- b. The Series 7 examination and Series 66 examination as implemented January 1, 2000. In the event that an applicant for registration as an investment adviser representative has received a waiver by FINRA of the Series 7 examination otherwise required by this paragraph, the FINRA waiver will be accepted in lieu of the examination requirement.

**50.33(2)** Unless otherwise ordered by the administrator in connection with a violation of the Act, the following individuals shall be exempt from the examination requirements of subrule 50.33(1):

- a. Any individual who is registered as an investment adviser or investment adviser representative in any jurisdiction in the United States on or before January 19, 2000.
- b. Any individual who is registered as an investment adviser or investment adviser representative in any jurisdiction in the United States after November 1, 2001, provided that the jurisdiction in which the investment adviser or investment adviser representative is registered requires the passage of the examinations in subrule 50.33(1).
- c. Any individual who has not been registered as an investment adviser or investment adviser representative in any jurisdiction for a period of two years shall be required to comply with the examination requirements of this rule.
- d. Any individual who currently holds one of the following professional designations:
  - (1) Certified Financial Planner or CFP designation awarded by the Certified Financial Planner Board of Standards, Inc.;
  - (2) Chartered Financial Consultant (ChFC) designation awarded by The American College, Bryn Mawr, Pennsylvania;
  - (3) Personal Financial Specialist (PFS) designation administered by the American Institute of Certified Public Accountants;
  - (4) Chartered Financial Analyst (CFA) designation granted by the Association for Investment Management and Research;

(5) Chartered Investment Counselor (CIC) designation granted by the Investment Counsel Association of America; or

(6) Any other professional designation recognized by order of the administrator.

This rule is intended to implement Iowa Code section 502.412(5).

[ARC 9169B, IAB 10/20/10, effective 11/24/10]

**191—50.34(502) Notice filing requirements for federal covered investment advisers.**

**50.34(1) Notice filing.** The notice filing for a federal covered investment adviser pursuant to Iowa Code section 502.405 shall be filed with IARD on an executed Form ADV. A notice filing of a federal covered investment adviser shall be deemed filed for purposes of this subrule when Form ADV and the fee of \$100 required pursuant to Iowa Code section 502.410(5) are received by IARD.

**50.34(2) Form ADV Part 2.** The administrator may:

a. Accept a copy of Part 2 of Form ADV as filed electronically with IARD; or  
b. Deem Part 2 of Form ADV filed if a federal covered investment adviser provides, within five days of a request, Part 2 of Form ADV to the administrator. Because the administrator deems Part 2 of Form ADV to be filed, a federal covered investment adviser is not required to submit Part 2 of Form ADV to the administrator unless specifically requested to do so.

**50.34(3) Renewal.** The annual renewal of the notice filing for a federal covered investment adviser pursuant to Iowa Code section 502.405 shall be filed with IARD. The renewal of the notice filing shall be deemed filed for purposes of this subrule when the \$100 fee required pursuant to Iowa Code section 502.410(5) is accepted by IARD.

**50.34(4) Updates and amendments.** A federal covered investment adviser must file with IARD any amendments to the federal covered investment adviser's Form ADV.

This rule is intended to implement Iowa Code section 502.405.

[ARC 1076C, IAB 10/2/13, effective 11/6/13]

**191—50.35(502) Withdrawal of investment adviser registration.** The application for withdrawal of registration as an investment adviser pursuant to Iowa Code section 502.409 shall be completed on Form ADV-W and filed with IARD.

This rule is intended to implement Iowa Code section 502.409.

**191—50.36(502) Investment adviser brochure.**

**50.36(1) General requirements.**

a. Unless otherwise provided in this rule, an investment adviser registered or required to be registered pursuant to Section 403 of the Act shall furnish each advisory client and prospective advisory client with:

(1) A brochure which may be a copy of Part 2A of its Form ADV or written documents containing the information required by Part 2A of Form ADV;

(2) A copy of its Part 2B brochure supplement for each individual:

1. Providing investment advice and having direct contact with clients in this state; or

2. Exercising discretion over assets of clients in this state, even if no direct contact is involved;

(3) A copy of its Part 2A Appendix 1 wrap fee brochure if the investment adviser sponsors or participates in a wrap fee account;

(4) A summary of material changes, which may be included in Form ADV Part 2 or given as a separate document; and

(5) Such other information as the administrator may require.

b. The brochure must comply with the language, organizational format and filing requirements specified in the Instructions to Form ADV Part 2.

c. Notwithstanding the SEC's Instructions for Part 2A of Form ADV, fee changes constitute material changes requiring an update to all parts of Form ADV.

**50.36(2) Delivery.**

*a. Initial delivery.* An investment adviser, except as provided in paragraph 50.36(2)“c,” shall deliver the Part 2A brochure and any brochure supplements required by rule 191—50.36(502) to a prospective advisory client:

(1) Not less than 48 hours before an investment adviser enters into any advisory contract with such client or prospective client; or

(2) At the time an advisory client enters into any such contract, if the advisory client has a right to terminate the contract without penalty within five business days after entering into the contract.

*b. Annual delivery.* An investment adviser, except as provided in paragraph 50.36(2)“c,” must:

(1) Deliver within 120 days of the end of its fiscal year a free, updated brochure and related brochure supplements which include or are accompanied by a summary of material changes; or

(2) Deliver a summary of material changes that includes an offer to provide a copy of the updated brochures and supplements and information on how the client may obtain a copy of the brochures and supplements, provided that advisers are not required to deliver a summary of material changes if no material changes have taken place since the last summary and brochure delivery.

*c. Exceptions to delivery.* Delivery of the brochure and related brochure supplements required by paragraphs 50.36(2)“a” and “b” need not be made to:

(1) Clients who receive only impersonal advice and who pay less than \$500 in fees per year; or

(2) An investment company registered under the Investment Company Act of 1940; or

(3) A business development company as defined in the Investment Company Act of 1940 and whose advisory contract meets the requirements of Section 15c of that Act.

*d. Electronic delivery.* Delivery of the brochure and related supplements may be made electronically if the investment adviser:

(1) In the case of an initial delivery to a potential client, obtains verification that readable copies of the brochure and supplements were received by the client;

(2) In the case of other than initial deliveries, obtains each client’s prior consent to provide the brochure and supplements electronically;

(3) Prepares the electronically delivered brochure and supplements in the format prescribed in subrule 50.36(1) and Instructions to Form ADV Part 2;

(4) Delivers the brochure and supplements in a format that can be retained by the client in either electronic or paper form; or

(5) Establishes procedures to supervise personnel transmitting the brochure and supplements and to prevent violations of this rule.

**50.36(3) Other disclosures.** Nothing in this rule shall relieve any investment adviser from any obligation pursuant to any provision of the Act or the rules thereunder or other federal or state law to disclose any information to its advisory clients or prospective advisory clients not specifically required by this rule.

**50.36(4) Definitions.** For the purpose of this rule:

*a. “Contract for impersonal advisory services”* means any contract relating solely to the provision of investment advisory services:

(1) By means of written material or oral statements which do not purport to meet the objectives or needs of specific individuals or accounts;

(2) Through the issuance of statistical information containing no expression of opinion as to the investment merits of a particular security; or

(3) Any combination of the foregoing services.

*b. “Entering into,”* in reference to an advisory contract, does not include an extension or renewal without material change of any such contract which is in effect immediately prior to such extension or renewal.

This rule is intended to implement Iowa Code section 502.411(7).

[ARC 1076C, IAB 10/2/13, effective 11/6/13]

**191—50.37(502) Cash solicitation.**

**50.37(1)** Payment of a cash fee, directly or indirectly, by an investment adviser to a solicitor for solicitation activities shall constitute an act, practice, or course of conduct operating as a fraud or deceit upon a person, pursuant to Iowa Code section 502.502(2), if:

*a.* The solicitor:

- (1) Is subject to an order issued by the administrator pursuant to Iowa Code section 502.412(4);
- (2) Has been convicted of a felony or within the previous ten years has been convicted of a misdemeanor involving conduct described in Iowa Code section 502.412(4) “*c*”; or
- (3) Is found by the administrator to have engaged or has been convicted of engaging in any of the conduct specified in Iowa Code section 502.505, 502.412(4) “*b*” or 502.412(4) “*i*”; has materially aided in violating Iowa Code section 502.412(4) “*d*”; or is subject to an order, judgment, or decree pursuant to Iowa Code section 502.412(4) “*d*” to “*f*.”

*b.* The cash fee is not paid pursuant to a written agreement to which the investment adviser is a party. If the cash fee is paid pursuant to a written agreement, the written agreement must:

- (1) Describe the solicitation activities to be engaged in by the solicitor on behalf of the investment adviser and the compensation to be received for the solicitation activities;
- (2) Contain an undertaking by the solicitor to perform the solicitor’s duties under the agreement in a manner consistent with the instructions of the investment adviser and the provisions of the Act and its implementing rules, as applicable; and
- (3) Require that the solicitor, at the time of any solicitation activities for which compensation is paid or is to be paid by the investment adviser, provide the client with a current copy of the investment adviser’s written disclosure statement required by subparagraph 50.36(2) “*a*”(2) or SEC Rule 204-3, if applicable, and a separate written disclosure statement as described in subrule 50.37(2). Prior to or upon entering into a written or oral investment advisory contract with a client, the investment adviser shall obtain a signed and dated acknowledgment of receipt by the client of the investment adviser’s and solicitor’s written disclosure statements. Additionally, the investment adviser shall make a bona fide effort to ascertain whether the solicitor has complied in all aspects with the written agreement, and shall have a reasonable basis for believing that the solicitor has complied.

*c.* The cash fee is paid to a solicitor:

- (1) For solicitation activities regarding anything other than impersonal advisory services; or
- (2) Who is a partner, officer, director, or employee of the investment adviser or is a partner, officer, director, or employee of a person who controls, is controlled by, or is under common control with the investment adviser without disclosure of the status of the solicitor as a partner, officer, director, or employee of the investment adviser or other person and of any affiliation between the investment adviser and the solicitor to the client at the time of solicitation or referral.

**50.37(2)** The separate written disclosure statement required to be furnished pursuant to subparagraph 50.37(1) “*b*”(3) shall contain the following information:

- a.* The name of the solicitor;
- b.* The name of the investment adviser;
- c.* The nature of the relationship, including any affiliation, between the solicitor and the investment adviser;
- d.* A statement that the solicitor will be compensated for the solicitor’s solicitation services by the investment adviser;
- e.* The terms of such compensation arrangement, including a description of the compensation paid or to be paid to the solicitor; and
- f.* The amount, if any, the client will be charged for the cost of obtaining the client’s account in addition to the advisory fee, and the differential, if any, in advisory fees charged by the investment adviser if the differential is the result of the investment adviser’s agreement to compensate the solicitor for soliciting or referring clients.

**50.37(3)** Nothing in this rule relieves any person of any fiduciary duty or other obligation to which the person may be subject pursuant to contract or law.

**50.37(4)** For the purpose of this rule:

“*Client*” includes any prospective client.

“*Impersonal advisory services*” means investment advisory services provided solely through written materials or oral statements not purporting to meet the objectives or needs of the specific client, statistical information containing no expressions of opinion as to the investment merits of particular securities, or any combination of the foregoing.

“*Principal place of business*” of an investment adviser means the executive office of the investment adviser from which the officers, partners, or managers of the investment adviser direct, control, and coordinate the activities of the investment adviser.

“*Solicitor*” means any person who, directly or indirectly, solicits any client for or refers any client to an investment adviser.

**50.37(5)** An investment adviser shall retain a copy of each written agreement, acknowledgment and solicitor disclosure statement required by this rule in accordance with Iowa Code section 502.411(3) and paragraph 50.42(1)“o.” However, an investment adviser registered in Iowa whose principal place of business is located outside Iowa shall not be subject to the record maintenance requirements of this subrule and the applicable provisions of paragraph 50.42(1)“o” if:

a. The investment adviser is registered or licensed as an investment adviser in the state in which the investment adviser maintains the investment adviser’s principal place of business;

b. The investment adviser complies with the applicable books and records requirements of the state in which the investment adviser maintains the investment adviser’s principal place of business; and

c. The provisions of this rule would require the investment adviser to maintain books or records in addition to those required by the laws of the state in which the investment adviser maintains the investment adviser’s principal place of business.

This rule is intended to implement Iowa Code section 502.502(2).

#### **191—50.38(502) Prohibited conduct in providing investment advice.**

**50.38(1)** An investment adviser, an investment adviser representative, or a federal covered investment adviser is a fiduciary and has a duty to act primarily for the benefit of its clients. Rule 191—50.38(502) applies to federal covered investment advisers to the extent that the alleged conduct is fraudulent, deceptive, or as otherwise permitted by the NSMIA. While the extent and nature of this duty varies according to the nature of the relationship between an investment adviser, an investment adviser representative, or a federal covered investment adviser and its clients and the circumstances of each case, an investment adviser, an investment adviser representative, or a federal covered investment adviser shall not engage in prohibited fraudulent, deceptive, or manipulative conduct including, but not limited to:

a. Recommending to a client to whom investment advisory services are provided the purchase, sale, or exchange of any security without reasonable grounds to believe that the recommendation is suitable for the client on the basis of information furnished by the client after reasonable inquiry concerning the client’s investment objectives, financial situation and needs, and any other information known by the investment adviser, investment adviser representative, or federal covered investment adviser;

b. Exercising any discretionary authority in placing an order for the purchase or sale of securities for a client without obtaining written discretionary authority from the client within ten business days after the date of the first transaction placed pursuant to discretionary authority, unless the discretionary authority relates solely to the price at which, or the time when, an order for a definite amount of a specified security shall be executed, or both;

c. Inducing trading in a client’s account that is excessive in size or frequency compared to the financial resources, investment objectives, and character of the account;

d. Placing an order to purchase or sell a security for a client account without authority to do so;

e. Placing an order to purchase or sell a security for a client account upon instruction of a third party without first obtaining a written third-party trading authorization from the client;

f. Borrowing money or securities from a client unless the client is a broker-dealer, an affiliate of the investment adviser, or a financial institution engaged in the business of loaning funds;

g. Loaning money or securities to a client unless the investment adviser is a financial institution engaged in the business of loaning funds or the client is an affiliate of the investment adviser;

h. Misrepresenting to any client, or prospective client, the qualifications of the investment adviser, investment adviser representative, or federal covered investment adviser or any employee, or affiliated persons, or misrepresenting the nature of the advisory services being offered or fees to be charged for such service, or omitting to state a material fact necessary to make the statements made regarding qualifications, services or fees, in light of the circumstances under which they are made, not misleading;

i. Providing a report or recommendation to any advisory client prepared by someone other than the investment adviser, investment adviser representative, or federal covered investment adviser without disclosing that fact. This prohibition does not apply when the investment adviser, investment adviser representative, or federal covered investment adviser uses published research reports or statistical analyses to render advice or when an investment adviser, investment adviser representative, or federal covered investment adviser orders such a report in the normal course of providing service;

j. Charging a client an unreasonable fee;

k. Failing to disclose to clients in writing before any advice is rendered any material conflict of interest regarding the investment adviser, investment adviser representative, or federal covered investment adviser or any of its employees, or affiliated persons which could reasonably be expected to impair the rendering of unbiased and objective advice including, but not limited to:

(1) Compensation arrangements connected with investment advisory services to clients which are in addition to compensation from such clients for such services; and

(2) Charging a client an investment advisory fee for rendering advice when compensation for effecting securities transactions pursuant to such advice will be received by the investment adviser, investment adviser representative, or federal covered investment adviser or its employees or affiliated persons;

l. Knowingly selling any security to or purchasing any security from a client while acting as principal for an advisory account of the investment adviser, investment adviser representative, or federal covered investment adviser, or knowingly effecting any sale or purchase of any security for the account of the client while acting as broker-dealer for a person other than the client, without disclosing to the client in writing before the completion of the transaction the capacity in which the investment adviser, investment adviser representative, or federal covered investment adviser is acting and without obtaining the written consent of the client to the transaction.

(1) The prohibitions of paragraph 50.38(1) "l" shall not apply to any transaction with a customer of a broker-dealer if the broker-dealer is not acting as an investment adviser in relation to the transaction.

(2) The prohibitions of paragraph 50.38(1) "l" shall not apply to any transaction with a customer of a broker-dealer if the broker-dealer acts solely as an investment adviser:

1. By means of publicly distributed written materials or publicly made oral statements;

2. By means of written materials or oral statements not purporting to meet the objectives or needs of specific individuals or accounts;

3. Through the issuance of statistical information containing no expressions of opinion as to the investment merits of a particular security; or

4. Any combination of the foregoing services.

(3) Publicly distributed written materials or publicly made oral statements shall disclose that, if the purchaser of the advisory communication uses the investment adviser's services in connection with the sale or purchase of a security which is a subject of the communication, the investment adviser may act as principal for its own account or as agent for another person. Compliance by the investment adviser with the foregoing disclosure requirement shall not relieve the investment adviser of any other disclosure obligations under the Act.

(4) Definitions for purposes of rule 191—50.38(502):

1. "*Publicly distributed written materials*" means written materials which are distributed to 35 or more persons who pay for those materials.

2. “Publicly made oral statements” means oral statements made simultaneously to 35 or more persons who pay for access to those statements.

*m.* Guaranteeing a client that a specific result will be achieved with advice rendered;

*n.* Making, in the solicitation of clients, any untrue statement of a material fact, or omitting to state a material fact necessary in order to make the statement made, in light of the circumstances under which they are made, not misleading;

*o.* Disclosing the identity, affairs, or investments of any client unless required by law to do so, or unless disclosed with the client’s consent;

*p.* Taking any action, directly or indirectly, regarding securities or funds in which any client has any beneficial interest when the investment adviser has custody or possession of such securities or funds and when the action of the investment adviser or investment adviser representative is subject to and in violation of the custody requirements provided by rule 191—50.39(502);

*q.* Failing to establish, maintain, and enforce written policies and procedures reasonably designed to prevent the misuse of material nonpublic information in violation of Section 204A of the Investment Advisers Act of 1940;

*r.* Engaging in any act, practice, or course of business which is fraudulent, deceptive, manipulative, or unethical;

*s.* Engaging in conduct or any act, indirectly or through or by any other person, which is unlawful for such person to do directly under the provisions of this Act, its implementing rules, or order of the administrator;

*t.* Failing to disclose or providing incomplete disclosure to a client regarding any securities-related activities, or engaging in deceptive practices;

*u.* Soliciting or accepting a gift, directly or indirectly, from an unrelated customer that in the aggregate exceeds \$250 in a calendar year. A gift accepted by an immediate family member from an unrelated client shall be included in the aggregate limit. An investment adviser shall not solicit or accept from a client a gift transferred through a relative or third party to the investment adviser’s benefit that would have the effect of evading this paragraph;

*v.* Soliciting or accepting being named as a beneficiary, executor, or trustee in a will or trust of an unrelated customer;

*w.* Evading or otherwise negating the requirements of paragraph 50.38(1) “*f*,” “*g*,” “*u*” or “*v*,” by terminating the customer relationship for the purpose of soliciting or accepting a loan or gift or being named as a beneficiary, executor or trustee in a will or trust that the agent is otherwise not permitted to solicit or accept. An investment adviser or investment adviser representative will not be in violation of this rule if the investment adviser or investment adviser representative has made a bona fide termination of the client relationship and conducted no securities-related business or other business for a period of three years with the client;

*x.* Engaging in conduct deemed dishonest or unethical in rule 191—50.55(502); and

*y.* Employing any method or tactic which uses undue pressure, force, fright, or threat, whether explicit or implied, in connection with providing investment advice, or committing any act which shows that an investment adviser or investment adviser representative has exerted undue influence over a client.

**50.38(2)** An investment adviser, investment adviser representative, or federal covered investment adviser shall not, directly or indirectly, publish, circulate, or distribute any advertisement that does any one of the following:

*a.* Refers to any testimonial of any kind concerning the investment adviser, investment adviser representative, or federal covered investment adviser or concerning any advice, analysis, report, or other service rendered by such investment adviser, investment adviser representative, or federal covered investment adviser.

*b.* Refers to past specific recommendations of the investment adviser, investment adviser representative, or federal covered investment adviser that were or would have been profitable to any person, except that an investment adviser, investment adviser representative, or federal covered investment adviser may furnish or offer to furnish a list of all recommendations made by the investment

adviser, investment adviser representative, or federal covered investment adviser within the immediately preceding period of not less than one year if the advertisement or list also includes both of the following:

(1) The name of each security recommended, the date and nature of each recommendation, the market price at that time, the price at which the recommendation was to be acted upon, and the most recently available market price of each such security.

(2) A legend on the first page in prominent print or type that states that the reader should not assume that recommendations made in the future will be profitable or will equal the performance of the securities in the list.

*c.* Represents that any graph, chart, formula, or other device being offered can in and of itself be used to determine which securities to buy or sell, or when to buy or sell them; or which represents, directly or indirectly, that any graph, chart, formula, or other device being offered will assist any person in making that person's own decisions as to which securities to buy or sell, or when to buy or sell them, without prominently disclosing in such advertisement the limitations thereof and the difficulties with respect to the use of any graph, chart, formula or device.

*d.* Represents that any report, analysis, or other service will be furnished for free or without charge, unless such report, analysis, or other service actually is or will be furnished entirely free and without any direct or indirect condition or obligation.

*e.* Represents that the administrator has approved any advertisement.

*f.* Contains any untrue statement of a material fact, or any statement that is otherwise false or misleading.

**50.38(3)** With respect to federal covered investment advisers, the provisions of subrule 50.38(2) apply only to the extent permitted by Section 203A of the Investment Advisers Act of 1940.

**50.38(4)** For the purposes of subrule 50.38(2), the term "advertisement" shall include any notice, circular, letter, or other written communication addressed to more than one person, or any notice or other announcement in any electronic or paper publication, by radio or television, or by any medium, that offers any one of the following:

*a.* Any analysis, report, or publication concerning securities.

*b.* Any analysis, report, or publication that is to be used in making any determination as to when to buy or sell any security, or which security to buy or sell.

*c.* Any graph, chart, formula, or other device to be used in making any determination as to when to buy or sell any security, or which security to buy or sell.

*d.* Any other investment advisory service with regard to securities.

**50.38(5)** The prohibitions of rule 191—50.38(502) shall not apply to an investment adviser effecting an agency cross transaction for an advisory client provided the following conditions are met:

*a.* The advisory client executes a written consent prospectively authorizing the investment adviser to effect agency cross transactions for such client;

*b.* Before obtaining such written consent from the client, the investment adviser makes full written disclosure to the client that, with respect to agency cross transactions, the investment adviser will act as broker-dealer for, receive commissions from, and have a potentially conflicting division of loyalties and responsibilities regarding both parties to the transactions;

*c.* At or before the completion of each agency cross transaction, the investment adviser or any other person relying on subrule 50.38(5) sends the client a written confirmation. The written confirmation shall include:

(1) A statement of the nature of the transaction;

(2) The date the transaction took place;

(3) An offer to furnish, upon request, the time when the transaction took place; and

(4) The source and amount of any other remuneration the investment adviser received or will receive in connection with the transaction. In the case of a purchase, if the investment adviser was not participating in a distribution, or, in the case of a sale, if the investment adviser was not participating in a tender offer, the written confirmation may state whether the investment adviser has been receiving or will receive any other remuneration and that the investment adviser will furnish the source and amount of such remuneration to the client upon the client's written request;

*d.* At least annually, and with or as part of any written statement or summary of the account from the investment adviser, the investment adviser or any other person relying on subrule 50.38(5) sends each client a written disclosure statement identifying:

(1) The total number of agency cross transactions for the client during the period since the date of the last such statement or summary; and

(2) The total amount of all commissions or other remuneration the investment adviser received or will receive in connection with agency cross transactions for the client during the period;

*e.* Each written disclosure and confirmation required by subrule 50.38(5) must include a conspicuous statement indicating that the client may revoke the written consent required under paragraph 50.38(5) “a” at any time by providing written notice to the investment adviser;

*f.* No agency cross transaction may be effected in which the same investment adviser recommended the transaction to both any seller and any purchaser;

*g.* “Agency cross transaction for an advisory client,” for purposes of subrule 50.38(5), means a transaction in which a person acts as an investment adviser in relation to a transaction in which the investment adviser, or any person controlling, controlled by, or under common control with such investment adviser, including an investment adviser representative, acts as a broker-dealer for both the advisory client and for another client on the other side of the transaction. When acting in such capacity, such person acting as an investment adviser, or any person controlling, controlled by, or under common control with such investment adviser, including an investment adviser representative, is required to be registered as a broker-dealer in this state unless excluded from the definition of investment adviser;

*h.* Nothing in subrule 50.38(5) shall be construed to relieve an investment adviser or investment adviser representative from acting in the best interests of the client, including fulfilling the duty with respect to the best price and execution for the particular transaction for the client, nor shall subrule 50.38(5) relieve any investment adviser or investment adviser representative of any other disclosure obligations imposed by the Act.

This rule is intended to implement Iowa Code section 502.502(2).  
[ARC 1076C, IAB 10/2/13, effective 11/6/13]

### **191—50.39(502) Custody of client funds or securities by investment advisers.**

**50.39(1) Safekeeping required.** It is unlawful and deemed to be a fraudulent, deceptive, or manipulative act, practice, or course of business for an investment adviser, registered or required to be registered, to have custody of client funds or securities unless the following conditions are met:

*a. Notice to administrator.* The investment adviser notifies the administrator promptly in writing that the investment adviser has or may have custody. Such notification is required to be given on Form ADV.

*b. Qualified custodian.* A qualified custodian maintains those funds and securities:

(1) In a separate account for each client under that client’s name; or

(2) In accounts that contain only the investment adviser’s clients’ funds and securities, under the investment adviser’s name as agent or trustee for the clients, or, in the case of a pooled investment vehicle that the investment adviser manages, in the name of the pooled investment vehicle.

*c. Notice to clients.* If an investment adviser opens an account with a qualified custodian on its client’s behalf, under the client’s name, under the name of the investment adviser as agent, or under the name of a pooled investment vehicle, the investment adviser must notify the client in writing of the qualified custodian’s name and address and the manner in which the funds or securities are maintained, promptly when the account is opened and following any changes to this information. If the investment adviser sends account statements to a client to whom the investment adviser is required to provide this notice, the investment adviser must include in the notification provided to that client and in any subsequent account statement the investment adviser sends that client a statement urging the client to compare the account statements from the custodian with those from the investment adviser.

*d. Account statements.* The investment adviser has a reasonable basis, after due inquiry, for believing that the qualified custodian sends an account statement, at least quarterly, to each client for which the qualified custodian maintains funds or securities, identifying the amount of funds and of each

security in the account at the end of the period and setting forth all transactions in the account during that period.

*e. Special rule for limited partnerships and limited liability companies.* If the investment adviser or a related person is a general partner of a limited partnership (or managing member of a limited liability company, or holds a comparable position for another type of pooled investment vehicle):

(1) The account statements required under paragraph 50.39(1)“d” must be sent to each limited partner (or member or other beneficial owner); and

(2) The investment adviser must:

1. Enter into a written agreement with an independent party who is obliged to act in the best interest of the limited partners, members, or other beneficial owners to review all fees, expenses and capital withdrawals from the pooled accounts; and

2. Send all invoices or receipts to the independent party, detailing the amount of the fee, expenses or capital withdrawal and the method of calculation such that the independent party can:

- Determine that the payment is in accordance with the pooled investment vehicle standards (generally the partnership agreement or membership agreement); and

- Forward, to the qualified custodian, approval for payment of the invoice with a copy to the investment adviser.

*f. Independent verification.* The client funds and securities of which the investment adviser has custody are verified by actual examination at least once during each calendar year, by an independent certified public accountant (CPA), pursuant to a written agreement between the investment adviser and the independent CPA, at a time that is chosen by the independent CPA without prior notice or announcement to the investment adviser and that is irregular from year to year. The written agreement must provide for the first examination to occur within six months of execution of the written agreement, except that, if the investment adviser maintains client funds or securities pursuant to rule 191—50.38(502) as a qualified custodian, the agreement must provide for the first examination to occur no later than six months after the investment adviser obtains the internal control report. The written agreement must require the independent CPA to:

(1) File a certificate on Form ADV-E with the administrator within 120 days of the time chosen by the independent CPA in paragraph 50.39(1)“f,” stating that the independent CPA has examined the funds and securities and describing the nature and extent of the examination;

(2) Notify the administrator within one business day of the finding of any material discrepancies during the course of the examination, by means of a facsimile transmission or electronic mail, followed by first-class mail, directed to the attention of the administrator; and

(3) File within four business days of the resignation or dismissal from, or other termination of, the engagement, or removing itself or being removed from consideration for being reappointed, Form ADV-E accompanied by a statement that includes:

1. The date of such resignation, dismissal, removal, or other termination, and the name, address, and contact information of the independent CPA; and

2. An explanation of any problems relating to examination scope or procedure that contributed to such resignation, dismissal, removal, or other termination.

*g. Investment advisers acting as qualified custodians.* If the investment adviser maintains, or if the investment adviser has custody because a related person maintains, client funds or securities pursuant to rule 191—50.39(502) as a qualified custodian in connection with advisory services the investment adviser provides to clients:

(1) The independent CPA that the investment adviser retains to perform the independent verification required by paragraph 50.39(1)“f” must be registered with, and subject to regular inspection as of the commencement of the professional engagement period, and as of each calendar year-end, by, the Public Company Accounting Oversight Board in accordance with its rules; and

(2) The investment adviser must obtain, or receive from its related person, within six months of execution of the written agreement and thereafter no less frequently than once each calendar year a written internal control report prepared by an independent CPA.

1. The internal control report must include an opinion of an independent CPA as to whether controls have been placed in operation as of a specific date, and are suitably designed and are operating effectively to meet control objectives relating to custodial services, including the safeguarding of funds and securities held by either the investment adviser or a related person on behalf of the investment adviser's clients, during the year;

2. The independent CPA must verify that the funds and securities are reconciled to a custodian other than the investment adviser or the investment adviser's related person; and

3. The independent CPA must be registered with, and subject to regular inspection as of the commencement of the professional engagement period, and as of each calendar year-end, by, the Public Company Accounting Oversight Board in accordance with its rules.

*h. Independent representatives.* A client may designate an independent representative to receive, on the client's behalf, notices and account statements as required under paragraphs 50.39(1) "c" and "d."  
**50.39(2) Exceptions.**

*a. Shares of mutual funds.* With respect to shares of an open-end company as defined in Section 5(a)(1) of the Investment Company Act of 1940 ("mutual fund"), the investment adviser may use the mutual fund transfer agent in lieu of a qualified custodian for purposes of complying with subrule 50.39(1).

*b. Certain privately offered securities.*

(1) The investment adviser is not required to comply with paragraph 50.39(1) "b" with respect to securities that are:

1. Acquired from the issuer in a transaction or chain of transactions not involving any public offering;

2. Uncertificated and ownership thereof is recorded only on the books of the issuer or its transfer agent in the name of the client; and

3. Transferable only with prior consent of the issuer or holders of the outstanding securities of the issuer.

(2) Notwithstanding subparagraph 50.39(2) "b"(1), the provisions of paragraph 50.39(2) "b" are available with respect to securities held for the account of a limited partnership (or limited liability company, or other type of pooled investment vehicle) only if the limited partnership is audited, and the audited financial statements are distributed, as described in paragraph 50.39(2) "d," and the investment adviser notifies the administrator in writing that the investment adviser intends to provide audited financial statements, as described in this subparagraph. Such notification is required to be provided on Form ADV.

*c. Fee deduction.* Notwithstanding paragraph 50.39(1) "f," an investment adviser is not required to obtain an independent verification of client funds and securities maintained by a qualified custodian if all of the following conditions are met:

(1) The investment adviser has custody of the funds and securities solely as a consequence of its authority to make withdrawals from client accounts to pay its advisory fee;

(2) The investment adviser has written authorization from the client to deduct advisory fees from the account held with the qualified custodian;

(3) Each time a fee is directly deducted from a client account, the investment adviser concurrently:

1. Sends the independent party designated pursuant to subparagraph 50.39(1) "e"(2) an invoice or statement of the amount of the fee to be deducted from the client's account; and

2. Sends the client an invoice or statement itemizing the fee. Itemization includes the formula used to calculate the fee, the amount of assets under management on which the fee is based, and the time period covered by the fee; and

(4) The investment adviser notifies the administrator in writing that the investment adviser intends to use the safeguards provided in paragraph 50.39(2) "c." Such notification is required to be given on Form ADV.

*d. Limited partnerships subject to annual audit.* An investment adviser is not required to comply with paragraphs 50.39(1) "c" and "d" and shall be deemed to have complied with paragraph 50.39(1) "f"

with respect to the account of a limited partnership (or limited liability company, or another type of pooled investment vehicle) if each of the following conditions is met:

(1) The adviser sends to all limited partners (or members or other beneficial owners), at least quarterly, a statement showing:

1. The total amount of all additions to and withdrawals from the fund as a whole as well as the opening and closing value of the fund at the end of the quarter based on the custodian's records;

2. A listing of all long and short positions on the closing date of the statement in accordance with the Financial Accounting Standards Board, Rule ASC 946-210-50; and

3. The total amount of additions to and withdrawals from the fund by the investor as well as the total value of the investor's interest in the fund at the end of the quarter;

(2) At least annually the fund is subject to an audit and distributes the fund's audited financial statements prepared in accordance with generally accepted accounting principles to all limited partners (or members or other beneficial owners) and the administrator within 120 days of the end of the fund's fiscal year;

(3) The audit is performed by an independent CPA that is registered with, and subject to regular inspection as of the commencement of the professional engagement period, and as of each calendar year-end, by, the Public Company Accounting Oversight Board in accordance with its rules;

(4) Upon liquidation, the adviser distributes the fund's final audited financial statements prepared in accordance with generally accepted accounting principles to all limited partners (or members or other beneficial owners) and the administrator promptly after the completion of such audit;

(5) The written agreement with the independent CPA must require the independent CPA, upon resignation or dismissal from, or other termination of, the engagement, or upon removing itself or being removed from consideration for being reappointed, to notify the administrator within four business days accompanied by a statement that includes:

1. The date of such resignation, dismissal, removal, or other termination, and the name, address, and contact information of the independent CPA; and

2. An explanation of any problems relating to audit scope or procedure that contributed to such resignation, dismissal, removal, or other termination;

(6) The investment adviser must also notify the administrator in writing that the investment adviser intends to employ the use of the statement delivery and audit safeguards described in paragraph 50.39(2) "d." Such notification is required to be given on Form ADV.

*e. Registered investment companies.* The investment adviser is not required to comply with rule 191—50.39(502) with respect to the account of an investment company registered under the Investment Company Act of 1940.

**50.39(3) Delivery to related persons.** Sending an account statement under paragraph 50.39(1) "e" or distributing audited financial statements under paragraph 50.39(2) "d" shall not satisfy the requirements of rule 191—50.39(502) if such account statements or financial statements are sent solely to limited partners (or members or other beneficial owners) that themselves are limited partnerships (or limited liability companies, or another type of pooled investment vehicle) and are related persons of the investment adviser.

**50.39(4) Definitions.** For the purposes of this rule:

*a. "Control"* means the power, directly or indirectly, to direct the management or policies of a person whether through ownership of securities, by contract, or otherwise. "Control" includes the following:

(1) Each of the investment adviser's officers, partners, or directors exercising executive responsibility (or persons having similar status or functions) is presumed to control the investment adviser;

(2) A person is presumed to control a corporation if the person:

1. Directly or indirectly has the right to vote 25 percent or more of a class of the corporation's voting securities; or

2. Has the power to sell or direct the sale of 25 percent or more of a class of the corporation's voting securities;

(3) A person is presumed to control a partnership if the person has the right to receive upon dissolution, or has contributed, 25 percent or more of the capital of the partnership;

(4) A person is presumed to control a limited liability company if the person:

1. Directly or indirectly has the right to vote 25 percent or more of a class of the interests of the limited liability company;

2. Has the right to receive upon dissolution, or has contributed, 25 percent or more of the capital of the limited liability company; or

3. Is an elected manager of the limited liability company; or

(5) A person is presumed to control a trust if the person is a trustee or managing agent of the trust.

b. "*Custody*" means holding, directly or indirectly, client funds or securities, having any authority to obtain possession of client funds or securities, or having the ability to appropriate client funds or securities. The investment adviser has custody if a related person holds, directly or indirectly, client funds or securities, or has any authority to obtain possession of them, in connection with advisory services the investment adviser provides to clients.

(1) "*Custody*" includes:

1. Possession of client funds or securities unless received inadvertently and returned to the sender within three business days of receiving them and the investment adviser maintains the records required under paragraph 50.42(1) "v";

2. Any arrangement including, but not limited to, a general power of attorney pursuant to which the investment adviser is authorized or permitted to withdraw client funds or securities maintained with a custodian upon the investment adviser's instruction; and

3. Any capacity including, but not limited to, general partner of a limited partnership, managing member of a limited liability company, a comparable position for another type of pooled investment vehicle, or trustee of a trust that gives the investment adviser or a person supervised by the investment adviser legal ownership of or access to client funds or securities.

(2) Receipt of checks drawn by clients and made payable to third parties will not meet the definition of custody if forwarded to the third party within three business days of receipt and the investment adviser maintains the records required under paragraph 50.42(1) "v."

c. "*Independent certified public accountant*" means a certified public accountant that meets the standards of independence described in Rule 2-01(b) and (c) of Regulation S-X (17 CFR 210.2-01(b) and (c)).

d. "*Independent representative*" means a person who:

(1) Acts as agent for an advisory client including, in the case of a pooled investment vehicle, limited partners of a limited partnership, members of a limited liability company, or other beneficial owners of another type of pooled investment vehicle, and who is by law or contract required to act in the best interest of the advisory client or the limited partners or members, or other beneficial owners;

(2) Does not control, is not controlled by, and is not under common control with the investment adviser; and

(3) Does not have and has not had within the past two years a material business relationship with the investment adviser.

e. "*Qualified custodian*" means the following independent institutions or entities that are not affiliated with the investment adviser by any direct or indirect common control and have not had a material business relationship with the investment adviser in the previous two years:

(1) A bank or savings association that has deposits insured by the Federal Deposit Insurance Corporation under the Federal Deposit Insurance Act;

(2) A broker-dealer registered in Iowa and with the SEC holding client assets in customer accounts;

(3) A registered futures commission merchant registered pursuant to Section 4(f)(a) of the Commodity Exchange Act that is holding client funds and security futures or other securities incidental to transactions in contracts for the purchase or sale of a commodity for future delivery and options thereon in customer accounts; and

(4) A foreign financial institution that customarily holds financial assets for its customers, provided that the foreign financial institution keeps the advisory clients' assets in customer accounts segregated from its proprietary assets.

*f. "Related person"* means any person, directly or indirectly, controlling or controlled by the investment adviser, and any person that is under common control with the investment adviser.

This rule is intended to implement Iowa Code section 502.411(5).  
[ARC 1076C, IAB 10/2/13, effective 11/6/13]

**191—50.40(502) Minimum financial requirements for investment advisers.**

**50.40(1)** An investment adviser registered or required to be registered under the Act that has custody of client funds or securities shall maintain at all times a minimum net worth of \$35,000 except:

*a.* An investment adviser that has custody solely due to direct fee deduction and that is also in compliance with the applicable safekeeping requirements of paragraph 50.39(2)“c” and the record-keeping requirements of rule 191—50.42(502) is not required to comply with the net worth requirements of this rule; and

*b.* An investment adviser having custody solely due to advising pooled investment vehicles and that is in compliance with the applicable safekeeping requirements of paragraph 50.39(1)“e” or 50.39(2)“d” and the record-keeping requirements of rule 191—50.42(502) is not required to comply with the net worth requirements of this rule.

**50.40(2)** An investment adviser registered or required to be registered pursuant to the Act that has discretionary authority over client funds or securities but does not have custody of client funds or securities shall maintain a minimum net worth of \$10,000 at all times.

**50.40(3)** An investment adviser registered or required to be registered pursuant to the Act shall maintain a positive net worth at all times.

**50.40(4)** Unless otherwise exempted, an investment adviser registered or required to be registered pursuant to the Act shall notify the administrator if the investment adviser's net worth is less than the minimum required. Notice must be filed in a report to the administrator no later than the close of business on the next business day following the decrease in net worth. Additionally, an investment adviser shall file by the close of business on the next business day a report with the administrator of the investment adviser's financial condition including, at a minimum, the following:

- a.* A trial balance of all ledger accounts;
- b.* A list of all client funds or securities which are not segregated;
- c.* A computation of the aggregate amount of client ledger debit balances; and
- d.* The total number of client accounts managed by the investment adviser.

**50.40(5)** The administrator may require the submission of a current appraisal for the purpose of establishing the worth of any asset.

**50.40(6)** An investment adviser that has its principal place of business in a state other than this state is not required to maintain the minimum capital required by this rule provided that the investment adviser is registered as an investment adviser in the state in which the investment adviser has its principal place of business and is in compliance with that state's laws regarding minimum capital requirements.

**50.40(7)** For purposes of this rule:

*a.* “Net worth” means an excess of assets over liabilities calculated in accordance with generally accepted accounting principles. The calculation of assets shall not include the following: prepaid expenses (except those prepaid expenses classified as assets under generally accepted accounting principles); deferred charges, goodwill, franchise rights, organizational expenses, patents, copyrights, marketing rights, unamortized debt discount and expense, and all other assets of intangible nature; in the case of an individual, home(s), home furnishings, automobile(s), or any other personal items not readily marketable; in the case of a corporation, advances or loans to stockholders or officers; and in the case of a partnership, advances or loans to partners.

*b.* “Custody” means the same as defined in paragraph 50.39(4)“b.”

*c.* An investment adviser shall not be deemed to be exercising discretion when the investment adviser places trade orders with a broker-dealer pursuant to a third-party trading agreement if:

(1) The investment adviser has executed a separate investment adviser contract exclusively with the investment adviser's client which acknowledges that a third-party trading agreement will be executed to allow the investment adviser to effect securities transactions for the client in the client's broker-dealer account;

(2) The investment adviser contract specifically states that the client does not grant discretionary authority to the investment adviser and the investment adviser in fact does not exercise discretion with respect to the account; and

(3) A third-party trading agreement is executed between the client and a broker-dealer which specifically limits the investment adviser's authority in the client's broker-dealer account to the placement of trade orders and deduction of investment adviser fees.

This rule is intended to implement Iowa Code section 502.411(1).  
[ARC 1076C, IAB 10/2/13, effective 11/6/13]

#### **191—50.41(502) Bonding requirements for investment advisers.**

**50.41(1)** Every investment adviser registered or required to be registered under the Act:

*a.* Having custody of or discretionary authority over client funds or securities shall be bonded in an amount determined by the administrator based upon the number of clients and the total assets under management of the investment adviser; and

*b.* Having custody of or discretionary authority over client funds or securities when the investment adviser does not meet the minimum net worth standard provisions of subrules 50.40(1) and 50.40(2) must be bonded in the amount of the net worth deficiency rounded up to the nearest \$5,000.

**50.41(2)** A bond required by this rule shall be issued by a company qualified to do business in this state in the form determined by the administrator and shall be subject to the claims of clients of the investment adviser regardless of the client's state of residence.

**50.41(3)** An investment adviser that has a principal place of business in a state other than Iowa is exempt from this rule provided that the investment adviser is registered as an investment adviser in the state in which the investment adviser has its principal place of business and is in compliance with that state's laws regarding bonding requirements.

**50.41(4)** For purposes of this rule, "custody" means the same as defined in paragraph 50.39(4) "b."

This rule is intended to implement Iowa Code section 502.411(5).  
[ARC 1076C, IAB 10/2/13, effective 11/6/13]

#### **191—50.42(502) Record-keeping requirements for investment advisers.**

**50.42(1)** An investment adviser registered or required to be registered pursuant to the Act shall make and keep true, accurate and current the following books, ledgers and records:

*a.* A journal or journals, including cash receipts and disbursements records, and any other records of original entry forming the basis of any ledger entries.

*b.* General and auxiliary ledgers (or other comparable records) reflecting asset, liability, reserve, capital, income, and expense accounts.

*c.* A memorandum of each order given by the investment adviser for the purchase or sale of any security, of any instruction received by the investment adviser from the client concerning the purchase, sale, receipt or delivery of a particular security, and of any modification or cancellation of any such order or instruction. The memorandum shall describe the terms and conditions of the order, instruction, modification or cancellation; identify the person connected with the investment adviser who recommended the transaction to the client and the person who placed the order; indicate whether discretionary power was exercised; and indicate the account for which entered, the date of entry, and, where applicable, the bank or broker-dealer by or through whom executed.

*d.* All checkbooks, bank statements, canceled checks and cash reconciliations of the investment adviser.

*e.* All invoices, bills, or statements, or copies of those documents, relating to the investment adviser's business as an investment adviser regardless of whether the expense or debt is paid or unpaid.

*f.* All trial balances, financial statements, and internal audit working papers relating to the investment adviser's business as an investment adviser. For the purposes of this paragraph, "financial

statements” means a balance sheet prepared in accordance with generally accepted accounting principles, an income statement, a cash flow statement, and a net worth computation, if applicable, as required by subrule 50.40(7).

*g.* Originals of all written communications received by and copies of all written communications sent by the investment adviser relating to:

(1) Any recommendation made or proposed to be made and any advice given or proposed to be given;

(2) Any receipt, disbursement, or delivery of funds or securities; or

(3) The placing or execution of any order to purchase or sell any security, except:

1. The investment adviser shall not be required to keep any unsolicited market letters and other similar communications of general public distribution not prepared by or for the investment adviser; and

2. The investment adviser is not required to keep a record of the names and addresses of persons to whom a notice, circular, or other advertisement offering any report, analysis, publication or other investment advisory service is sent if sent to more than ten persons; however, if the notice, circular, or other advertisement is distributed to persons named on any list, the investment adviser must retain with the copy of the notice, circular, or advertisement a memorandum describing the list and its source.

*h.* A list or other record of all accounts identifying the accounts in which the investment adviser is vested with any discretionary power with respect to the funds, securities or transactions of any client.

*i.* Copies of all powers of attorney and other documents granting discretionary authority by any client to the investment adviser.

*j.* Copies of each agreement entered into by the investment adviser with any client, and all other written agreements otherwise relating to the investment adviser’s business as an investment adviser.

*k.* A file containing copies of each notice, circular, advertisement, newspaper article, investment letter, bulletin, or other communication including electronic media that the investment adviser circulates or distributes, directly or indirectly, to two or more persons not affiliated with the investment adviser and, if the notice, circular, advertisement, newspaper article, investment letter, bulletin, or other communication including one in electronic media format recommends the purchase or sale of a specific security and does not state the reasons for the recommendation, a memorandum indicating the investment adviser’s reasons for the recommendation.

*l.* Transactions involving beneficial ownership.

(1) A record of every transaction in a security in which the investment adviser or any advisory representative of the investment adviser has or by reason of any transaction acquires a direct or indirect beneficial ownership, except the following:

1. Transactions effected in any account over which neither the investment adviser nor any advisory representative of the investment adviser has any direct or indirect influence or control; and

2. Transactions in securities which are direct obligations of the United States.

(2) The required record shall state, at a minimum, the title and amount of the security involved, the date and nature of the transaction (i.e., purchase, sale or other acquisition or disposition), the price at which the transaction was effected, and the name of the bank or broker-dealer with or through which the transaction was effected. The record may also contain a statement declaring that the reporting or recording of any transaction shall not be construed as an admission that the investment adviser or advisory representative has any direct or indirect beneficial ownership in the security. A transaction must be recorded no later than ten days after the end of the calendar quarter in which the transaction was effected. An investment adviser shall not be in violation of this paragraph because of a failure to record securities transactions of an advisory representative if the investment adviser establishes that the investment adviser instituted adequate procedures and used reasonable diligence to promptly obtain reports of all transactions required by this paragraph to be recorded.

*m.* Notwithstanding the provisions of paragraph 50.42(1)“l,” when the investment adviser is primarily engaged in a business or businesses other than advising investment advisory clients, a record must be maintained of every transaction in a security in which the investment adviser or any advisory representative of the investment adviser has, or by reason of any transaction acquires, any direct or indirect beneficial ownership, except:

(1) Transactions effected in any account over which neither the investment adviser nor any advisory representative of the investment adviser has any direct or indirect influence or control; or

(2) Transactions in securities which are direct obligations of the United States.

The record shall state the title and amount of the security involved, the date and nature of the transaction (i.e., purchase, sale, or other acquisition or disposition), the price at which it was effected, and the name of the broker-dealer or bank with or through which the transaction was effected. The record may also contain a statement declaring that the reporting or recording of any transaction shall not be construed as an admission that the investment adviser or advisory representative has any direct or indirect beneficial ownership in the security. A transaction shall be recorded not later than ten days after the end of the calendar quarter in which the transaction was effected. An investment adviser shall not be deemed to have violated the provisions of this subparagraph because of a failure to record securities transactions of an advisory representative if the investment adviser establishes that the investment adviser instituted adequate procedures and used reasonable diligence to promptly obtain reports of all transactions required to be recorded.

*n.* A copy of each written statement and each amendment or revision, given or sent to any client or prospective client of the investment adviser in accordance with rule 191—50.36(502), and a record of the dates on which each written statement, amendment and revision was given or offered to be given to any client or any prospective client who subsequently becomes a client.

*o.* For each client that was obtained by the investment adviser by means of a solicitor to whom a cash fee was paid by the investment adviser:

(1) A copy of any written agreement relating to the payment of a cash fee to which the investment adviser is a party;

(2) A signed and dated acknowledgment of receipt from the client evidencing the client's receipt of the investment adviser's disclosure statement and a written disclosure statement of the solicitor; and

(3) A copy of the solicitor's written disclosure statement.

The written agreement, acknowledgment and solicitor disclosure statement will be deemed to be in compliance if such documents comply with Rule 275.206(4)-3 of the Investment Advisers Act of 1940.

*p.* All accounts, books, internal working papers, and any other records or documents that are necessary to form the basis for or demonstrate the calculation of the performance or rate of return of all managed accounts or securities recommendations provided in any notice, circular, advertisement, newspaper article, investment letter, bulletin, or other communication, including electronic media, that is directly or indirectly circulated or distributed by the investment adviser to two or more persons (other than persons connected with the investment adviser). However, with respect to the performance of managed accounts only, the retention of all account statements reflecting all debits, credits, and other transactions in a client's account for the period of the statement, and the retention of all worksheets necessary to demonstrate the calculation of the performance or rate of return of the managed account shall satisfy the requirements of this paragraph.

*q.* A file containing copies of all written communications received or sent regarding any litigation or customer or client complaints involving the investment adviser or any investment adviser representative or employee.

*r.* The basis, in writing, for any recommendation or investment advice provided to an investment advisory client.

*s.* Copies of all written procedures regarding the supervision of the employees and investment adviser representatives that are reasonably designed to achieve compliance with securities laws and regulations.

*t.* A file containing a copy of each document (other than any notices of general dissemination) that was filed with or received from any state or federal agency or self-regulatory organization pertaining to the investment adviser or its investment adviser representatives, as defined by subrule 50.42(11), including but not limited to all applications, amendments, renewal filings, and correspondence.

*u.* Original copies signed by the lawful signatory of the investment adviser and the investment adviser representative of each initial Form U-4 and each U-4 Amendment to Disclosure Reporting Pages (DRPs).

v. For each transaction in which the investment adviser inadvertently held or obtained the client's securities or funds and returned them to the client within three business days of receipt or forwarded a check drawn by a client and made payable to a third party within three business days of receipt, a ledger or list of all funds or securities held or obtained with the following information:

- (1) Issuer;
- (2) Type of security and series;
- (3) Date of issue;
- (4) For debt instruments, the denomination, interest rate and maturity date;
- (5) Certificate number, including alphabetical prefix or suffix;
- (6) Name in which registered;
- (7) Date submitted to the investment adviser;
- (8) Date sent to client or sender;
- (9) Form of delivery to client or sender, or copy of the form of delivery to client or sender; and
- (10) Mail confirmation number, if applicable, or confirmation by client or sender of the return of the security or fund.

w. If an investment adviser obtains possession of securities that are acquired from the issuer in a transaction or chain of transactions not involving a public offering that comply with the exception from custody in paragraph 50.39(2) "b," the adviser shall keep:

(1) A record showing the issuer's or current transfer agent's name, address, telephone number, and other applicable contact information pertaining to the party responsible for recording the client's interests in the securities; and

(2) A copy of any legend, shareholder agreement, or other agreement providing that the securities are transferable only with prior consent of the issuer or holders of the outstanding securities of the issuer.

**50.42(2)** In addition to the retention requirements of subrule 50.42(1), an investment adviser having custody of client funds or securities, as defined by paragraph 50.39(3) "b," shall retain the following records:

a. Copies of all documents executed by each client, including but not limited to a limited power of attorney, pursuant to which the investment adviser is authorized or permitted to withdraw a client's funds or securities maintained with a custodian upon the adviser's instruction to the custodian;

b. A journal or other record for all accounts reflecting all purchases, sales, receipts, and deliveries of securities, including but not limited to certificate numbers, and all other debits and credits to the accounts;

c. A separate ledger account for each client showing all purchases, sales, receipts and deliveries of securities, the date and price of each purchase or sale, and all debits and credits;

d. Copies of confirmations of all transactions effected by or for the account of any client;

e. A record for each security in which any client has a position showing, at a minimum, the name of each client having an interest in the security, the amount of interest of each client in the security, and the location of each security;

f. A copy of each client's quarterly account statements as generated and delivered by the qualified custodian. Additionally, if the investment adviser generates a statement that is delivered to the client, the investment adviser shall retain copies of those statements along with information indicating the dates on which the statements were provided to the client;

g. If applicable, a copy of the special examination report, financial statements, and letter verifying the completion of and describing the nature and extent of an examination by an independent certified public accountant and documentation describing the nature and extent of the examination and a record regarding any findings of any material discrepancies found during the examination; and

h. If applicable, evidence of the client's designation of an independent representative.

**50.42(3)** An investment adviser deemed to have custody of client securities or funds because the investment adviser advises a pooled investment vehicle shall, in addition to any other applicable record retention requirements, keep the following records:

a. True, accurate, and current account statements;

*b.* If utilizing the exception provided by paragraph 50.39(2) “*c*,” the date(s) of the audit, a copy of the audited financial statements, and evidence of the mailing of the audited financial statements to all limited partners, members, or other beneficial owners within 120 days of the end of the fiscal year;

*c.* If subject to paragraph 50.39(1) “*e*,” a copy of the written agreement with the independent party reviewing all fees and expenses and describing the responsibilities of the independent third party, and copies of all invoices and receipts showing approval by the independent third party for payment through the qualified custodian.

**50.42(4)** Each investment adviser subject to subrule 50.42(1) that renders investment supervisory or management services to any client shall, with respect to the portfolio being supervised or managed and to the extent that the information is reasonably available to or obtainable by the investment adviser, retain the following records:

*a.* For each client, detailed information regarding the securities purchased and sold including, but not limited to, the date of the purchase or sale, the total dollar amount of the purchase or sale, and the price at which the security was purchased or sold.

*b.* For each security in which any client has a current position, the name of each client and current amount or interest of the client.

**50.42(5)** Records required to be retained pursuant to rule 191—50.42(502) shall be kept as follows:

*a.* Except as provided in paragraphs 50.42(1) “*k*” and “*p*,” all records required to be made under subrules 50.42(1) to 50.42(3) and paragraph 50.42(4) “*a*” shall be maintained and preserved in a readily accessible location for a period of not less than five years from the end of the fiscal year during which the last entry was made on record, with no less than the first two years being kept in the principal office of the investment adviser.

*b.* Partnership articles and any amendments, articles of incorporation, charters, minute books, and stock certificate books of the investment adviser and of any predecessor shall be maintained in the principal office of the investment adviser and preserved until at least three years after termination of the enterprise.

*c.* Books and records required to be retained pursuant to paragraphs 50.42(1) “*k*” and 50.42(1) “*p*” shall be maintained and preserved in a readily accessible location for a period of not less than five years from the end of the fiscal year during which the investment adviser last published or otherwise disseminated, directly or indirectly, the notice, circular, advertisement, newspaper article, investment letter, bulletin, or other communication including by electronic media, with no less than the first two years being kept in the principal office of the investment adviser.

*d.* Books and records required to be retained pursuant to paragraphs 50.42(1) “*q*” to “*v*” shall be maintained and preserved in a readily accessible location for a period of not less than five years from the end of the fiscal year during which the last entry was made on such record, with no less than the first two years being kept in the principal office of the investment adviser, or the time period during which the investment adviser is registered or required to be registered in this state, whichever is less.

*e.* Notwithstanding other record preservation requirements of rule 191—50.42(502), an investment adviser that has rendered or renders investment advisory services shall maintain at all times the following records at the investment adviser’s business location from which the customer or client is being provided or has been provided investment advisory services during the applicable retention period:

(1) All records required to be preserved pursuant to paragraphs 50.42(1) “*c*,” “*g*” to “*j*,” “*n*,” “*o*,” and “*q*” to “*s*” and subrules 50.42(2) to 50.42(4); and

(2) All records required pursuant to paragraphs 50.42(1) “*k*” to “*p*” identifying the name of the investment adviser representative providing investment advice from that business location, or identifying the physical address, mailing address, electronic mailing address, or telephone number of the business location. The records will be maintained for the period described in paragraph 50.42(5) “*a*.”

**50.42(6)** An investment adviser subject to subrule 50.42(1) that ceases to conduct or discontinues business as an investment adviser shall arrange for and be responsible for the retention of the records required to be retained pursuant to this rule for the applicable retention period. The investment adviser shall notify the administrator in writing prior to ceasing to conduct or discontinuing business as an

investment adviser of the exact address where the books and records will be maintained during the retention period.

**50.42(7)** An investment adviser required to retain records pursuant to this rule may maintain the records in such manner that the identity of any client to whom the investment adviser renders investment supervisory services is indicated by numerical code, alphabetical code, or similar designation.

**50.42(8)** Record maintenance.

*a.* Pursuant to subrule 50.42(4), the records required to be maintained and preserved may be immediately produced or reproduced, and maintained and preserved for the required time, by an investment adviser in:

- (1) Paper or hard-copy form, as those records are kept in their original form; or
- (2) Micrographic media, including microfilm, microfiche, or any similar medium; or
- (3) Electronic storage media, including any digital storage medium or system, that meet the terms of this subrule.

*b. The investment adviser must:*

- (1) Arrange and index the records in a way that permits easy location, access, and retrieval of any particular record;
- (2) Provide promptly any of the following that the administrator may request:
  1. A legible, true, and complete copy of the record in the medium and format in which it is stored;
  2. A legible, true, and complete printout of the record; and
  3. Means to access, view, and print the records; and
- (3) Separately store, for the time required for preservation of the original record, a duplicate copy of the record in any medium allowed by this subrule.

*c.* In the case of records created or maintained in electronic storage media, the investment adviser must establish and maintain procedures:

- (1) To maintain and preserve the records, so as to reasonably safeguard them from loss, alteration, or destruction;
- (2) To limit access to the records to properly authorized personnel and the administrator; and
- (3) To reasonably ensure that any reproduction of a nonelectronic original record in electronic storage media is complete, true, and legible when retrieved.

**50.42(9)** Compliance with any substantially similar record-keeping requirements of Rules 17a-3 [17 CFR 240.17a-3] and 17a-4 [17 CFR 240.17a-4] of the Securities Exchange Act of 1934 shall be deemed to be in compliance with this rule.

**50.42(10)** Every investment adviser that is registered or required to be registered in this state and that has its principal place of business in a state other than this state shall be exempt from the requirements of this rule, provided the investment adviser is properly registered in that state and is in compliance with that state's record-keeping requirements.

**50.42(11)** For purposes of this rule:

*"Advisory representative"* means any partner, officer or director of the investment adviser; any employee who participates in any way in the determination of which recommendations shall be made; any employee who, in connection with the employee's duties, obtains any information concerning which securities are being recommended prior to the effective dissemination of the recommendations; and any of the following persons who obtain information concerning securities recommendations being made by the investment adviser prior to the effective dissemination of the recommendations:

1. Any person in a relationship of control with the investment adviser;
2. Any person affiliated with a controlling person; and
3. Any person affiliated with an affiliated person.

*"Control"* means the power to exercise a controlling influence over the management or policies of a company, unless that power results solely from an official position with the company. Any person who owns beneficially, either directly or through one or more controlled companies, more than 25 percent of the voting securities of a company shall be presumed to control the company.

An investment adviser shall not be deemed to be exercising a discretionary power as to the price at which or the time when a transaction is effected or is to be effected if, before the order is given by the

investment adviser, the client has directed or approved the purchase or sale of a definite amount of the particular security.

*“Investment adviser primarily engaged in a business or businesses other than advising investment advisory clients”* means an investment adviser that for each of the most recent three fiscal years or for the period of time since organization, whichever is less, derives on an unconsolidated basis more than 50 percent of total sales and revenues and income (or loss) before income taxes and extraordinary items from business activities other than advising investment advisory clients.

*“Investment supervisory services”* means continuous advice regarding investment of funds provided to each client on the basis of the individual needs of the client.

*“Solicitor”* means any person or entity that for compensation acts as an agent of an investment adviser in referring potential clients.

This rule is intended to implement Iowa Code section 502.411(3).  
[ARC 1076C, IAB 10/2/13, effective 11/6/13]

### **191—50.43(502) Financial reporting requirements for investment advisers.**

**50.43(1)** Every registered investment adviser that has custody of client funds or securities or requires payment of advisory fees six months or more in advance and in excess of \$500 per client shall file with the administrator an audited balance sheet as of the end of the investment adviser’s fiscal year. Each balance sheet filed pursuant to this rule must be:

- a. Examined in accordance with generally accepted auditing standards and prepared in conformity with generally accepted accounting principles;
- b. Audited by an independent certified public accountant; and
- c. Accompanied by an opinion of the accountant as to the report of financial position, and by a note stating the principles used to prepare the opinion, the basis of included securities, and any other explanations required for clarity.

**50.43(2)** Every registered investment adviser that has discretionary authority over, but not custody of, client funds or securities shall file with the administrator a balance sheet, which need not be audited, but which must be prepared in accordance with generally accepted accounting principles or such other basis of accounting acceptable to the administrator and represented by the investment adviser or the person who prepared the statement as true and accurate, as of the end of the investment adviser’s fiscal year.

**50.43(3)** The financial statements required by this rule shall be filed with the administrator within 90 days following the end of the investment adviser’s fiscal year.

**50.43(4)** Every investment adviser that has its principal place of business in a state other than this state shall file only such reports as required by the state in which the investment adviser maintains its principal place of business, provided the investment adviser is licensed in such state and is in compliance with such state’s financial reporting requirements.

This rule is intended to implement Iowa Code section 502.411(2).  
[ARC 1076C, IAB 10/2/13, effective 11/6/13]

### **191—50.44(502) Solely incidental services by certain professionals.**

#### **50.44(1) General approach.**

a. Certain professionals may rely on an exclusion from the definition of “investment adviser” contained in Iowa Code section 502.102(15) “b” for lawyers, accountants, engineers or teachers whose performance of investment advice is solely incidental to the practice of the person’s profession. Whether the exclusion from the definition of “investment adviser” is available to a lawyer, accountant, engineer or teacher providing investment advisory services within the meaning of Iowa Code section 502.102(15) “b” depends upon the relevant facts and circumstances.

b. In general, the administrator will determine whether the investment advisory services provided and the fees charged are solely incidental to the total services provided to the individual client by comparing whether the aggregate of such fees and services is solely incidental to the aggregate of services provided to all clients. In addition, the administrator will take other relevant factors into consideration in determining the applicability of the exclusion including, but not limited to, whether the

firm establishes a separate subsidiary, division, or other business entity to perform advisory services or maintains an investment adviser registration with the U.S. Securities and Exchange Commission under the Investment Advisers Act of 1940. In this context, the administrator would refer to U.S. Securities and Exchange Commission Release IA-1092 relating to the analogous exclusion in the Investment Advisers Act of 1940 which states that “. . . the exclusion . . . is not available . . . to a lawyer or accountant who holds himself out to the public as providing financial planning, pension consulting, or other financial advisory services. In such a case it would appear that the performance of investment advisory services by the person would not be solely incidental to his practice as a lawyer or accountant.”

**50.44(2) *General versus specific advice.*** A lawyer, accountant, engineer or teacher, whether or not holding oneself out to the public as providing financial planning or other financial advisory services, who does not render advice with respect to investing in specific securities, types of securities, or categories of securities need not register as an investment adviser. Registration is not required when the securities advice provided to clients in this state is limited to a general recommendation that the client should be more aggressive or more conservative in securities investments, a general recommendation as to the percentage of the client's assets that should be in securities, or a general recommendation that the client pursue an income-producing or growth-oriented investment strategy, provided the recommendation does not identify specific securities, types of securities, or categories of securities. For the purpose of this subrule, the phrase “types of securities” means classes of securities in which the issuer is not specifically identified, such as common stock, preferred stock, options, warrants, bonds, and mutual funds, and the phrase “categories of securities” means general areas of securities investments where neither the issuer nor the types of securities are identified such as cyclical securities, automotive industry securities, international securities, and NYSE securities. Asset allocation recommendations, however, generally do include advice on types of securities.

EXAMPLE: An accountant provides clients accounting and financial planning services. No advice with respect to specific securities, types of securities, or categories of securities is provided. The accountant need not register as an investment adviser.

**50.44(3) *Professional does not hold self out as a financial planner.*** When the securities advice is provided by a lawyer, accountant, engineer, or teacher who does not hold oneself out to the public as providing financial planning or other financial advisory services, the availability of the exclusion from the definition of “investment adviser” contained in Iowa Code section 502.102(15) “b” for securities advice rendered solely incidental to the profession will depend on those factors set forth in paragraph 50.44(1) “b.”

EXAMPLE A: An accountant who does not hold oneself out to the public as providing financial planning or other financial advisory services provides the client both accounting and financial planning services. The services involve advice with respect to specific securities, types of securities, or categories of securities. Whether the accountant is excluded from the definition of investment adviser depends on those factors set forth in paragraph 50.44(1) “b,” including a comparison of the extent of the securities advisory services provided to any client as contrasted with the accounting services provided to that client. The comparison is measured by the compensation paid for each service.

EXAMPLE B: An accountant provides a client financial planning services only. The financial planning services involve advice with respect to specific securities, types of securities, or categories of securities. The accountant is not excluded from the definition of investment adviser and therefore must register as an investment adviser.

**50.44(4) *Professional holds self out as a financial planner.***

*a.* If the investment advice provided by a lawyer, accountant, engineer, or teacher who holds oneself out to the public as providing financial planning or other financial advisory services is part of the financial plan being provided to a financial planning client, the professional cannot rely on the exclusion from the definition of “investment adviser” contained in Iowa Code section 502.102(15) “b” for investment advice rendered incidentally to the practice of the profession.

EXAMPLE: An accountant who holds oneself out to the public as providing financial planning or other financial advisory services provides the client both accounting and financial planning services. The financial planning services involve advice with respect to specific securities, types of securities,

or categories of securities. The accountant is not excluded from the definition of investment adviser no matter how insignificantly the securities advice compares to the other financial planning advice or accounting services rendered.

*b.* When a lawyer, accountant, engineer, or teacher holding oneself out to the public as providing financial planning or other financial advisory services does not provide advice on specific securities, types of securities, or categories of securities as part of financial planning services but provides such advice in connection with the practice of the profession, in most instances the exclusion from the definition of investment adviser would be unavailable because the professional is holding oneself out as a financial planner or financial adviser. If, however, securities advice is not part of financial planning services and is both limited and isolated, the exclusion may still be available.

EXAMPLE: An accountant who holds oneself out to the public as providing financial planning or other financial advisory services provides clients both accounting and financial planning services. No securities advice is rendered as part of the financial planning services. Clients, on a few occasions, request the accountant's advice on investing in certain limited partnerships. The fees charged to such a client for the advice total only a small percentage of the fees charged to that client for accounting services provided. The accountant is excluded from the definition of investment adviser. The example presented is intentionally narrow in order to illustrate that once the accountant holds oneself out as a financial planner or financial adviser, even if the only securities advice provided for compensation is not part of the financial planning or advisory activities, only limited and isolated securities advice may be provided without registration as an investment adviser.

This rule is intended to implement Iowa Code section 502.102(15)“*b.*”

#### **191—50.45(502) Registration exemption for investment advisers to private funds.**

**50.45(1) Definitions.** For purposes of this rule, the following definitions shall apply:

“*3(c)(1) fund*” means a qualifying private fund that is eligible for the exclusion from the definition of an investment company under Section 3(c)(1) of the Investment Company Act of 1940, 15 U.S.C. 80a-3(c)(1).

“*Private fund adviser*” means an investment adviser who provides advice solely to one or more qualifying private funds.

“*Qualifying private fund*” means a private fund that meets the definition of a qualifying private fund in SEC Rule 203(m)-1, 17 CFR § 275.203(m)-1.

“*Value of primary residence*” means the fair market value of a person's primary residence, less the amount of debt secured by the property up to its fair market value.

“*Venture capital fund*” means a private fund that meets the definition of a venture capital fund in SEC Rule 203(l)-1, 17 CFR § 275.203(l)-1.

**50.45(2) Exemption for private fund advisers.** Subject to the additional requirements of subrule 50.45(3), a private fund adviser shall be exempt from the registration requirements of Iowa Code section 502.403 if the private fund adviser satisfies each of the following conditions:

*a.* Neither the private fund adviser nor any of its advisory affiliates are subject to a disqualification as described in Rule 262 of SEC Regulation A, 17 CFR § 230.262;

*b.* The private fund adviser files with the state each report and amendment thereto that an exempt reporting adviser is required to file with the SEC pursuant to SEC Rule 204-4, 17 CFR § 275.204-4;

*c.* The private fund adviser pays any applicable fees.

**50.45(3) Additional requirements for private fund advisers to certain 3(c)(1) funds.** In order to qualify for the exemption described in subrule 50.45(2), a private fund adviser who advises at least one 3(c)(1) fund that is not a venture capital fund shall, in addition to satisfying each of the conditions specified in paragraph 50.45(3)“*b.*” comply with the following requirements:

*a.* The private fund adviser shall advise only those 3(c)(1) funds (other than venture capital funds) whose outstanding securities (other than short-term paper) are beneficially owned entirely by persons who, after deducting the value of the primary residence from the person's net worth, would each meet the definition of a qualified client in SEC Rule 205-3, 17 CFR § 275.205-3, at the time the securities are purchased from the issuer.

*b.* At the time of purchase, the private fund adviser shall disclose the following in writing to each beneficial owner of a 3(c)(1) fund that is not a venture capital fund:

- (1) All services, if any, to be provided to individual beneficial owners;
- (2) All duties, if any, the private fund adviser owes to the beneficial owners; and
- (3) Any other material information affecting the rights or responsibilities of the beneficial owners.

*c.* The private fund adviser shall obtain on an annual basis audited financial statements of each 3(c)(1) fund that is not a venture capital fund and shall deliver a copy of such audited financial statements to each beneficial owner of the fund.

**50.45(4) *Federal covered investment advisers.*** If a private fund adviser is registered with the SEC, the adviser shall not be eligible for this exemption and shall comply with the state notice filing requirements applicable to federal covered investment advisers.

**50.45(5) *Investment adviser representatives.*** A person is exempt from the registration requirements if the person is employed by or associated with an investment adviser that is exempt from registration in this state pursuant to rule 191—50.45(502) and does not otherwise act as an investment adviser representative.

**50.45(6) *Electronic filing.*** The report filings described in paragraph 50.45(2)“*b*” shall be made electronically through the IARD. A report shall be deemed filed when the report and the fee required are filed and accepted by the IARD on the state’s behalf.

**50.45(7) *Transition.*** An investment adviser that becomes ineligible for the exemption provided by rule 191—50.45(502) must comply with all applicable laws and rules requiring registration or notice filing within 90 days from the date the investment adviser’s eligibility for this exemption ceases.

**50.45(8) *Grandfathering for investment advisers to 3(c)(1) funds with nonqualified clients.*** An investment adviser to a 3(c)(1) fund (other than a venture capital fund) that has one or more beneficial owners who are not qualified clients as described in paragraph 50.45(3)“*a*” is eligible for the exemption contained in subrule 50.45(2) if the following conditions are satisfied:

- a.* The subject fund existed prior to November 6, 2013;
- b.* As of November 6, 2013, the subject fund ceases to accept beneficial owners who are not qualified clients, as described in paragraph 50.45(3)“*a*”;
- c.* The investment adviser discloses in writing the information described in paragraph 50.45(3)“*b*” to all beneficial owners of the fund; and
- d.* As of November 6, 2013, the investment adviser delivers audited financial statements as required by paragraph 50.43(3)“*c*.”

This rule is intended to implement Iowa Code section 502.403.  
[ARC 1076C, IAB 10/2/13, effective 11/6/13]

**191—50.46(502) Contents of investment advisory contract.** The provisions of this rule shall apply to federal covered investment advisers to the extent that the conduct alleged is fraudulent, deceptive, or as otherwise permitted by the National Securities Markets Improvement Act of 1996.

**50.46(1)** It is unlawful for any investment adviser, investment adviser representative, or federal covered investment adviser to enter into, extend, or renew any investment advisory contract unless it provides in writing:

*a.* The services to be provided, the term of the contract, the investment advisory fee, the formula for computing the fee, the amount of prepaid fee to be returned in the event of termination or nonperformance of the contract, and any grant of discretionary power to the investment adviser, investment adviser representative, or federal covered investment adviser;

*b.* That no direct or indirect assignment or transfer of the contract may be made by the investment adviser, investment adviser representative, or federal covered investment adviser without the consent of the client or other party to the contract;

*c.* That the investment adviser, investment adviser representative, or federal covered investment adviser shall not be compensated on the basis of a share of capital gains upon or capital appreciation of the funds or any portion of the funds of the client;

*d.* That the investment adviser, investment adviser representative, or federal covered investment adviser, if a partnership, shall notify the client or other party to the investment contract of any change in the membership of the partnership within a reasonable time after the change.

**50.46(2)** It is unlawful for any investment adviser, investment adviser representative, or federal covered investment adviser to:

*a.* Include in an advisory contract any condition, stipulation, or provisions binding any person to waive compliance with any provision of this Act or of the Investment Advisers Act of 1940, or any other practice contrary to the provisions of Section 215 of the Investment Advisers Act of 1940; or

*b.* Enter into, extend or renew any advisory contract contrary to the provisions of Section 205 of the Investment Advisers Act of 1940. This provision shall apply to all advisers and investment adviser representatives registered or required to be registered under this Act, notwithstanding whether such adviser or representative would be exempt from federal registration pursuant to Section 203(b) of the Investment Advisers Act of 1940.

**50.46(3)** Notwithstanding paragraph 50.46(1) “*c.*,” an investment adviser may enter into, extend or renew an investment advisory contract which provides for compensation to the investment adviser on the basis of a share of capital gains upon or capital appreciation of the funds, or any portion of the funds, of the client if the conditions in paragraphs 50.46(3) “*a.*” to “*d.*” are met.

*a.* The client entering into the contract must be:

(1) A natural person or a company that, immediately after entering into the contract, has at least \$750,000 under the management of the investment adviser; or

(2) A person that the investment adviser and its investment adviser representatives reasonably believe, immediately before entering into the contract, is a natural person or a company whose net worth, at the time the contract is entered into, exceeds \$1,500,000. The net worth of a natural person may include assets held jointly with that person’s spouse.

*b.* The compensation paid to the investment adviser with respect to the performance of any securities over a given period must be based on a formula with the following characteristics:

(1) In the case of securities for which market quotations are readily available within the meaning of Rule 2a-4(a)(1) under the Investment Company Act of 1940 (definition of “current net asset value” for use in computing periodically the current price of redeemable security), the formula must include the realized capital losses and unrealized capital depreciation of the securities over the period;

(2) In the case of securities for which market quotations are not readily available within the meaning of Rule 2a-4(a)(1) under the Investment Company Act of 1940, the formula must include:

1. The realized capital losses of securities over the period; and

2. If the unrealized capital appreciation of the securities over the period is included, the unrealized capital depreciation of the securities over the period; and

(3) The formula must provide that any compensation paid to the investment adviser under paragraph 50.46(3) “*b.*” is based on the gains less the losses (computed in accordance with subparagraphs 50.46(3) “*b.*”(1) and (2)) in the client’s account for a period of not less than one year.

*c.* Before entering into the advisory contract and in addition to the requirements of Form ADV, the investment adviser must disclose in writing to the client or the client’s independent agent all material information concerning the proposed advisory arrangement, including the following:

(1) That the fee arrangement may create an incentive for the investment adviser to make investments that are riskier or more speculative than would be the case in the absence of a performance fee;

(2) Where relevant, that the investment adviser may receive increased compensation with regard to unrealized appreciation as well as realized gains in the client’s account;

(3) The periods which will be used to measure investment performance throughout the contract and their significance in the computation of the fee;

(4) The nature of any index which will be used as a comparative measure of investment performance, the significance of the index, and the reason the investment adviser believes that the index is appropriate; and

(5) When the investment adviser's compensation is based in part on the unrealized appreciation of securities for which market quotations are not readily available within the meaning of Rule 2a-4(a)(1) under the Investment Company Act of 1940, how the securities will be valued and the extent to which the valuation will be independently determined.

*d.* The investment adviser (and any investment adviser representative) that enters into the contract must reasonably believe, immediately before entering into the contract, that the contract represents an arm's length arrangement between the parties and that the client (or in the case of a client which is a company as defined in paragraph 50.46(6) "d," the person representing the company), alone or together with the client's independent agent, understands the proposed method of compensation and its risks. The representative of a company may be a partner, director, officer or an employee of the company or of the trustee, where the company is a trust, or any other person designated by the company or trustee, but must satisfy the definition of client's independent agent set forth in paragraph 50.46(6) "c."

**50.46(4)** Any person entering into or performing an investment advisory contract under rule 191—50.46(502) is not relieved of any obligations under rule 191—50.38(502) or any other applicable provision of the Act or any rule or order thereunder.

**50.46(5)** Nothing in rule 191—50.46(502) shall relieve a client's independent agent from any obligation to the client under applicable law.

**50.46(6)** The following definitions apply for purposes of rule 191—50.46(502):

*a.* "Affiliate" shall have the same definition as in Section 2(a)(3) of the Investment Company Act of 1940.

*b.* "Assignment," as used in paragraph 50.46(1) "b," includes, but is not limited to, any transaction or event that results in any change to the individuals or entities with the power, directly or indirectly, to direct the management or policies of, or to vote more than 50 percent of any class of voting securities of, the investment adviser or federal covered investment adviser as compared to the individuals or entities that had such power as of the date when the contract was first entered into, extended or renewed.

*c.* "Client's independent agent" means any person who agrees to act as an investment advisory client's agent in connection with the contract. "Client's independent agent" does not include:

- (1) The investment adviser relying on rule 191—50.46(502);
- (2) An affiliated person of the investment adviser or an affiliated person of an affiliated person of the investment adviser including an investment adviser representative;
- (3) An interested person of the investment adviser;
- (4) A person who receives, directly or indirectly, any compensation in connection with the contract from the investment adviser, an affiliated person of the investment adviser, an affiliated person of an affiliated person of the investment adviser or an interested person of the investment adviser; or
- (5) A person with any material relationship between the person (or an affiliated person of that person) and the investment adviser (or an affiliated person of the investment adviser) that exists, or has existed at any time during the past two years.

*d.* "Company" means a corporation, partnership, association, joint stock company, trust, or any organized group of persons, whether incorporated or not; or any receiver, trustee in a case under Title 11 of the United States Code, or similar official or any liquidating agent for any of the foregoing, in the liquidating agent's capacity as such. "Company" shall not include:

- (1) A company required to be registered under the Investment Company Act of 1940 but which is not so registered;
- (2) A private investment company is an entity which would be defined as an investment company under Section 3(a) of the Investment Company Act of 1940 but for the exception from that definition provided by Section 3(c)(1) of that Act;
- (3) An investment company registered under the Investment Company Act of 1940; or
- (4) A business development company as defined in Section 202(a)(22) of the Investment Advisers Act of 1940, unless each of the equity owners of any such company, other than the investment adviser entering into the contract, is a natural person or a company within the meaning of "company."

*e.* "Interested person" means:

(1) Any member of the immediate family of any natural person who is an affiliated person of the investment adviser;

(2) Any person who knowingly has any direct or indirect beneficial interest in, or who is designated as trustee, executor, or guardian of any legal interest in, any security issued by the investment adviser or by a controlling person of the investment adviser if that beneficial or legal interest exceeds:

1. One-tenth of one percent of any class of outstanding securities of the investment adviser or a controlling person of the investment adviser; or

2. Five percent of the total assets of the person seeking to act as the client's independent agent; or

(3) Any person or partner or employee of any person who has acted as legal counsel for the investment adviser within the past two years.

[ARC 1076C, IAB 10/2/13, effective 11/6/13]

**191—50.47 to 50.49** Reserved.

DIVISION IV  
RULES COVERING ALL REGISTERED PERSONS

**191—50.50(502) Internet advertising by broker-dealers, investment advisers, broker-dealer agents, investment adviser representatives, and federal covered investment advisers.**

**50.50(1)** Broker-dealers, investment advisers, broker-dealer agents, investment adviser representatives, and federal covered investment advisers who use the Internet, the World Wide Web, or similar proprietary or common carrier electronic systems (collectively described as the "Internet") to disseminate information regarding products and services through communications directed generally to anyone having access to the Internet and transmitted through posting on bulletin boards, displays on home pages or similar methods (hereinafter "Internet communications") will not be considered to be transacting business in Iowa pursuant to Iowa Code section 502.401, 502.402, 502.403, 502.404, or 502.405 based solely on that communication, if:

*a.* The Internet communication contains a legend clearly stating that:

(1) The broker-dealer, investment adviser, broker-dealer agent, investment adviser representative, or federal covered investment adviser may only transact business in a state if first registered pursuant to or excluded or exempt from the state broker-dealer, investment adviser, broker-dealer agent, or investment adviser representative registration requirements, or federal covered investment adviser notice requirement; and

(2) The broker-dealer, investment adviser, broker-dealer agent, investment adviser representative, or federal covered investment adviser will not effect or attempt to effect transactions in securities or render personalized investment advice for compensation absent compliance with applicable state broker-dealer, investment adviser, broker-dealer agent, or investment adviser representative registration requirements, or federal covered investment adviser notice requirement or applicable exemption or exclusion;

*b.* The Internet communication contains a mechanism, including but not limited to technical firewalls or other policies and procedures, to ensure that, prior to effecting or attempting to effect transactions with customers in Iowa or prior to direct communication with prospective customers or clients in Iowa, the broker-dealer, investment adviser, broker-dealer agent, or investment adviser representative is first registered in Iowa or, in the case of a federal covered investment adviser, has made a notice filing, or qualifies for an exemption or exclusion from registration requirements;

*c.* The Internet communication is limited to general information regarding products and services, and the broker-dealer, investment adviser, broker-dealer agent, investment adviser representative, or federal covered investment adviser does not effect or attempt to effect transactions in securities in Iowa or provide personalized investment advice for compensation; and

*d.* In the case of a broker-dealer agent or investment adviser representative:

(1) The agent's broker-dealer, investment adviser, or federal covered investment adviser affiliation is prominently disclosed within the Internet communication;

(2) The broker-dealer, investment adviser, or federal covered investment adviser with whom the agent or representative is affiliated reviews and approves the content of any Internet communication by the broker-dealer agent or investment adviser representative;

(3) The broker-dealer, investment adviser, or federal covered investment adviser with whom the agent or representative is associated first authorizes the dissemination of information on the particular products and services through the Internet communication; and

(4) The broker-dealer agent or investment adviser representative acts within the scope of the authority granted by the broker-dealer, investment adviser, or federal covered investment adviser in the dissemination of information through the Internet communication.

**50.50(2)** Nothing in this rule shall excuse broker-dealer, investment adviser, broker-dealer agent, investment adviser representative, and federal covered investment adviser compliance with applicable securities registration, notice filing, antifraud or related provisions.

**50.50(3)** Nothing in this rule shall be construed to affect the activities of any broker-dealer, investment adviser, broker-dealer agent, investment adviser representative, or federal covered investment adviser engaged in business in Iowa that is not subject to the jurisdiction of the administrator as a result of NSMIA.

This rule is intended to implement Iowa Code sections 502.401 to 502.405.

**191—50.51(502) Consent to service.**

**50.51(1)** Every consent appointing the administrator or successor to be an attorney to receive service of any lawful process as required by Iowa Code section 502.611 shall be properly notarized and shall contain, at a minimum, the following information:

- a. Name of the applicant;
- b. Address of the applicant;
- c. A statement that the consent is irrevocable;
- d. A statement that the consent is valid as to any noncriminal suit, action or proceeding against the applicant or the successor, executor or administrator of the applicant which arises out of the Act; and
- e. A statement that the applicant stipulates and agrees that service upon the administrator shall have the same validity as if served personally upon the applicant.

**50.51(2)** A form of consent to service of process provided by the administrator, a Form U-2, or a consent to service of process contained in any other form authorized or required to be filed by these rules shall satisfy subrule 50.51(1).

**50.51(3)** A broker-dealer, investment adviser, agent, investment adviser representative, federal covered investment adviser, or issuer may incorporate by reference any consent to service of process required to be filed pursuant to Iowa Code sections 502.302(1)“a,” 502.302(3), 502.303(2), 502.304(2), 502.406(1) and 502.611, or the administrative rules implementing these sections.

This rule is intended to implement Iowa Code section 502.611.

**191—50.52(252J) Denial, suspension or revocation of agent or investment adviser representative registration for failure to pay child support.**

**50.52(1)** Upon receipt of a certificate of noncompliance from the CSRU for default on debts owed to or collected by the CSRU, the administrator shall issue a notice to a securities agent or investment adviser representative applicant or registrant that any pending application for registration will be denied or any current registration will be suspended or revoked 30 days after the date of the notice. The notice shall be served by restricted certified mail, return receipt requested, or by personal service as provided by the Iowa Rules of Civil Procedure, unless the applicant or registrant accepts service personally or through authorized counsel.

**50.52(2)** The administrator shall provide the applicant or registrant with a copy of the certificate of noncompliance and shall provide a notice advising the applicant that:

- a. The administrator intends to deny an application or to suspend or revoke a registration due to receipt of a certificate of noncompliance from the CSRU;

*b.* The applicant or registrant must contact the CSRU to schedule a conference or to otherwise obtain a withdrawal of a certificate of noncompliance;

*c.* Unless the CSRU furnishes a withdrawal of a certificate of noncompliance to the administrator within 30 days of issuance of the notice, the application shall be denied or the registration shall be suspended or revoked;

*d.* The applicant or registrant does not have a right to a hearing before the administrator, but may, pursuant to Iowa Code section 252J.9, request a court hearing within 30 days of provision of notice by the administrator; and

*e.* The filing of an application for hearing with the district court will stay the proceedings of the division.

**50.52(3)** The filing of an application for hearing with the district court under Iowa Code section 252J.9 automatically stays action of the administrator until the administrator is notified of the resolution of the application.

**50.52(4)** If the administrator does not receive a withdrawal of the certificate of noncompliance from the CSRU or a notice that an application for district court hearing has been filed, the administrator shall deny, suspend or revoke the application or registration 30 days after the notice prescribed in subrule 50.52(2) is issued.

**50.52(5)** Upon receiving a withdrawal of the certificate of noncompliance from the CSRU, the administrator shall immediately halt action to deny an application or suspend or revoke a registration. The applicant or registrant shall be notified that action has been halted. If the application has already been denied or if a registration has already been suspended or revoked, the applicant or former registrant shall reapply for registration. The application shall be granted if the individual is otherwise in compliance with applicable laws, rules, regulations and orders.

**50.52(6)** All application fees must be paid by the applicant before a registration will be issued after the administrator has denied, suspended, or revoked a registration pursuant to Iowa Code chapter 252J.

**50.52(7)** Notwithstanding any statutory confidentiality provision, the administrator may share information with the CSRU for the sole purpose of identifying applicants or registrants subject to enforcement pursuant to Iowa Code chapter 252J.

This rule is intended to implement Iowa Code chapter 252J.

**191—50.53(261) Denial, suspension or revocation of agent or investment adviser representative registration for failure to pay debts owed to or collected by the college student aid commission.**

**50.53(1)** Upon receipt of a certificate of noncompliance from the college student aid commission for defaults on debts owed to or collected by the commission, the administrator shall issue a notice to a securities agent or investment adviser representative applicant or registrant that any pending application for registration or any current registration will be denied, suspended or revoked 30 days after the date of the notice. The notice shall be served by restricted certified mail, return receipt requested, or by personal service as provided by the Iowa Rules of Civil Procedure, unless the applicant or registrant accepts service personally or through authorized counsel.

**50.53(2)** The administrator shall provide the applicant or registrant with a copy of the certificate of noncompliance and shall provide a notice advising the applicant or registrant that:

*a.* The administrator intends to deny an application or suspend or revoke a registration due to receipt of a certificate of noncompliance from the college student aid commission;

*b.* The applicant or registrant must contact the college student aid commission to schedule a conference or to otherwise obtain a withdrawal of a certificate of noncompliance;

*c.* Unless the college student aid commission furnishes a withdrawal of a certificate of noncompliance to the administrator within 30 days of issuance of the notice, the application shall be denied or the registration shall be suspended or revoked;

*d.* The applicant or registrant does not have a right to a hearing before the administrator but may, pursuant to Iowa Code section 261.126, request a district court hearing within 30 days of provision of notice by the administrator; and

*e.* The filing of an application for hearing with the district court will stay the proceedings of the division.

**50.53(3)** The filing of an application for hearing with the district court under Iowa Code section 261.127 automatically stays action of the administrator until the administrator is notified of the resolution of the application.

**50.53(4)** If the administrator does not receive a withdrawal of the certificate of noncompliance from the college student aid commission or a notice that an application for district court hearing has been filed, the administrator shall deny the application or suspend or revoke the registration 30 days after the notice prescribed in subrule 50.53(2) is issued.

**50.53(5)** If the administrator receives a withdrawal of the certificate of noncompliance from the college student aid commission, the administrator shall immediately halt action to deny, suspend or revoke an application or registration. The applicant or registrant shall be notified that action has been halted. If the application or registration has already been denied, suspended or revoked, the applicant or former registrant shall reapply for registration. The application shall be granted if the individual is otherwise in compliance with applicable laws, rules, regulations and orders.

**50.53(6)** All application fees must be paid by the applicant before a registration will be issued after the administrator has denied, suspended, or revoked a registration pursuant to Iowa Code section 261.126.

**50.53(7)** Notwithstanding any statutory confidentiality provision, the administrator may share information with the college student aid commission for the sole purpose of identifying applicants or registrants subject to enforcement pursuant to Iowa Code section 261.126.

This rule is intended to implement Iowa Code section 261.126.  
[ARC 1076C, IAB 10/2/13, effective 11/6/13]

**191—50.54(272D) Denial, suspension or revocation of agent or investment adviser representative registration for failure to pay state debt.**

**50.54(1)** Upon receipt of a certificate of noncompliance from the centralized collection unit of the department of revenue (CCU), the administrator shall issue a notice to a securities agent or investment adviser representative applicant or registrant that any pending application for registration will be denied or any current registration will be suspended or revoked 60 days after the date of the notice. The notice shall be served by restricted certified mail, return receipt requested, or by personal service as provided by the Iowa Rules of Civil Procedure, unless the applicant or registrant accepts service personally or through authorized counsel.

**50.54(2)** The administrator shall provide the applicant or registrant with a copy of the certificate of noncompliance and shall provide a notice advising the applicant that:

*a.* The administrator intends to deny an application or to suspend or revoke a registration due to receipt of a certificate of noncompliance from the CCU;

*b.* The applicant or registrant must contact the CCU to schedule a conference or to otherwise obtain a withdrawal of a certificate of noncompliance;

*c.* Unless the CCU furnishes a withdrawal of a certificate of noncompliance to the administrator within 60 days of issuance of the notice, the application shall be denied or the registration shall be suspended or revoked;

*d.* The applicant or registrant does not have a right to a hearing before the administrator, but may file an application for hearing in district court pursuant to Iowa Code section 272D.9; and

*e.* The filing of an application for hearing with the district court will stay the proceedings of the division.

**50.54(3)** The filing of an application for hearing with the district court under Iowa Code section 272D.9 automatically stays action of the administrator until the administrator is notified of the resolution of the application.

**50.54(4)** If the administrator does not receive a withdrawal of the certificate of noncompliance from the CCU or a notice that an application for district court hearing has been filed, the administrator shall

deny, suspend or revoke the application or registration 60 days after the notice prescribed in subrule 50.54(2) is issued.

**50.54(5)** Upon receiving a withdrawal of the certificate of noncompliance from the CCU, the administrator shall immediately halt action to deny an application or suspend or revoke a registration. The applicant or registrant shall be notified that action has been halted. If the application has already been denied or if a registration has already been suspended or revoked, the applicant or former registrant shall reapply for registration. The application shall be granted if the individual is otherwise in compliance with applicable laws, rules, regulations and orders.

**50.54(6)** All application fees must be paid by the applicant before a registration will be issued after the administrator has denied, suspended, or revoked a registration pursuant to Iowa Code chapter 272D.

**50.54(7)** Notwithstanding any statutory confidentiality provision, the administrator may share information with the CCU for the sole purpose of identifying applicants or registrants subject to enforcement pursuant to Iowa Code chapter 272D.

This rule is intended to implement Iowa Code chapter 272D.

[ARC 1076C, IAB 10/2/13, effective 11/6/13]

**191—50.55(502) Use of senior-specific certifications and professional designations.**

**50.55(1)** The use of a senior-specific certification or designation by any person in connection with the offer, sale, or purchase of securities or the provision of advice as to the value of or the advisability of investing in, purchasing, or selling securities, either directly or indirectly or through publications or writings, or by issuing or promulgating analyses or reports relating to securities, that indicate or imply that the user has special certification or training in advising or servicing senior citizens or retirees in such a way as to mislead any person shall be a dishonest and unethical practice in the securities, commodities, investment, franchise, banking, finance, or insurance business within the meaning of Iowa Code section 502.412(4) “m.” The prohibited use of such certifications or professional designation includes, but is not limited to, the following:

- a. Use of a certification or professional designation by a person who has not actually earned or is otherwise ineligible to use such certification or designation;
- b. Use of a nonexistent or self-conferred certification or professional designation;
- c. Use of a certification or professional designation that indicates or implies a level of occupational qualifications obtained through education, training, or experience that the person using the certification or professional designation does not have; and
- d. Use of a certification or professional designation that was obtained from a designating or certifying organization that:
  - (1) Is primarily engaged in the business of instruction in sales or marketing;
  - (2) Does not have reasonable standards or procedures for ensuring the competency of its designees or certificants;
  - (3) Does not have reasonable standards or procedures for monitoring and disciplining its designees or certificants for improper or unethical conduct; or
  - (4) Does not have reasonable continuing education requirements for its designees or certificants in order to maintain the designation or certificate.

**50.55(2)** There is a rebuttable presumption that a designating or certifying organization is not disqualified solely for purposes of 50.55(1) “d” when the organization has been accredited by:

- a. The American National Standards Institute;
- b. The National Commission for Certifying Agencies; or
- c. An organization that is on the United States Department of Education’s list entitled “Accrediting Agencies Recognized for Title IV Purposes” and the designation or credential issued therefrom does not primarily apply to sales or marketing.

**50.55(3)** In determining whether a combination of words or an acronym standing for a combination of words constitutes a certification or professional designation indicating or implying that a person has special certification or training in advising or servicing senior citizens or retirees, the administrator shall consider the following factors:

*a.* Use of one or more words such as “senior,” “retirement,” “elder,” or similar words combined with one or more words such as “certified,” “registered,” “chartered,” “adviser,” “specialist,” “consultant,” “planner,” or similar words in the name of the certification or professional designation; and

*b.* The manner in which those words are combined.

**50.55(4)** For purposes of this rule, a certification or professional designation does not include a job title within an organization that is licensed or registered by a state or federal financial services regulatory agency, when that job title:

*a.* Indicates seniority or standing within the organization; or

*b.* Specifies an individual’s area of specialization within the organization.

For purposes of this subrule, financial services regulatory agency includes, but is not limited to, an agency that regulates broker-dealers, investment advisers, or investment companies as defined under the Investment Company Act of 1940.

**50.55(5)** Nothing in this rule shall limit the administrator’s authority to enforce existing provisions of law.

This rule is intended to implement Iowa Code section 502.605(1).

[ARC 1076C, IAB 10/2/13, effective 11/6/13]

**191—50.56 to 50.59** Reserved.

DIVISION V  
REGISTRATION OF SECURITIES

**191—50.60(502) Notice filings for investment company securities offerings.**

**50.60(1)** Except as provided in subrule 50.60(5), no investment company that is registered under the Investment Company Act of 1940 or that has a currently filed registration statement under the Securities Act of 1933 is required to file with the administrator, either prior to the initial offer or after the initial offer in Iowa of a security which is a covered security under Section 18(b)(2) of the Securities Act of 1933, a copy of any document which is part of a federal registration statement filed with the SEC or is part of an amendment to such federal registration statement.

**50.60(2)** Prior to the initial offer of a federal covered security in Iowa, an investment company that is registered under the Investment Company Act of 1940 or that has filed a registration statement under the Securities Act of 1933 shall file with the administrator:

*a.* A notice of filing on Form NF;

*b.* A filing fee; and

*c.* A consent to service of process.

**50.60(3)** A notice of filing may be renewed prior to expiration by filing the following with the administrator:

*a.* A notice of filing on Form NF; and

*b.* Payment of the applicable fee under Iowa Code section 502.302(1) “a.”

**50.60(4)** Amendments to notice filings are made on Form NF and are effective upon receipt by the administrator. Withdrawal or termination of a notice filing is made by filing Form NF or providing the administrator with notice of the withdrawal or termination in a similar format. An amendment, withdrawal, or termination is effective upon receipt by the administrator of the required notice and all fees required by Iowa Code section 502.302(1) “a.”

**50.60(5)** An investment company that is registered under the Investment Company Act of 1940 or that has filed a registration statement under the Securities Act of 1933 shall file, upon written request of the administrator and within the time period set forth in the request, a copy of any document identified in the request that is part of the federal registration statement filed with the SEC or part of an amendment to such federal registration statement.

**50.60(6)** An investment company that makes a notice filing under subrule 50.60(2) and that pays an initial \$250 filing fee under Iowa Code section 502.302(1) “a” shall pay an additional \$1,250 filing fee within 90 days after the notice filing’s annual renewal date, or shall file on Form NF an annual or periodic

report of the value of the federal covered securities offered or sold in Iowa, together with a filing fee of one-tenth of 1 percent of the amount of securities sold in excess of \$250,000.

This rule is intended to implement Iowa Code section 502.302(1).

**191—50.61(502) Registration of small corporate offerings.**

**50.61(1)** Form U-7 may be obtained by contacting the Iowa Securities and Regulated Industries Bureau, 340 East Maple Street, Des Moines, Iowa 50319-0066; via E-mail at [iowa.sec.@iid.state.ia.us](mailto:iowa.sec.@iid.state.ia.us); or from the division Web site at <http://www.iid.state.ia.us/division/securities>. Form U-7 has been developed under the Small Business Investment Incentive Act of 1980 which prescribes state and federal cooperation in furthering the policies of the Act: diminishing the burden of raising investment capital and minimizing interference with the business of capital formation.

**50.61(2)** To be eligible to use Form U-7, the issuer shall comply with each of the following requirements:

*a.* The issuer shall:

(1) Be a corporation or limited liability company organized under the laws of the United States or Canada, or any state, province, or territory or possession thereof, or the District of Columbia and have its principal place of business in one of the foregoing;

(2) Not be subject to the reporting requirements of Section 13 or 15(d) of the Securities Exchange Act of 1934;

(3) Not be an investment company registered or required to be registered under the Investment Company Act of 1940;

(4) Not be engaged in or propose to be engaged in petroleum exploration and production, mining, or other extractive industries;

(5) Not be a development stage company that either has no specific business plan or purpose or has indicated that its business plan is to engage in a merger or acquisition with an unidentified company or companies or other entity or person; and

(6) Not be disqualified under subrule 50.61(3).

*b.* The offering price for common stock or common ownership interests (hereinafter, collectively referred to as “common stock”), the exercise price for options, warrants, or rights to common stock, or the conversion price for securities convertible into common stock must be greater than or equal to U.S. \$1 per share or unit of interest. The issuer must agree with the administrator that the issuer will not split its common stock, or declare a stock dividend for two years after the effective date of the registration if such action has the effect of lowering the price below U.S. \$1.

*c.* Commissions, fees or other remuneration for soliciting any prospective purchaser in connection with the offering in the state are only paid to persons who, if required to be registered or licensed, the issuer believes, and has reason to believe, are appropriately registered or licensed in the state.

*d.* Financial statements shall be prepared in accordance with either U.S. or Canadian generally accepted accounting principles. If appropriate, a reconciliation note should be provided. If the company has not conducted significant operations, statements of receipts and disbursements shall be included in lieu of statements of income. Interim financial statements may be unaudited. All other financial statements shall be audited by independent certified public accountants, provided, however, that if each of the following four conditions are met, such financial statements in lieu of being audited may be reviewed by independent certified public accountants in accordance with the Accounting and Review Service Standards promulgated by the American Institute of Certified Public Accountants or the Canadian equivalent:

(1) The company shall not have previously sold securities through an offering involving the general solicitation of prospective investors by means of advertising, mass mailings, public meetings, “cold call” telephone solicitation, or any other method directed toward the public;

(2) The company has not been previously required under federal, state, provincial or territorial securities laws to provide audited financial statements in connection with any sale of its securities;

(3) The aggregate amount of all previous sales of securities by the company (exclusive of debt financing with banks and similar commercial lenders) shall not exceed U.S. \$1 million; and

(4) If the offering is a Rule 504 offering, the amount of the present offering does not exceed U.S. \$1 million.

*e.* The offering shall be made in compliance with Rule 504 of Regulation D, Regulation A, or Section 3(a)(11) of the Securities Act of 1933.

*f.* The issuer shall comply with the General Instructions to SCOR in Part I of the NASAA SCOR Issuer's Manual.

**50.61(3) Disqualifications.**

*a.* Unless the administrator determines that it is not necessary under the circumstances that the disqualification under this subrule be applied, application for registration referred to in subrule 50.61(2) shall be denied if the issuer, any of its officers, directors, stockholders who own 10 percent or greater of the issuer, promoters, or selling agents, or any officer, director or partner of any selling agent:

(1) Has filed a registration statement which is subject to a currently effective stop order entered pursuant to any state or provincial securities laws within five years prior to the filing of the registration statement;

(2) Has been convicted, within five years prior to the filing of the registration statement, of any felony or misdemeanor in connection with the offer, purchase, or sale of securities, or of any felony involving fraud or deceit including, but not limited to, forgery, embezzlement, obtaining money under false pretenses, larceny, or conspiracy to defraud;

(3) Is currently subject to any state or provincial administrative enforcement order or judgment entered by that state's or province's securities administrator within five years prior to the filing of the registration statement;

(4) Is subject to any state or provincial administrative enforcement order or judgment in which fraud or deceit including, but not limited to, making untrue statements of material facts and omitting to state material facts, was found, and the order or judgment was entered within five years prior to the filing of the current application for registration;

(5) Is subject to any state or provincial administrative enforcement order or judgment which prohibits, denies, or revokes the use of any exemption from registration in connection with the offer, purchase or sale of securities;

(6) Is currently subject to any order, judgment, or decree of any court of competent jurisdiction that temporarily, preliminarily, or permanently restrains or enjoins such party from engaging in or continuing any conduct or practice in connection with the purchase or sale of any security, or involving the making of any false filing with the state, entered within five years prior to the filing of the registration statement; or

(7) Has violated the law of a foreign jurisdiction governing or regulating any aspect of the business of securities or banking or, within the past five years, has been the subject of an action of a securities regulator of a foreign jurisdiction denying, revoking or suspending the right to engage in the business of securities as a broker-dealer, agent or investment adviser or is the subject of an action of any securities exchange or self-regulatory organization operating under the authority of the securities regulator of a foreign jurisdiction suspending or expelling such person from membership in such exchange or self-regulatory organization.

*b.* The prohibitions of subparagraphs (1) to (3) and (5) of paragraph 50.61(3) "a" shall not apply if the person subject to the disqualification is duly registered or licensed to conduct securities-related business in the state or province in which the administrative order or judgment was entered against such person, or if the broker-dealer employing such person is registered or licensed in the state and the Form BD filed in the state discloses the order, conviction, judgment or decree relating to such person.

*c.* No person disqualified shall act in any capacity other than the capacity for which the person is registered or licensed.

*d.* Disqualification is automatically waived if the jurisdiction which created the basis for disqualification determines upon a showing of good cause that it is not necessary under the circumstances that registration be denied.

This rule is intended to implement Iowa Code section 502.304.

**191—50.62(502) Streamlined registration for certain equity securities.**

**50.62(1)** An equity security meeting the conditions of this rule may be registered pursuant to Iowa Code section 502.303 if all of the following conditions are satisfied, unless waived by the administrator, and except as provided by subrule 50.62(2):

*a.* The issuer must be a corporation organized under the laws of one of the states or possessions of the United States;

*b.* The offering price for common stock, the exercise price if the securities are options, warrants, or rights for common stock, or the conversion price if the securities are convertible into common stock must be equal to or greater than \$5 per share;

*c.* The issuer of the security has (or will have upon completion of the offering) total assets exceeding \$10 million;

*d.* The security will be offered under a firm underwriting;

*e.* The security is the subject of a registration statement filed on Form S-1 or Form SB-2 with the SEC; and

*f.* The registration statement filed with the administrator contains audited financial statements for each of the two most recently concluded fiscal years of its operations, and the audit for the most recent fiscal year does not include an auditor's report expressing substantial doubt about the issuer's ability to continue as a going concern.

**50.62(2)** Registration pursuant to this rule is not available if:

*a.* The issuer is a blind pool or other offering for which the specific business or properties cannot now be described; or

*b.* The issuer, a principal officer or a principal shareholder thereof, or a broker-dealer offering or selling the securities:

(1) Is subject to statutory disqualification, as defined by subparagraphs (A), (B), (C), or (D) of Section 3(a)(39) of the Securities Exchange Act of 1934;

(2) Has been convicted of any felony under federal or state law regarding the offer, purchase, or sale of any security, or any felony under federal or state law involving fraud or deceit in the ten years prior to the date of the offering;

(3) Is currently named in and subject to any order, judgment, or decree of any court of competent jurisdiction acting under federal or state law temporarily or permanently restraining or enjoining the person from engaging in or continuing any conduct or practice in connection with the offer, purchase, or sale of a security;

(4) Has filed a registration statement which is currently the subject of a stop order entered pursuant to any state's securities law within five years prior to the offering;

(5) Is currently subject to any state administrative enforcement order or judgment entered by that state's securities administrator within five years prior to the offering, or is currently subject to any state's administrative enforcement order or judgment in which fraud or deceit was found within five years prior to the offering; or

(6) Is currently subject to any state's administrative order or judgment prohibiting, denying, or revoking the use of any exemption from registration regarding the offer, sale, or purchase of any security, or involving the making of a false filing with the state within five years of the offering.

**50.62(3)** The unavailability of streamlined registration pursuant to this rule as a result of the disqualification of a party pursuant to paragraph 50.62(2) "b" may be waived by the administrator if the order, conviction, judgment or decree relating to the party's disqualification was disclosed in writing to the administrator and the administrator determines, based upon good cause shown, that the public interest no longer requires the party to be disqualified.

**50.62(4)** The administrator shall review a filing made pursuant to this rule within ten business days of receipt. Registration shall be effective upon review, or earlier if the administrator permits a shorter time frame, or comments explaining noncompliance will be promptly sent to the applicant.

**50.62(5)** The administrator shall not deny the effectiveness of a registration made pursuant to this rule based on subrule 50.66(13) or 50.66(15), or based upon the financial condition of the issuer under Iowa Code section 502.306(1) "h."

**50.62(6)** The following securities shall be the subject of a lockup with the managing underwriter for no less than 180 days, or a longer period if requested by the managing underwriter of the offering:

*a.* A security issued to a promoter within three years immediately preceding the offering or to be issued to a promoter for consideration substantially less than the offering price; or

*b.* A security issued to a promoter for a consideration other than cash, unless the registrant demonstrates that the value of the noncash consideration received in exchange for the security is substantially equal to the offering price for the security. A copy of the lockup agreement shall be filed with the administrator.

**50.62(7)** For purposes of this rule, a “promoter” is:

*a.* A person who, acting alone or in concert with one or more other persons, founds or organizes the business or enterprise of the issuer;

*b.* An officer or director owning securities of the issuer, or a person who owns, beneficially or of record, 10 percent or more of a class of securities of the issuer if the officer, director, or person acquires any of those securities in a non-arm’s-length transaction within the three years prior to the filing of the registration statement pursuant to this rule; or

*c.* A member of the immediate family of a person described in paragraph “a” or “b” of subrule 50.62(7) if the family member receives securities of the issuer from that person in a non-arm’s-length transaction within the three years prior to the filing of the registration statement pursuant to this rule.

This rule is intended to implement Iowa Code section 502.303.

#### **191—50.63(502) Registration of multijurisdictional offerings.**

**50.63(1)** Pursuant to Iowa Code section 502.303(2), offerings filed on SEC Form F-7, Form F-8, Form F-9 or Form F-10 shall become effective the later of three days after filing, or the effective date with the SEC.

**50.63(2)** Pursuant to Iowa Code section 502.605(3), financial statements and financial information for offerings filed under subrule 50.63(1) shall comply with instructions provided with SEC Form F-7, Form F-8, Form F-9 or Form F-10.

**50.63(3)** In a Rights Offering, SEC Form F-7 will be accepted in lieu of any state form required to claim an exemption for any transaction pursuant to an offer to existing securities holders.

**50.63(4)** After the SEC has declared effective an issuer’s Form F-8, Form F-9 or Form F-10 registration statement, a nonissuer transaction in any class of the issuer’s securities is exempt from registration, whether or not the transaction is effected through a broker-dealer.

This rule is intended to implement Iowa Code sections 502.303(2) and 502.605(3).

#### **191—50.64(502) Form of financial statements.**

**50.64(1)** Except as otherwise provided by this rule, the balance sheet, statement of cash flows, and statement of income required by Iowa Code section 502.304(2) “q” shall be certified by an independent certified public accountant who shall also issue an opinion on the financial statements. The audit and opinion requirements may be waived by the administrator upon written application and for good cause shown.

**50.64(2)** The balance sheet, statement of cash flows, and statement of income provided for compliance with the four-month requirement of Iowa Code section 502.304(2) “q” need not be certified in accordance with subrule 50.64(1) if such certification was submitted for the last fiscal year prior to the application and the date of the financial statements subject to certification is not more than 12 months prior to the registration date.

This rule is intended to implement Iowa Code section 502.304.

**191—50.65(502) Reports contingent to registration by qualification.** In the administrator’s discretion, a registration by qualification statement filed pursuant to Iowa Code section 502.304 may not become effective until one or both of the following are filed:

1. When the value, after its purchase, of certain property does or will constitute a material portion of the assets of the issuer or any other person whose financial condition is significant to the registration, the report of any appraiser or engineer; and

2. When the ownership of any such property is material to the registration, a signed opinion of legal counsel regarding ownership of any property.

This rule is intended to implement Iowa Code section 502.304(2A).

**191—50.66(502) NASAA guidelines and statements of policy.**

**50.66(1) *Overview of national models.*** In cooperation with the securities administrators of other states and with a view to effectuating a policy to achieve maximum uniformity of regulations regarding the registration of securities, registration and business practices of securities industry and investment advisory registrants, and enforcement of antifraud laws, and in the interest of streamlining the rules contained in Chapter 50, the administrator incorporates by reference the following guidelines and statements of policy promulgated by NASAA. This rule does not include any later amendments or editions of the incorporated matter.

The official reporter for NASAA statements of policy is the NASAA Reports volume printed by CCH. A copy of the CCH NASAA Reports is available to the public during regular business hours at the office of the administrator. Upon request, and for a reasonable fee not to exceed the cost of providing the service, the administrator will furnish to any person photostatic or other copies of the following NASAA guidelines and statements of policy. The office of the administrator is located at and requests may be mailed to the Iowa Securities and Regulated Industries Bureau, 340 Maple Street, Des Moines, Iowa 50319-0066; via E-mail at [iowa.sec@iid.state.ia.us](mailto:iowa.sec@iid.state.ia.us); or from the division Web site at <http://www.iid.state.ia.us/division/securities>. NASAA statements of policy may also generally be found at [www.nasaa.org](http://www.nasaa.org).

**50.66(2) *Registration of oil and gas programs.*** All oil and gas programs filing for registration by coordination or qualification shall substantially comply, as determined by the administrator, with the NASAA Guidelines for Registration of Oil and Gas Programs, which were initially adopted by the NASAA membership on September 22, 1976, as amended on October 12, 1977; October 31, 1979; April 23, 1983; July 1, 1984; September 3, 1987; September 14, 1989; October 24, 1991; May 7, 2007; and May 6, 2012; and published in CCH NASAA Reports at paragraph 2621.

**50.66(3) *Uniform disclosure guidelines—legend.*** All registrations of securities filing for registration by coordination or qualification shall substantially comply, as determined by the administrator, with the NASAA Guidelines for Cover Legends as adopted by the NASAA membership on October 2, 2004, and published in CCH NASAA Reports at paragraph 1351.

**50.66(4) *Omnibus guidelines.*** All registrations of limited or general partnerships, joint ventures, unincorporated associations, or similar organizations, other than a corporation formed and operated for the primary purpose of investment in and the operation of or gain from and interest in the assets to be acquired by such entity for which statements of policy have not been adopted by the NASAA membership, filing for registration by coordination or qualification shall substantially comply, as determined by the administrator, with the NASAA Omnibus Guidelines as adopted by the NASAA membership on March 29, 1992, as amended on May 7, 2007; and published in CCH NASAA Reports at paragraph 2321.

**50.66(5) *Registration of commodity pool programs.*** All registrations of securities filing for registration by coordination or qualification shall substantially comply, as determined by the administrator, with the NASAA Guidelines for Registration of Commodity Pool Programs as adopted by the NASAA membership on September 21, 1983, effective January 1, 1984, amended August 30, 1990, amended May 7, 2007, amended May 6, 2012, and published in CCH NASAA Reports at paragraph 1201.

**50.66(6) *Registration of equipment programs.*** All registrations of securities filing for registration by coordination or qualification shall substantially comply, as determined by the administrator, with the NASAA Guidelines for Equipment Programs as adopted by the NASAA membership on November 20,

1986, effective January 1, 1987, amended April 22, 1988, October 24, 1991, May 7, 2007, and May 6, 2012, and published in CCH NASAA Reports at paragraph 1601.

**50.66(7) *Registration of real estate programs.*** All registrations of securities filing for registration by coordination or qualification shall substantially comply, as determined by the administrator, with the NASAA Guidelines for Real Estate Programs as adopted by the NASAA membership on September 29, 1993, last revised, May 7, 2007, and published in CCH NASAA Reports at paragraph 3601.

**50.66(8) *Registration of mortgage programs.*** All registrations of securities filing for registration by coordination or qualification shall substantially comply, as determined by the administrator, with the NASAA Guidelines for Mortgage Programs as adopted by the NASAA membership on September 10, 1996, amended May 2007, and published in CCH NASAA Reports, paragraph 701.

**50.66(9) *Real estate investment trusts.*** The registration of a real estate investment trust may be disallowed if it does not substantially comply, as determined by the administrator, with the NASAA Statement of Policy Regarding Real Estate Investment Trusts as revised and adopted by the NASAA membership on September 29, 1993, as revised on May 7, 2007, and published in CCH NASAA Reports at paragraph 3401.

**50.66(10) *Corporate securities definitions.*** For securities registration purposes, the administrator adopts the various definitions set out in the NASAA Statement of Policy Regarding Corporate Securities Definitions as adopted by the NASAA membership on April 27, 1997, and as amended September 28, 1999, and March 31, 2008, and published in CCH NASAA Reports at paragraph 3812.

**50.66(11) *Impoundment of proceeds.*** When an impoundment of proceeds is necessary, it shall substantially comply, as determined by the administrator, with the NASAA Statement of Policy Regarding the Impoundment of Proceeds as adopted by the NASAA membership on April 27, 1997, and as amended September 28, 1999, and March 31, 2008, and published in CCH NASAA Reports at paragraph 2151.

**50.66(12) *Loans and other material affiliated transactions.*** When there have been or will be loans or other material affiliated transactions, the transactions shall substantially comply, as determined by the administrator, with the NASAA Statement of Policy Regarding Loans and Other Material Affiliated Transactions as amended by the NASAA membership on April 27, 1997, and March 31, 2008, and published in CCH NASAA Reports at paragraph 374.

**50.66(13) *Options and warrants.*** The issuance of options and warrants may be allowed by the administrator if the issuance is in substantial compliance, as determined by the administrator, with the NASAA Statement of Policy Regarding Options and Warrants as adopted by the NASAA membership on November 17, 1997, and as amended September 28, 1999, and as amended March 31, 2008, and published in CCH NASAA Reports at paragraph 2801.

**50.66(14) *Preferred stock.*** A public offering of preferred stock may be allowed by the administrator if the offering substantially complies, as determined by the administrator, with the NASAA Statement of Policy Regarding Preferred Stock as adopted by the NASAA membership on April 27, 1997, and as amended March 31, 2008, and published in CCH NASAA Reports at paragraph 3001.

**50.66(15) *Promotional shares.*** The registration of a security may include promotional shares if it substantially complies, as determined by the administrator, with the NASAA Statement of Policy Regarding Promotional Shares as adopted by the NASAA membership on April 27, 1997, and as amended September 28, 1999, and March 31, 2008, and published in CCH NASAA Reports at paragraph 3201.

**50.66(16) *Risk disclosure.*** All registrations of securities filing for registration by coordination or qualification shall substantially comply, as determined by the administrator, with the NASAA Guidelines for Risk Disclosure as adopted by the NASAA membership on September 8, 2001, and published in CCH NASAA Reports at paragraph 1362.

**50.66(17) *Unsound financial condition.*** An issuer may be deemed to be in an unsound financial condition if it substantially meets, as determined by the administrator, the conditions provided within the NASAA Statement of Policy Regarding Unsound Financial Condition as adopted by the NASAA membership on April 27, 1997, and as amended September 28, 1999, and March 31, 2008, and published in CCH NASAA Reports at paragraph 3821.

**50.66(18) Use of proceeds.** The registration of a security may be disallowed if it does not substantially comply, as determined by the administrator, with the NASAA Statement of Policy Regarding Specificity in Use of Proceeds as adopted by the NASAA membership on April 27, 1997, and as amended September 28, 1999, and March 31, 2008, and published in CCH NASAA Reports at paragraph 3831.

**50.66(19) Registration of asset-backed securities.** All registrations of securities filing for registration by coordination or qualification shall substantially comply, as determined by the administrator, with the NASAA Guidelines for Registration of Asset-Backed Securities as adopted by the NASAA membership on October 25, 1995, amended May 7, 2007, and May 6, 2012, and published in CCH NASAA Reports at paragraph 501.

This rule is intended to implement Iowa Code sections 502.305(6) and 502.306(1).  
[ARC 1076C, IAB 10/2/13, effective 11/6/13]

**191—50.67(502) Amendments to registration by qualification.** A registration statement registered by qualification pursuant to Iowa Code section 502.304 is presumed to be reasonably current for purposes of Iowa Code section 502.305(9) if:

1. The issuer notifies the administrator in writing of any change in a material fact contained in the registration statement no later than 7 days after the issuer learns of the change; and
2. The issuer notifies the administrator in writing of the results of an annual audit or semiannual report no later than 14 days after receiving such audit results or semiannual report unless the results constitute a change in material fact subject to the provisions of paragraph “1.”

This rule is intended to implement Iowa Code section 502.305(9).

**191—50.68(502) Delivery of prospectus.** As a condition to registration by qualification pursuant to Iowa Code section 502.304, a prospectus containing the information required by Iowa Code section 502.304(2) shall be delivered to each person to which an offer is made, before or concurrently with the earliest of the following events:

1. The first offer made in a record to each person otherwise than by means of a public advertisement, by or for the account of the issuer or any other person on whose behalf the offering is made, or by any underwriter or broker-dealer offering part of an unsold allotment or subscription taken as a participant in the distribution;
2. The confirmation of any sale made by or for the account of the person;
3. The payment pursuant to any such sale; or
4. The delivery of the security pursuant to any such sale.

This rule is intended to implement Iowa Code section 502.304(5).

**191—50.69(502) Advertisements.**

**50.69(1)** The following advertising regarding the offer, sale or purchase of any security in Iowa is exempt from the filing requirements of Iowa Code section 502.504:

*a.* A prospectus published or circulated regarding an offering of a security registered pursuant to Iowa Code section 502.303 or 502.304 that is not yet effective, or an offering of a security for which a notice or application for exemption, including the prospectus, has been filed pursuant to Iowa Code section 502.201 or 502.202;

*b.* Advertising which provides information regarding only from whom a prospectus may be obtained, a description of the security offered for sale, the price of the security, or the names of broker-dealers having an interest in its sale;

*c.* Advertising published by a registered broker-dealer or investment adviser concerning the qualifications or business of the registrant, the general advisability of investing in securities or market quotations or other factual information relating to particular securities or issuers, provided the advertising contains no recommendation concerning the purchase or sale of a particular security;

*d.* Unless specifically requested by the administrator, advertising filed with FINRA or that satisfies the requirements of Securities Act of 1933 Rules 230.135a, 230.156, or 230.482; and

*e.* Any other advertising the administrator may specify by order.

**50.69(2)** All advertising required to be filed with the administrator by a registrant shall be filed prior to the date of use. All advertising required to be filed by a person other than a registrant shall be filed at least ten days prior to the date of use, or a shorter period if provided by the administrator. The advertising shall not be used in Iowa until the registrant receives approval from the administrator.

**50.69(3)** Sales literature of an investment company registered pursuant to the Investment Company Act of 1940 which is materially misleading within the meaning of rules or a statement of policy of the SEC constitutes false or misleading advertising as prohibited by Iowa Code section 502.504(2A).

**50.69(4)** False or misleading advertisements prohibited by Iowa Code section 502.504(2A) include, but are not limited to, the following:

*a.* Comparison charts or graphs showing a distorted, unfair, or unrealistic relationship between the issuer's past performance, progress, or success and that of another company, business, industry, or investment media;

*b.* Layout or format omitting information necessary to make the entire advertisement a fair and truthful representation;

*c.* Statements or representations without accreditation predicting future profit, success, appreciation, or performance, or otherwise addressing the merit or potential of the securities;

*d.* Generalizations, generalized conclusions, opinions, representations, and general statements based upon a particular set of facts and circumstances unless those facts and circumstances are stated and modified or explained by additional facts or circumstances as are necessary to make the entire advertisement a full, fair, and truthful representation;

*e.* Sales kits or film clips, displays or exposures, which alone or by sequence and progressive compilation present a misleading impression of guaranteed or exaggerated potential, profit, safety, or return;

*f.* Distribution of any nonfactual or inaccurate data or material by words, pictures, charts, or graphs, or otherwise based upon conjectural, unfounded, extravagant, or flamboyant claims, assertions, or predictions, or upon excessive optimism; and

*g.* Any package or bonus deal, prize, gimmick, or similar inducement regarding the offer or sale of a security that is combined with or dependent upon the sale of some other product, contract, or service unless the combination has been fully disclosed and specifically described and identified in the advertisement.

**50.69(5)** Any business card or other advertisement containing the name of an agent shall:

*a.* Clearly designate the agent as a securities agent or registered representative of the broker-dealer, as applicable, and indicate clearly that the broker-dealer is a broker-dealer;

*b.* Contain no advertising other than agent name, office address, broker-dealer name, and broker-dealer logo or trademark on the business cards;

*c.* Provide the office address and telephone number of the location where the agent conducts securities business; and

*d.* Clearly state the business of that entity and the relationship of the agent to that entity if the name, logo or trademark of any business entity other than that of the broker-dealer appears on the business card or in an advertisement.

**50.69(6)** A firm employing a sales agent who is offering securities on its behalf is responsible for ensuring that the name of the broker-dealer is displayed on the agent's business cards as prominently as the individual's name.

**50.69(7)** For the purpose of this rule, "advertisement" means any written or printed communication or any communication by means of recorded telephone messages or transmitted on radio, television, or other electronic communications media, published regarding the offer, sale, or purchase of a security.

This rule is intended to implement Iowa Code section 502.504.

[ARC 9169B, IAB 10/20/10, effective 11/24/10]

DIVISION VI  
EXEMPTIONS**191—50.80(502) Uniform limited offering exemption.**

**50.80(1)** This rule is the NASAA Uniform Limited Offering Exemption as adopted in September 1983, with amendments adopted through April 29, 1989, without any of the footnotes and may be cited as the “Uniform Limited Offering Exemption.”

*a.* Nothing in this exemption is intended to or should be in any way construed as relieving issuers or persons acting on behalf of issuers from providing disclosure to prospective investors adequate to satisfy the antifraud provisions of Iowa Code chapter 502 and these rules.

*b.* In view of the objective of this rule and the purposes and policies underlying Iowa Code chapter 502, the exemption is not available to any issuer for any transaction which, although in technical compliance with this rule, is part of a plan or scheme to evade registration or the conditions or limitations explicitly stated in this rule.

*c.* Nothing in this rule is intended to relieve registered broker-dealers or agents from the due diligence, suitability, “know your customer” standards, or any other requirements of law otherwise applicable to such registered persons.

**50.80(2)** Under the authority delegated to the administrator to promulgate rules by Iowa Code sections 502.203 and 502.605(1), the following transaction is exempt from the registration provisions of the Act:

*a.* Any offer or sale of securities offered or sold in compliance with the Securities Act of 1933, Regulation D, Rule 230.505, including any offer or sale made exempt by Rule 508(a), as made effective in Release No. 33-6389 and as amended by Release Nos. 33-6437, 33-6663, 33-6758, and 33-6825, and which satisfies all of the following:

(1) No commission, fee or other remuneration shall be paid or given, directly or indirectly, to any person for soliciting any prospective purchaser in Iowa unless the person is registered under Iowa Code section 502.406 or is exempt from registration as a broker-dealer by Iowa Code section 502.401(2).

(2) It is a defense to a violation of this subrule if the issuer sustains the burden of proof to establish that the issuer did not know, and in the exercise of reasonable care could not have known, that the person receiving a commission, fee, or other remuneration was not appropriately registered in Iowa.

*b.* No exemption under this rule is available for the securities of any issuer if any of the parties described in the Securities Act of 1933, Regulation A, Rule 230.262(a), (b), or (c):

(1) Has filed a registration statement subject to a currently effective registration stop order entered under any state’s securities law within five years prior to filing the notice required under this exemption;

(2) Has been convicted, within five years prior to filing the notice required under this exemption, of any felony or misdemeanor regarding the offer, purchase or sale of any security or any felony involving fraud or deceit including, but not limited to, forgery, embezzlement, obtaining money under false pretenses, larceny, or conspiracy to defraud;

(3) Is currently subject to any state administrative enforcement order or judgment entered by that state’s securities administrator within five years prior to filing the notice required under this exemption, or is currently subject to any state’s administrative enforcement order or judgment in which fraud or deceit including, but not limited to, making untrue statements of material facts and omitting to state material facts, was found and the order or judgment was entered within five years prior to filing the notice required under this exemption;

(4) Is currently subject to any state administrative enforcement order or judgment prohibiting, denying, or revoking the use of any exemption from registration regarding the offer, purchase or sale of securities; or

(5) Is currently subject to any order, judgment, or decree of any court of competent jurisdiction temporarily or preliminarily restraining or enjoining, or permanently restraining or enjoining the party from engaging in or continuing any conduct or practice regarding the purchase or sale of any security, or involving the making of any false filing with the state entered within five years prior to filing the notice required under this exemption.

(6) The disqualification of a person under paragraph 50.80(2)“b” may be waived by the administrator if the order, conviction, judgment or decree relating to the person’s disqualification has been disclosed in writing to the administrator and the administrator has determined, for good cause shown, that the public interest no longer requires the person to be disqualified.

(7) It is a defense to a violation of this subrule if the issuer sustains the burden of proof to establish that the issuer did not know, and in the exercise of reasonable care could not have known, that a disqualification under this subrule existed.

*c.* The issuer shall file with the administrator a notice on Form D (17 CFR 239.500) not later than 15 days following the date of the first sale in Iowa. This notice shall be accompanied by:

- (1) A copy of any written information furnished to investors;
- (2) A Form U-2 consent to service of process; and
- (3) A \$100 filing fee.

*d.* Filing occurs on the earlier of:

- (1) The date the notice is received by the administrator; or
- (2) The date the documents are mailed with the United States Postal Service by registered or certified mail addressed to the administrator at the Iowa Securities and Regulated Industries Bureau, 340 Maple Street, Des Moines, Iowa 50319-0066.

*e.* In all sales to nonaccredited investors in Iowa, one of the following conditions must be satisfied or the issuer and any person acting on its behalf shall have reasonable grounds to believe, and after making reasonable inquiry shall believe, that one of the following conditions is satisfied:

(1) The investment is suitable for the purchaser based upon facts, if any, disclosed by the purchaser regarding the purchaser’s other security holdings, financial situation and needs. For this condition only, it is presumed that if the investment does not exceed 10 percent of the investor’s net worth, it is suitable.

(2) The purchaser, either alone or with a purchaser’s representative, has such knowledge and experience in financial and business matters that the purchaser is, or they are, capable of evaluating the merits and risks of the prospective investment.

**50.80(3)** The failure to comply with a term, condition or requirement of subparagraph 50.80(2)“a”(1), paragraph 50.80(2)“c” or paragraph 50.80(2)“e” will not result in loss of the exemption from the requirements of Iowa Code section 502.301 for any offer or sale to a particular individual or entity if the person relying on the exemption shows:

*a.* The failure to comply did not pertain to a term, condition or requirement directly intended to protect that particular individual or entity;

*b.* The failure to comply was insignificant regarding the offering as a whole; and

*c.* A good-faith and reasonable attempt was made to comply with all applicable terms, conditions, and requirements of subparagraph 50.80(2)“a”(1), paragraph 50.80(2)“c” and paragraph 50.80(2)“e.”

**50.80(4)** Where an exemption is established only through reliance upon subrule 50.80(3), the failure to comply is actionable under Iowa Code sections 502.603 and 502.604.

**50.80(5)** Transactions exempt under this rule may not be combined with offers and sales exempt under any other rule or provision of the Act. However, nothing in this limitation shall act as an election. Should for any reason the offer and sale fail to comply with all of the conditions for this exemption, the issuer may claim the availability of any other applicable exemption.

**50.80(6)** The administrator may, by rule or order, increase the number of purchasers or waive any other conditions of this exemption.

This rule is intended to implement Iowa Code section 502.203.

#### **191—50.81(502) Notice filings for Rule 506 offerings.**

**50.81(1)** An issuer offering a security that is a covered security pursuant to Section 18(b)(4)(D) of the Securities Act of 1933 shall submit no later than 15 days after the first sale of such federal covered security in Iowa:

- a.* A notice on Form D, including the Appendix;
- b.* A consent to service of process on Form U-2; and
- c.* A \$100 filing fee, or a \$250 fee for any late filing.

**50.81(2)** “SEC Form D,” for the purposes of this rule, means the document, as adopted by the SEC and in effect on September 1, 1996, as may be amended by the SEC from time to time, entitled “FORM D: Notice of Sale of Securities pursuant to Regulation D, Section 4(6), and/or Uniform Limited Offering Exemption,” including Part E and the Appendix.

This rule is intended to implement Iowa Code section 502.302(3).

**191—50.82(502) Notice filings for agricultural cooperative associations.**

**50.82(1)** An agricultural cooperative association issuing notes or other evidence of indebtedness shall notify the administrator in writing 30 days before the security is initially sold. Notification shall include:

- a.* The name of the issuer, the date of organization of the issuer, and the name of a contact person.
- b.* A description of the class of persons to whom the offer of securities will be made. If the offering is being made to certain persons or within a specified area, a description of such offerees or area shall be included.
- c.* A description of the type of security to be offered which includes information regarding interest and interest payment schedules, default, redemption, reinvestment, and other facts regarding the rights of holders that the issuer deems material to the offering.

*d.* Financial statements of the agricultural cooperative association including a balance sheet as of the end of its most recent fiscal year, prepared under generally accepted accounting principles and accompanied by an independent auditor’s report and any other audited financial statements of the association that are available. However, if the filing by the agricultural cooperative association is made within 90 days of the end of its most recent fiscal year and current audited financial statements are not yet available, the filing may consist of an audited balance sheet and other available audited financial statements for the previous fiscal year, prepared under generally accepted accounting principles and accompanied by an independent auditor’s report. The agricultural cooperative association shall file an audited balance sheet and any other available audited financial statements for the most recent fiscal year end as soon as they become available, but in no event later than 90 days after the end of its fiscal year.

**50.82(2)** If, after the anniversary date of its initial notice filing, an agricultural cooperative association continues to issue notes or other evidence of indebtedness under its initial notice filing in order to maintain the exemption, the agricultural cooperative association shall on an annual basis file with the administrator an audited balance sheet and any other audited financial statements within 30 days of the anniversary of its initial notice filing. An agricultural cooperative association making its initial filing based upon a previous year’s audited financial statements because of the unavailability of current audited financial statements shall consider its anniversary date to be the date on which the cooperative filed the audited financial statements for the most recent fiscal year. An agricultural cooperative association not issuing notes or other evidence of indebtedness after an anniversary date of its initial filing is not required to make any further filing of financial information as a condition of qualifying for the exemption from registration.

**50.82(3)** Form ICP may be used to make the filing required by subrule 50.82(1). Form ICP may be obtained by contacting the administrator at the Iowa Securities and Regulated Industries Bureau, 340 Maple Street, Des Moines, Iowa 50319-0066; or via E-mail at [iowa.sec@iid.state.ia.us](mailto:iowa.sec@iid.state.ia.us).

This rule is intended to implement Iowa Code section 502.201(8B) “b.”

**191—50.83(502) Unsolicited order exemption.**

**50.83(1)** Any unregistered broker-dealer effecting a transaction under an unsolicited order or offer to buy and claiming an exemption from registration based solely upon Iowa Code section 502.202(6) shall obtain acknowledgment from the customer on or before the settlement date of the transaction that the transaction is unsolicited.

**50.83(2)** The acknowledgment shall take one of the following forms:

- a.* A confirmation statement, as required pursuant to subrule 50.83(1), displaying in bold print on the face of the statement the words “Unsolicited Order, Notify Immediately if Otherwise”; or

*b.* A signed statement from the customer acknowledging that the order was unsolicited and containing the name of the customer, the name of the securities involved, the number of securities involved in the transaction, the purchase price of the securities, the transaction date, and the total dollar amount, including commissions paid, of the transaction.

**50.83(3)** The customer will be presumed to have acknowledged that the transaction was unsolicited if the customer does not indicate otherwise on or before the settlement date.

**50.83(4)** A broker-dealer shall notify the administrator in writing that it is executing unsolicited orders in a security when both of the following conditions are met:

*a.* More than six unsolicited orders or offers to buy such security are received during any three consecutive business days; and

*b.* The broker-dealer is relying solely upon the exemption provided by Iowa Code section 502.202(6).

This rule is intended to implement Iowa Code section 502.202(6).

**191—50.84(502) Solicitation of interest exemption.**

**50.84(1)** An offer, but not a sale, of a security made by or on behalf of an issuer for the sole purpose of soliciting an indication of interest in receiving a prospectus (or its equivalent) for such security is exempt from registration pursuant to Iowa Code section 502.301 if:

*a.* The issuer is or will be a business entity organized under the laws of one of the states or possessions of the United States or one of the provinces or territories of Canada, is engaged in or proposes to engage in a business other than petroleum exploration or production or mining or other extractive industries, and is not a blind pool offering or other offering for which the specific business or properties cannot now be described.

*b.* The offerer intends to register the security in Iowa and conduct its offering pursuant to either Regulation A or Rule 504 of Regulation D, as promulgated by the SEC.

*c.* The offerer files with the administrator a SOIF along with any other materials to be used to conduct solicitations of interest including, but not limited to, the script of any broadcast to be made and a copy of any notice to be published no less than ten business days prior to the initial solicitation of interest.

*d.* The issuer files with the administrator all amendments to any materials filed pursuant to paragraph “c” or additional materials it proposes to use in conducting solicitations of interest, except for materials provided to a particular investor solely pursuant to a request by that investor, no less than five business days prior to use.

*e.* The offerer does not use any SOIF, script, advertisement, or other material which the administrator has ordered or notified the offerer may not be used for the purpose of solicitations of interest.

*f.* Except for scripted broadcasts and except to the extent necessary to obtain information needed to provide a SOIF, the offerer does not orally communicate with any prospective investor about the contemplated offering unless the investor is provided with the most current SOIF at or before the time of the communication or within five days after the communication.

*g.* The offerer does not solicit or accept money or a commitment to purchase securities during the solicitation of interest period.

*h.* The offerer does not make a sale until at least seven days after delivery to the purchaser of a final prospectus or delivery of a preliminary prospectus as provided by Iowa Code section 502.202(17).

**50.84(2)** Unless the offerer does not know, and in the exercise of reasonable care could not know, the exemption under this rule is not available for securities of an offerer, if any of the issuer’s officers, directors, promoters, or 10 percent shareholders:

*a.* Have filed a registration statement which is the subject of a current effective registration stop order entered under any federal or state securities law within five years prior to filing the SOIF.

*b.* Have been convicted within five years prior to filing the SOIF of any felony or misdemeanor regarding the offer, purchase or sale of any security or any felony involving fraud or deceit including,

but not limited to, forgery, embezzlement, obtaining money under false pretenses, larceny, or conspiracy to defraud.

*c.* Are currently subject to any federal or state administrative enforcement order or judgment entered by any state securities administrator or the SEC within five years prior to filing the SOIF in which fraud or deceit, including, but not limited to, the making of untrue statements of material facts and omitting to state material facts, was found.

*d.* Are subject to any federal or state administrative order or judgment prohibiting, denying, or revoking the use of any exemption from registration regarding the offer, purchase or sale of securities.

*e.* Are currently subject to any order, judgment, or decree of any court of competent jurisdiction entered within five years prior to filing the SOIF temporarily, preliminarily, or permanently restraining or enjoining the person or entity from engaging in or continuing any conduct or practice regarding the purchase or sale of any security or the making of any false filing with any state.

The disqualifications listed in this subrule shall not apply if the person or entity subject to the disqualification is licensed or registered to conduct securities-related business in the state in which the administrative order or judgment was entered against the person or entity, or if the broker-dealer employing the person or entity is licensed or registered in Iowa and the Form BD filed with the administrator discloses the order, conviction, judgment, or decree. No person disqualified under this subrule may act in a capacity other than that for which the person is licensed or registered. Any disqualification caused by this subrule is automatically waived if the agency creating the disqualification determines for good cause shown that the exemption should not be denied.

**50.84(3)** The failure to comply with a term, condition or requirement of this rule shall not result in the loss of the exemption from the requirements of Iowa Code section 502.301 for an offer to a particular individual or entity if the offerer establishes all of the following:

*a.* The failure to comply did not pertain to a term, condition or requirement directly intended to protect that particular individual or entity; and

*b.* The failure to comply was insignificant regarding the offering as a whole; and

*c.* A good-faith and reasonable attempt was made to comply with all applicable terms, conditions and requirements of this rule.

Where an exemption is established only through reliance upon subrule 50.84(2), the failure to comply is still actionable as a violation of the Act by the administrator under Iowa Code section 502.603 or 502.604.

**50.84(4)** The offerer shall comply with the following requirements:

*a.* Any published notice or script for broadcast and any printed material delivered apart from the SOIF, unless a SOIF containing the disclosures described below was previously delivered to the person, shall contain, at a minimum, the identity of the chief executive officer of the issuer, a brief and general description of the issuer's business and products, and the following disclosure printed in capital letters and boldface type at least as large as that used in the body of the printed materials:

(1) NO MONEY OR OTHER CONSIDERATION IS BEING SOLICITED AND NONE WILL BE ACCEPTED.

(2) NO SALES OF SECURITIES WILL BE MADE OR A COMMITMENT TO PURCHASE ACCEPTED UNTIL THE DELIVERY OF AN OFFERING CIRCULAR THAT INCLUDES COMPLETE INFORMATION ABOUT THE ISSUER AND THE OFFERING.

(3) AN INDICATION OF INTEREST MADE BY A PROSPECTIVE INVESTOR INVOLVES NO OBLIGATION OR COMMITMENT OF ANY KIND.

(4) THIS OFFER IS BEING MADE PURSUANT TO AN EXEMPTION UNDER FEDERAL AND STATE SECURITIES LAWS. NO SALE MAY BE MADE UNTIL THE OFFERING STATEMENT IS QUALIFIED BY THE U.S. SECURITIES AND EXCHANGE COMMISSION AND IS REGISTERED IN IOWA.

*b.* All communications with prospective investors made in reliance upon this rule shall cease after a registration statement is filed with the administrator, and no sale may be made until at least 20 calendar days after the last communication made in reliance upon this rule.

*c.* A preliminary prospectus may be used with an offering for which indications of interest have been solicited under this rule only if the offering is conducted by a registered broker-dealer.

Failure to comply with the requirements of this subrule shall not result in losing the exemption from the requirements of Iowa Code section 502.301, but is a violation of the Act, is actionable by the

administrator under Iowa Code section 502.603 or 502.604, and constitutes grounds for denying or revoking the exemption for specific transactions.

**50.84(5)** Upon written application by the offerer and for good cause shown, the administrator may waive any condition of the solicitation of interest exemption. Neither compliance nor attempted compliance with this rule, nor the absence of any objection or order by the administrator regarding an offer of securities made under this rule, constitutes a waiver of any condition of the rule or a confirmation by the administrator of the availability of the rule.

**50.84(6)** Offers made in reliance upon this rule shall not be integrated with subsequent offers or sales of securities registered in Iowa. Issuers on whose behalf indications of interest are solicited under this rule may not make offers or sales in reliance upon Iowa Code section 502.202(14) or rule 191—50.80(502) until at least 12 months after the last communication with a prospective investor made pursuant to this rule.

**50.84(7)** Nothing in this rule limits the application of Iowa Code section 502.401, 502.402, 502.501 or 502.509 to offers made in reliance upon this rule.

**50.84(8)** The administrator may review the materials filed under this rule. Materials filed, if reviewed, will be judged under antifraud principles. Any discussion in the offering documents of the potential rewards of the investment must be balanced by a discussion of the possible risks.

**50.84(9)** Any offer effected in violation of this rule may constitute an unlawful offer of an unregistered security for which civil liability attaches under Iowa Code section 502.501 et seq. Any misrepresentation or omission may also give rise to civil liability under the Act. A subsequent registration of the security does not cure the previous unlawful offer. Only a rescission offer made in compliance with the Act can effect a cure.

This rule is intended to implement Iowa Code section 502.202(17).

**191—50.85(502) Internet offers exemption.** Offers of securities made by, or on behalf of, issuers on or through the Internet are exempt from registration pursuant to Iowa Code sections 502.301 and 502.504 if:

1. The Internet offer states, directly or indirectly, that the securities are not being offered to state residents; and
2. The Internet offer is not specifically directed to any person in Iowa by, or on behalf of, the issuer of the securities; and
3. No sales of the issuer's securities are made in Iowa as a result of the Internet offering until such time as the securities being offered have been registered under Iowa Code sections 502.301 and 502.504, and a final prospectus or Form U-7 is delivered to Iowa investors prior to such sales, or the issuer qualifies for the exemption provided in Iowa Code section 502.202(13).

This rule is intended to implement Iowa Code section 502.203.

**191—50.86(502) Denial, suspension, revocation, condition, or limitation of limited offering transaction exemption.** The administrator shall view the following as reasons for entering an order under Iowa Code section 502.204 to deny or revoke an exemption provided under Iowa Code section 502.202(14):

1. A public advertisement is used to promote the sale of securities for which such exemption is claimed; or
2. The offering is part of a registered offering under the Securities Act of 1933.

This rule is intended to implement Iowa Code section 502.204.

**191—50.87(502) Nonprofit securities exemption.**

**50.87(1)** Church extension funds or similar organizations making continuous offerings shall be exempt pursuant to Iowa Code section 502.201(7) "b" provided the issuer:

- a. Applies for the exemption;
- b. Files an offering circular and otherwise substantially complies with the NASAA Statement of Policy Regarding Church Extension Funds as adopted by the NASAA membership on April 17, 1994,

and amended by the NASAA membership on April 18, 2004, and published in CCH NASAA Reports at paragraph 1951;

- c.* Files all sales and advertising literature;
- d.* Files a consent to service of process;
- e.* Unless disallowed by the administrator within 15 days after the applicant has filed the items required by paragraphs 50.87(1)“*a*” to “*d*,” is authorized beginning 15 days after the filing is received to sell pursuant to the exemption;
- f.* After authorization, may sell securities for a period of 12 months; and
- g.* Upon the expiration of the 12-month period in paragraph 50.87(1)“*f*,” files a renewal application that complies with the requirements of this subrule.

**50.87(2)** Church bonds and other one-time offerings for a single specific project shall be exempt pursuant to Iowa Code section 502.201(7)“*a*” provided the issuer:

- a.* Files a notice specifying the material terms of the offering that comply with the NASAA Statement of Policy Regarding Church Bonds as adopted by the NASAA membership on April 14, 2002, and published in CCH NASAA Reports at paragraph 1001; and
- b.* Files a consent to service of process.

This rule is intended to implement Iowa Code section 502.201(7).  
[ARC 1076C, IAB 10/2/13, effective 11/6/13]

**191—50.88(502) Transactions with specified investors.** The administrator grants the exemption for transactions with specified investors to the following persons:

**50.88(1)** Any director, executive officer, or general partner of the issuer of the securities being offered or sold, or any director, executive officer, or general partner of a general partner of that issuer.

**50.88(2)** Any natural person whose individual net worth, or joint net worth with that person’s spouse, at the time of the purchase exceeds \$1 million, excluding the value of the primary residence of the natural person.

**50.88(3)** Any natural person who had an individual income in excess of \$200,000 in each of the two most recent years or joint income with that person’s spouse in excess of \$300,000 in each of those years and has a reasonable expectation of reaching the same income level in the current year.

**50.88(4)** Any venture or seed capital company. For purposes of this subrule, a venture or seed capital company is a corporation, partnership or association that has been in existence for five years or whose net assets exceed \$250,000 and whose primary business is investing in developmental stage companies or “eligible small business companies” as that term is defined in the regulations of the Small Business Administration.

This rule is intended to implement Iowa Code section 502.202(13).  
[ARC 1076C, IAB 10/2/13, effective 11/6/13]

**191—50.89(502) Designated securities manuals.** Nationally recognized securities manuals for purposes of Iowa Code section 502.202(2)“*d*” include Mergent’s Manuals, S & P Capital IQ Standard Corporation Descriptions, Fitch Investment Services, and Best’s Insurance Reports, Life-Health.

This rule is intended to implement Iowa Code section 502.202(2)“*d*.”  
[ARC 1076C, IAB 10/2/13, effective 11/6/13]

**191—50.90 to 50.99** Reserved.

DIVISION VII  
FRAUD AND OTHER PROHIBITED CONDUCT

**191—50.100(502) Fraudulent practices.**

**50.100(1)** An issuer of securities registered under the Act, or any person who is an officer, director or controlling person of such issuer, is presumed to employ a “device, scheme or artifice to defraud” the purchasers of such securities under Iowa Code section 502.501(1) if such person applies, authorizes or causes to be applied any material part of the proceeds from the sale of such securities in any material way

contrary to the purposes specified in the prospectus used in offering such securities and not reasonably related to the business of the issuer as described in the prospectus.

**50.100(2)** A broker-dealer or agent employing one or more of the following practices engages in an “act, practice, or course of business which operates or would operate as a fraud” under Iowa Code section 502.501(3):

*a.* Entering into any security transaction with a customer at an unreasonable price or at a price not reasonably related to the current market price of the security or receiving an unreasonable commission or profit.

*b.* Contradicting or negating the importance of any information contained in a prospectus or other offering materials with intent to deceive or mislead or using any advertising or sales presentation in a deceptive or misleading manner.

*c.* In connection with the offer, sale, or purchase of a security, falsely leading a customer to believe that the broker-dealer or agent possesses material, nonpublic information impacting the value of the security.

*d.* In connection with the solicitation of a sale or purchase of a security, engaging in a pattern or practice of making contradictory recommendations to different investors of similar investment objectives for some to sell and others to purchase the same security, at or about the same time, when the recommendation is not justified by the particular circumstances of each investor.

*e.* Failing to make a bona fide public offering of all the securities allotted to a broker-dealer for distribution by, among other things, (1) transferring securities to a customer, another broker-dealer or a fictitious account with the understanding that those securities will be returned to the broker-dealer or its nominees, or (2) parking or withholding securities.

*f.* Effecting any transaction in, or inducing the purchase or sale of, any security by means of any manipulative, deceptive or other fraudulent device or contrivance including, but not limited to, the use of “boiler-room” tactics such as repeated or harassing unsolicited telephone calls or the use of fictitious or nominee accounts.

**50.100(3)** Although nothing in this rule precludes applying the general antifraud provisions to any person who engages in practices similar to paragraphs “a” through “h” listed below, the listed practices apply only to soliciting a purchase or sale of OTC non-NASDAQ equity securities and excludes interests in direct participation programs and shares in open-end mutual funds:

*a.* Failing to disclose the entity’s present bid and ask price of a particular security at the time of solicitation.

*b.* Failing to advise the customer, both at the time of solicitation and on confirmation, of the total of all charges and fees related to a specific securities transaction.

*c.* In connection with a principal transaction, failing to disclose, both at the time of solicitation and upon confirmation, a short inventory position in the entity’s account of more than 5 percent of the issued and outstanding shares of that class of securities of the issuer, if the entity is a market maker at the time of solicitation.

*d.* Conducting sales contests in a particular security.

*e.* After a solicited purchase by a customer, failing or refusing, for a principal transaction, to promptly execute sell orders.

*f.* Refusing to sell existing securities held by the customer unless the customer executes a purchase transaction.

*g.* Soliciting a secondary market when there has not been a bona fide distribution in the primary market.

*h.* Engaging in a pattern of compensating an agent in different amounts for effecting sales and purchases in the same security.

This list is not intended to be all-inclusive. Engaging in other conduct including, but not limited to, forgery, embezzlement, conversion, nondisclosure, incomplete disclosure or misstatement of material facts may also be deemed fraudulent.

This rule is intended to implement Iowa Code section 502.501.

**191—50.101(502) Rescission offers.**

**50.101(1)** Rescission offers made pursuant to Iowa Code section 502.510 shall be typed or printed and shall be captioned “RESCISSION OFFER” in boldface print or type. The rescission offer shall be delivered to each offeree personally or shall be sent by certified mail to the offeree’s last-known address and shall contain the following information:

- a.* The name of the security which is the subject of the offer.
- b.* A reasonably detailed statement indicating why liability under Iowa Code section 502.509 may have arisen and fairly and adequately advising the offeree of the offeree’s rights pursuant to the Act.
- c.* An offer to repurchase the security pursuant to Iowa Code section 502.510(1) “*b*” to “*f*,” as applicable.
- d.* A statement that the offeree’s right to bring an action under the Act may be lost unless the offeree accepts the offer within 30 days after receiving the offer, or any shorter period, of not less than three days, that the administrator, by order, specifies.
- e.* Sufficient information about the issuer and the security offered to permit the offeree to make an informed decision regarding acceptance of the rescission offer including, but not limited to, information about the issuer’s organization and management, its operations and plan of business, and its financial condition as shown by a current financial statement prepared under generally accepted accounting principles.
- f.* A form by which the offeree may accept the offer and a statement explaining that the offeree may accept the offer by returning the form to the offerer at the provided address by first-class mail, or any other type of mail.
- g.* If the basis for relief under Iowa Code section 502.510 alleges a violation of Iowa Code section 502.509 which employed a device, scheme, or artifice to defraud, made an untrue statement of material fact necessary in order to make the statement made, in light of the circumstances under which it was made, not misleading, or engaged in an act, practice, or course of business that operated or would operate as a fraud or deceit on another person, in capital letters and boldface type at least as large as that used in the body of the printed materials, and placed immediately before the signature of the offerer, the following statement:

THIS IS A RESCISSION OFFER MADE PURSUANT TO IOWA CODE SECTION 502.510, A COPY OF WHICH IS ON FILE WITH THE IOWA SECURITIES AND REGULATED INDUSTRIES BUREAU. THE BUREAU MAKES NO RECOMMENDATION AS TO WHETHER THE OFFER SHOULD BE ACCEPTED OR REJECTED NOR HAS THE BUREAU PASSED UPON THE ADEQUACY OR ACCURACY OF THIS OFFER.

**50.101(2)** If the basis for relief under Iowa Code section 502.510 alleges a violation of Iowa Code section 502.509 which employed a device, scheme, or artifice to defraud, made an untrue statement of material fact necessary in order to make the statement made, in light of the circumstances under which it was made, not misleading, or engaged in an act, practice, or course of business that operated or would operate as a fraud or deceit on another person, prior to making a rescission offer pursuant to Iowa Code section 502.510, the offerer shall file with the administrator:

- a.* A copy of the rescission offer;
- b.* The names and addresses of all holders or sellers who are to receive the rescission offer; and
- c.* Financial statements proving that the offerer’s assets are sufficient to meet its obligations should all offerees accept the rescission offer.

**50.101(3)** Rescission offers made pursuant to Iowa Code section 502.510 shall be tendered to all persons to whom liability exists or may exist pursuant to Iowa Code section 502.509.

**50.101(4)** A rescission offer may be accepted at any time during the period stated in the rescission offer even if an offeree previously rejected the offer.

**50.101(5)** Rescission offers are subject to the provisions of Iowa Code sections 502.501, 502.501A, 502.505, 502.506, and 502.506A.

**50.101(6)** The administrator may, in the administrator’s discretion, require proof by the offerer of compliance with this rule and the terms of the rescission offer.

**50.101(7)** A proposal or the making of a rescission offer shall not limit the administrator’s administrative or enforcement authority provided by the Act.

This rule is intended to implement Iowa Code sections 502.509 and 502.510.

**191—50.102(502) Fraudulent, deceptive or manipulative act, practice, or course of business in providing investment advice.**

**50.102(1)** It shall constitute a fraudulent, deceptive or manipulative act, practice, or course of business for an investment adviser or an investment adviser representative acting as principal for such person's own account, knowingly to sell any security to or purchase any security from a client or, acting as broker for a person other than such client, knowingly to effect any sale or purchase of any security for the account of such client, without disclosing to such client in writing before the completion of such transaction the capacity in which the investment adviser is acting and obtaining the consent of the client to such transaction. The prohibitions of this subrule shall not apply to any transaction with a customer of a broker-dealer if such broker-dealer is not acting as an investment adviser in relation to such transaction.

**50.102(2)** It shall constitute a fraudulent, deceptive or manipulative act, practice, or course of business for an investment adviser or an investment adviser representative to fail to disclose to any client or prospective client all material facts regarding financial and disciplinary information as provided in 17 CFR Section 275.206(4)-4.

**50.102(3)** Pooled investment vehicles.

*a.* It shall constitute a fraudulent, deceptive, or manipulative act, practice, or course of business within the meaning of Iowa Code section 502.502(2) for any investment adviser to a pooled investment vehicle to:

(1) Make any untrue statement of a material fact or to omit to state a material fact necessary to make the statements made, in the light of the circumstances under which they were made, not misleading, to any investor or prospective investor in the pooled investment vehicle; or

(2) Otherwise engage in any act, practice, or course of business that is fraudulent, deceptive, or manipulative with respect to any investor or prospective investor in the pooled investment vehicle.

*b.* For purposes of this subrule, "pooled investment vehicle" means any investment company as defined in Section 3(a) of the Investment Company Act of 1940 (15 U.S.C. 80a-3(a)) or any company that would be an investment company under Section 3(a) of that Act but for the exclusion provided from that definition by either Section 3(c)(1) or Section 3(c)(7) of that Act (15 U.S.C. 80a-3(c)(1) or (7)).

This rule is intended to implement Iowa Code section 502.502(2).

**191—50.103(502) Investment advisory contracts.**

**50.103(1)** It is unlawful for any investment adviser to enter into, extend, or renew any investment advisory contract unless the contract provides in writing all of the following:

*a.* That the investment adviser shall not be compensated on the basis of a share of capital gains or capital appreciation of the funds or any portion of the funds of the client.

*b.* That no assignment of the contract may be made by the investment adviser without the consent of the other party to the contract.

*c.* That the investment adviser, if a partnership, shall notify the other party to the contract of any change in the membership of the partnership within a reasonable time after the change.

**50.103(2)** The provisions of subrule 50.103(1) shall be construed consistent with Sections 205(b) through (d) of the Investment Advisers Act of 1940, the terms of which shall be defined by Investment Advisers Act of 1940 Rules 275.205-1 and 275.205-2.

**50.103(3)** The provisions of subrule 50.103(1) shall not prohibit compensation on the basis of a share of capital gains or capital appreciation of the funds or any portion of the funds of the client in compliance with the exemption in 17 CFR Section 275.205-3.

This rule is intended to implement Iowa Code section 502.502(3).

**191—50.104 to 50.109** Reserved.

DIVISION VIII  
VIATICAL SETTLEMENT INVESTMENT CONTRACTS

**191—50.110(502) Application by viatical settlement investment contract issuers and registration of agents to sell viatical settlement investment contracts.**

**50.110(1)** Under this rule, the term “viatical settlement investment contract issuer” includes, but is not limited to, any individual, company, corporation or other entity that offers or sells, directly or indirectly, viatical settlement investment contracts to investors.

**50.110(2)** A viatical settlement investment contract issuer employing agents in Iowa must make prior application to the administrator for this authority. The application shall be made by letter and shall include:

- a. A statement of the issuer’s intent to employ agents for the sale of its viatical settlement investment contracts; and
- b. The name, address, social security number and proof of satisfaction of subrule 50.110(3) for each agent.

**50.110(3)** An applicant for registration as an Iowa-registered agent of an issuer of viatical settlement investment contracts shall file with the administrator:

- a. Proof of obtaining a passing grade on the FINRA Series 7 examination;
- b. Proof of obtaining a passing grade on the FINRA Series 63 examination;
- c. An accurate, complete and signed Form U-4; and
- d. A \$30 filing fee.

This rule is intended to implement Iowa Code sections 502.102(2), 502.301 and 502.402.  
[ARC 9169B, IAB 10/20/10, effective 11/24/10]

**191—50.111(502) Risk disclosure.** Viatical settlement investment contract issuers and registered agents of issuers must provide specific, written disclosures of risk to Iowa investors at the time of the initial offer to sell a viatical settlement investment contract. These disclosures must be preceded by the following caption, which must be in bold, 16-point typeface:

**IMPORTANT RISK DISCLOSURE INFORMATION—READ BEFORE SIGNING ANY  
VIATICAL SETTLEMENT INVESTMENT CONTRACT.**

The disclosure must include, at a minimum, the following information:

1. That the actual annual rate of return on any viatical settlement investment contract is dependent upon an accurate projection of the viator’s life expectancy and the actual date of the viator’s death and that an annual “guaranteed” rate of return is not possible;
2. Whether, after purchasing the viatical settlement investment contract, the investor will be responsible for payment of premiums on the contract if the viator lives longer than projected and if the investor will be responsible for such premiums, the amount of the premium payment and any resulting negative effect on the investor’s return;
3. Whether any premium payments on the contract have been escrowed and, if so, the date upon which the escrowed funds will be depleted, who is responsible for payment of premiums after depletion of the funds, and, if applicable, the amount of the premiums;
4. Whether any premium payments on the contract have been waived, whether the investor will be responsible for payment of the premiums if the insurer who wrote the policy terminates the waiver after purchase, and, if applicable, the amount of the premiums;
5. Whether the investor is responsible for payment of premiums on the contract if the viator returns to health and, if applicable, the amount of the premiums;
6. Whether the investor is entitled to all or part of the investor’s investment under the contract if the viator’s underlying policy is later determined to be null and void;
7. Whether the insurance policy is a group policy and, if so, the special risks associated with group policies including, but not limited to, whether the investor is responsible for payment of additional premiums if the policies are sold or converted;

8. Whether the insurance policy is term insurance and, if so, the special risks associated with term insurance including, but not limited to, whether the investor is responsible for additional premium costs if the viator continues the term policy at the end of the current term;

9. Whether the investor will be the beneficiary or owner of the insurance policy and, if the investor is the beneficiary, the special risks associated with beneficiary status;

10. Whether the insurance policy is contestable and, if so, the special risks associated with contestability including, but not limited to, the risk that the investor will have no claim or only a partial claim to death benefits should the insurer cancel the policy within the contestability period;

11. Who is making the projection of the viator's life expectancy, the information upon which the projection is based, and the relationship of the projection maker to the issuer;

12. Who is monitoring the viator's condition, how often the monitoring is done, how the date of death is determined, and how and when this information will be transmitted to the investor;

13. Whether the insurer who wrote the viator's underlying policy has any additional rights which could negatively affect or extinguish the investor's rights under the viatical settlement investment contract, what these rights are, and under what conditions these rights are activated;

14. That a viatical settlement investment contract is not a liquid investment and that there is no established secondary market for resale of these products by the investor;

15. That the investor will receive no returns (i.e., dividends and interest) until the viator dies; and

16. That the investor may lose all benefits or receive substantially reduced benefits if the insurer goes out of business during the term of the viatical investment.

This rule is intended to implement Iowa Code sections 502.102, 502.201(9E) and 502.301.

#### **191—50.112(502) Advertising of viatical settlement investment contracts.**

**50.112(1)** The issuer and agent shall file all viatical settlement investment contract advertisements with the administrator at least ten business days prior to the date of use or a shorter period as the administrator may permit. The administrator shall mark the advertisements with allowance for use or expressly disapprove them during this time frame. The advertisement shall not be used in Iowa until a copy thereof, marked with allowance for use, has been received from the administrator.

**50.112(2)** Viatical settlement investment contract advertisements shall contain no more than the following:

*a.* The name of the issuer;

*b.* The address and telephone number of the issuer;

*c.* A brief description of the security, including minimum purchase requirements and liquidity aspects;

*d.* If a rate of return is advertised, it must be stated as the annual average rate of return, with a disclaimer that this is an annual average rate of return, that individual investor rates of return will vary based upon the viator's projected and actual date of death, and that an annual rate of return on a viatical settlement investment contract cannot be guaranteed;

*e.* The name, address and telephone number of the agent of the issuer authorized to sell the viatical settlement investment contracts;

*f.* A statement that the advertisement is neither an offer to sell nor a solicitation of an offer to purchase and that any offer or solicitation may only be made by providing a disclosure document; and

*g.* How a copy of the disclosure document may be obtained.

**50.112(3)** Notwithstanding the provisions of rule 191—50.69(502), certain viatical settlement investment contract advertisements may be deemed false and misleading on their face by the administrator and are prohibited pursuant to Iowa Code sections 502.501 and 502.504. False and misleading viatical settlement investment contract advertisements include, but are not limited to, the following representations:

*a.* "Fully secured," "100% secured," "fully insured," "secure," "safe," "backed by rated insurance company(ies)," "backed by federal law," "backed by state law," or similar representations;

*b.* "No risk," "minimal risk," "low risk," "no speculation," "no fluctuation," or similar representations;

- c. “Qualified or approved for IRA, Roth IRA, 401K, SEP, 403B, Keogh plans, TSA, other retirement account rollovers,” “tax deferred,” or similar representations;
- d. “Guaranteed fixed return,” “guaranteed annual return,” “guaranteed principal,” “guaranteed earnings,” “guaranteed profits,” “guaranteed investment,” or similar representations;
- e. “No sales charges or fees” or similar representations;
- f. “High yield,” “superior return,” “excellent return,” “high return,” “quick profit,” or similar representations;
- g. “Perfect investment,” “proven investment,” or similar representations;
- h. Purported favorable representations or testimonials about the benefits of viaticals as an investment, taken out of context from newspapers, trade papers, journals, radio or television programs, or any other form of print or electronic media.

**50.112(4)** For purposes of this rule, the term “advertisement” includes any written, electronic or printed communication or any communication by means of recorded telephone messages or transmitted on radio, television, the Internet, or similar communications media, including filmstrips, motion pictures, and videos, published in connection with the offer or sale of a viatical settlement investment contract.

This rule is intended to implement Iowa Code sections 502.102, 502.301, and 502.504.

**191—50.113(502) Duty to disclose.** Issuers and agents equally share an affirmative duty to disclose all relevant and material information to prospective investors in viatical settlement investment contracts. The required disclosure is the registration statement required by Iowa Code section 502.304 which has been reviewed and made effective by the administrator.

This rule is intended to implement Iowa Code sections 502.102 and 502.201(9E).

[Filed 8/1/63; amended 5/18/71, 7/3/75]

[Filed 1/13/76, Notice 11/17/75—published 1/26/76, effective 3/1/76<sup>1</sup>]

[Filed 8/30/76, Notice 7/26/76—published 9/8/76, effective 10/13/76]

[Filed 12/30/82, Notice 10/27/82—published 1/19/83, effective 2/24/83]

[Filed emergency 7/15/83—published 8/3/83, effective 7/15/83]

[Filed 8/27/85, Notice 7/17/85—published 9/25/85, effective 10/30/85]

[Editorially transferred from [510] to [191], IAC Supp. 10/22/86; see IAB 7/30/86]

[Filed 10/17/86, Notice 9/10/86—published 11/5/86, effective 12/10/86]<sup>◇</sup>

[Filed 9/18/87, Notice 8/12/87—published 10/7/87, effective 11/11/87]

[Filed 12/28/87, Notice 10/7/87—published 1/13/88, effective 2/17/88]

[Filed emergency 6/24/88—published 7/13/88, effective 7/1/88]

[Filed emergency 9/30/88—published 10/19/88, effective 11/1/88]

[Filed 12/22/88, Notice 11/16/88—published 1/11/89, effective 2/15/89]

[Filed 9/29/89, Notice 7/12/89—published 10/18/89, effective 11/22/89]

[Filed 12/21/90, Notice 6/27/90—published 1/9/91, effective 2/13/91]

[Filed emergency 6/21/91—published 7/10/91, effective 6/21/91]<sup>◇</sup>

[Filed 2/14/92, Notice 12/25/91—published 3/4/92, effective 4/8/92]

[Filed 2/28/92, Notice 12/11/91—published 3/18/92, effective 4/22/92]

[Filed 2/28/92, Notice 12/25/91—published 3/18/92, effective 4/22/92]

[Filed 10/23/92, Notice 9/16/92—published 11/11/92, effective 12/16/92]<sup>◇</sup>

[Filed 4/30/93, Notice 3/17/93—published 5/26/93, effective 6/30/93]

[Filed 7/2/93, Notice 4/14/93—published 7/21/93, effective 8/25/93]

[Filed 12/30/93, Notice 7/21/93—published 1/19/94, effective 2/28/94]

[Filed 9/16/94, Notice 8/3/94—published 10/12/94, effective 11/16/94]

[Filed without Notice 10/20/94—published 11/9/94, effective 12/14/94]

[Filed 3/24/95, Notice 2/15/95—published 4/12/95, effective 5/17/95]

[Filed 6/16/95, Notice 2/15/95—published 7/5/95, effective 8/9/95]

[Filed 2/22/96, Notice 1/17/96—published 3/13/96, effective 4/17/96]

[Filed 7/25/96, Notice 6/19/96—published 8/14/96, effective 9/18/96]

[Filed 10/31/96, Notice 9/25/96—published 11/20/96, effective 12/25/96]

[Filed 2/19/97, Notice 1/15/97—published 3/12/97, effective 4/16/97]  
[Filed 5/2/97, Notice 3/26/97—published 5/21/97, effective 6/25/97]  
[Filed 7/23/97, Notice 6/18/97—published 8/13/97, effective 9/17/97]  
[Filed 1/23/98, Notice 12/17/97—published 2/11/98, effective 3/18/98]  
[Filed 7/22/98, Notice 6/17/98—published 8/12/98, effective 9/16/98]  
[Filed 10/30/98, Notice 9/23/98—published 11/18/98, effective 12/23/98]  
[Filed 3/5/99, Notice 12/16/98—published 3/24/99, effective 4/28/99]  
[Filed 4/16/99, Notice 12/16/98—published 5/5/99, effective 6/9/99]  
[Filed 4/30/99, Notice 12/16/98—published 5/19/99, effective 6/23/00]  
[Filed 11/24/99, Notice 9/22/99—published 12/15/99, effective 1/19/00]  
[Filed 1/5/00, Notice 8/11/99—published 1/26/00, effective 3/1/00]  
[Filed 5/24/01, Notice 4/4/01—published 6/13/01, effective 7/18/01]  
[Filed 8/31/01, Notice 7/25/01—published 9/19/01, effective 11/1/01]  
[Filed 8/2/02, Notice 6/26/02—published 8/21/02, effective 9/25/02]  
[Filed 6/1/07, Notice 4/11/07—published 6/20/07, effective 7/25/07]  
[Filed 11/29/07, Notice 10/10/07—published 12/19/07, effective 1/23/08]  
[Filed 10/30/08, Notice 9/24/08—published 11/19/08, effective 12/24/08]  
[Filed ARC 9169B (Notice ARC 9010B, IAB 8/11/10), IAB 10/20/10, effective 11/24/10]  
[Filed ARC 1076C (Notice ARC 0716C, IAB 5/1/13), IAB 10/2/13, effective 11/6/13]

<sup>0</sup> Two or more ARCs

<sup>1</sup> Objection to rules 50.19 and 50.44, see IAC Supplement 3/8/76



CHAPTER 8  
PROFESSIONAL CONDUCT OF LICENSEES

[Prior to 11/14/01, see 193C—Chapter 4]

**193C—8.1(542B) General statement.** In order to establish and maintain a high standard of integrity, skills and practice in the professions of engineering and land surveying, and to safeguard the life, health, property and welfare of the public, the following code of professional conduct shall be binding upon every person holding a certificate of licensure as a professional engineer or professional land surveyor in this state. The code of professional conduct is an exercise of the police power vested in the board by the Acts of the legislature.

[ARC 0362C, IAB 10/3/12, effective 11/7/12]

**193C—8.2(542B) Code of professional conduct.** All persons licensed under Iowa Code chapter 542B are charged with having knowledge of the existence of this code of professional conduct and shall be expected to be familiar with its provisions, to understand them, and to abide by them. Such knowledge includes the understanding that the practices of engineering and land surveying are a privilege, as opposed to a right, and the licensee shall be forthright and candid in statements or written response to the board or its representatives on matters pertaining to professional conduct.

**8.2(1) Responsibility to the public.** Licensees shall conduct their professional practices in a manner that will protect life, health and property and enhance the public welfare. If their professional judgment is overruled under circumstances where safety, health and welfare of the public are endangered, they shall inform their employer or client of the possible consequences, notify such other proper authority as may be appropriate, and withdraw from further services on the project.

Licensees shall neither approve nor certify engineering or land surveying documents that may be harmful to the public health and welfare and that are not in conformity with accepted engineering or land surveying standards.

**8.2(2) Competency for assignments.** Licensees shall undertake to perform engineering or land surveying assignments only when qualified by education or experience in the specific technical field of professional engineering or professional land surveying involved. Licensees shall engage experts or advise that experts and specialists be engaged whenever the client's or employer's interests are best served by such service.

Licensees may accept an assignment on a project requiring education or experience outside their field of competence, but only to the extent that their services are restricted to those phases of the project in which they are qualified. All other phases of such projects shall be performed by qualified associates, consultants or employees.

**8.2(3) Truth in reports and testimony.** Licensees, when serving as expert or technical witnesses before any court, commission, or other tribunal, shall express an opinion only when it is founded upon adequate knowledge of the facts in issue, upon a background of technical competence in the subject matter, and upon honest conviction of the accuracy and propriety of their testimony. Under these circumstances, the licensee must disclose inadequate knowledge.

Licensees shall be objective and truthful in all professional reports, statements or testimony. All relevant and pertinent information shall be included in such reports, statements or testimony. Licensees shall avoid the use of statements containing a material misrepresentation of fact or omitting a material fact.

**8.2(4) Conflict of interest.** The following guidelines regarding conflict of interest shall apply:

*a.* Licensees shall not issue statements, criticisms or arguments on engineering or land surveying matters connected with public policy which are influenced or paid for by an interested party, or parties, unless they have prefaced their comments by explicitly identifying themselves, by disclosing the identities of the party or parties on whose behalf they are speaking, and by revealing the existence of any pecuniary interest.

*b.* Licensees shall avoid all known conflicts of interest with their employers or clients and, when unforeseen conflicts arise, shall promptly inform their employers or clients of any business association, interest, or circumstances that could influence judgment or the quality of services.

c. Licensees shall not accept compensation, financial or otherwise, from more than one party for services on the same project, unless the circumstances are fully disclosed and agreed to by all interested parties.

d. Licensees shall act in professional matters for each employer or client as faithful agents or trustees and maintain full confidentiality on all matters in which the welfare of the public is not endangered.

**8.2(5) Ethics.** Licensees shall conduct their business and professional practices of engineering and land surveying in an ethical manner. In addition to the provisions of this chapter, the board will consider, although not necessarily be bound by, the ethical standards that address public protection issues adopted by a recognized state or national engineering or land surveying organization such as the National Society of Professional Engineers and the National Society of Professional Surveyors.

**8.2(6) Unethical or illegal conduct.**

a. *Business practices.* The following guidelines regarding unethical or illegal business practices shall apply:

(1) Licensees shall not pay or offer to pay, either directly or indirectly, any commission, percentage, brokerage fee, political contribution, gift, or other consideration to secure work, except to a bona fide employee or bona fide, established commercial or marketing agency retained by them or to secure positions through employment agencies.

(2) Licensees, as employers, shall not engage in any discriminatory practice prohibited by law and shall, in the conduct of their business, employ personnel upon the basis of merit.

(3) Licensees shall not solicit or accept gratuities, directly or indirectly, from contractors, their agents, or other parties dealing with their clients or employers in connection with work for which they are responsible.

(4) Licensees shall not solicit or accept an engineering or land surveying contract from a governmental body when a principal or officer of the licensee's organization serves as an elected, appointed, voting or nonvoting member of the same governmental body which is letting the contract. For purposes of this subparagraph, "governmental body" means a board, council, commission, or similar multimembered body.

(5) Licensees shall not associate with, or permit the use of their names or firms in a business venture by, any person or firm that they know, or have reason to believe, is engaging in business or professional practice of a fraudulent or dishonest nature.

(6) Brochures or other presentations incident to the solicitation of employment shall not misrepresent pertinent facts concerning employers, employees, associates, firms, joint ventures, or past accomplishments.

(7) When a licensee's organization or a principal, officer, other member, or employee of the licensee's organization has review authority over the engineering or land surveying projects performed by private contractors within the jurisdiction of a governmental body, the licensee shall not solicit or accept a private engineering or land surveying contract that falls under the review services performed for that governmental body. The purpose of this paragraph is to avoid a circumstance in which a licensee may be called upon to review on behalf of a governmental body the engineering or land surveying services performed by the licensee's own organization.

However, if the licensee exercising review authority does so as a member of a multimembered body with review authority, the conflict of interest may be addressed by the disqualification or recusal of the licensee when engineering or land surveying services of the licensee's organization are under review. In that circumstance, the solicitation or acceptance of a private engineering or land surveying contract by the licensee's organization would not be in violation of this rule.

b. *Individual professional conduct.* The following guidelines regarding illegal or unethical individual professional conduct shall apply:

(1) Licensees shall not use association with nonengineers, corporations or partnerships as "cloaks" for unethical acts.

(2) Licensees shall not violate any local, state or federal criminal law in the conduct of professional practice.

- (3) Licensees shall not violate licensure laws of any state or territory.
- (4) Licensees shall not affix their signatures or seals to any plans, plats or documents dealing with subject matter in which those licensees lack competence, nor to any plan, plat or document not prepared under their direct personal direction and control.
- (5) Licensees shall not falsify their qualifications or permit misrepresentation of their or their associates' qualifications. They shall not misrepresent or exaggerate their responsibility in or for the subject matter of prior assignments.

*c. Real property inspection reports.*

- (1) Licensees shall not represent themselves as licensed professional land surveyors or professional engineers on real property inspection reports (i.e., mortgage surveys).
- (2) Licensees shall not place their firm names, logos, or title blocks on real property inspection reports (i.e., mortgage surveys).

[ARC 0362C, IAB 10/3/12, effective 11/7/12; ARC 0470C, IAB 11/28/12, effective 1/2/13; ARC 1084C, IAB 10/2/13, effective 11/6/13]

**193C—8.3(542B) Reporting of acts or omissions.** Licensees shall report acts or omissions by a licensee that constitute negligence or carelessness. For the purposes of these rules, “negligence or carelessness” means demonstrating unreasonable lack of skill in the performance of engineering or land surveying services by failure of a licensee to maintain a reasonable standard of care in the licensee’s practice of engineering or land surveying. In the evaluation of reported acts or omissions, the board shall determine if the engineer or land surveyor has applied learning, skill and ability in a manner consistent with the standards of the professions ordinarily possessed and practiced in the same profession at the same time. Standards referred to in the immediately preceding sentence shall include any minimum standards adopted by this board and any standards adopted by recognized national or state engineering or land surveying organizations.

**193C—8.4(542B) Standards of integrity.**

- 1. Licensees shall answer all questions of a duly constituted investigative body of the state of Iowa concerning alleged violations by another person or firm.
- 2. When proven wrong, licensees shall admit and accept their own errors and shall not distort or alter the facts to justify their own decisions.
- 3. If licensees know or have reason to believe that another person or firm may be in violation of any Iowa law or rule regarding ethics or conduct of professional engineering or professional land surveying practice, those licensees shall present such information to the engineering and land surveying examining board in writing and shall cooperate with the board in furnishing further information or assistance required by the board.
- 4. Licensees shall not assist in the application of an individual they know is unqualified for licensure by reason of education, experience or character.

[ARC 0362C, IAB 10/3/12, effective 11/7/12]

**193C—8.5(542B) Engineering and land surveying services offered by business entities.**

**8.5(1) Purpose of rule.** The purpose of this rule is to protect the public from misleading or deceptive advertising by business entities that hold themselves out to the public as providing professional engineering or professional land surveying services and to guard against the unlicensed practice of professional engineering or professional land surveying by persons who are not properly licensed to perform such services in the state of Iowa. This rule shall not be construed as restricting truthful advertising by business entities that appropriately place professional engineers or professional land surveyors in responsible charge of the professional services offered to and performed for the public.

**8.5(2) Definitions.** For purposes of this rule, the following definitions shall apply:

“*Business entity*” shall include corporations, partnerships, limited liability companies, persons using fictitious or assumed names, or any other form of entity which may conduct business.

“*In responsible charge*” means having direct control of and personal supervision over any professional land surveying work or work involving the practice of professional engineering. One

or more persons, jointly or severally, may be in responsible charge. Indicia of being “in responsible charge” include:

1. Obtaining or setting the project or service parameters or criteria.
2. Dictating the manner and methods by which professional services are performed.
3. Establishing procedures for quality control and authority over professional services in a manner that ensures that the professional licensee is in control of the work and of all individuals performing the work under the licensee’s supervision.
4. Spending sufficient time directly performing the work or directly supervising the work to ensure that the licensee is familiar with all significant details of the work.
5. Maintaining familiarity with the capabilities and methods of the persons performing professional services, and providing adequate training for all persons working under the licensee’s direct supervision.
6. Sustaining readily accessible contact with all persons performing professional services by direct physical proximity, or as appropriate in the licensee’s professional judgment, by frequent communication, in clear and complete verbal and visual form, of information about the work being performed.
7. Specifically pertaining to land surveying, reviewing all field evidence and making all final decisions concerning the placement of survey monuments and surveyed lines.

“*Professional services*” shall include professional engineering and professional land surveying services, as defined in Iowa Code sections 542B.2(5) and (8) and 542B.27, as applicable to the fact situation at issue.

**8.5(3) *General rule.*** Business entities offering professional services to the public must be owned, managed, or appropriately staffed by one or more professional engineers or professional land surveyors, as applicable, who are in responsible charge of all professional services offered and performed.

**8.5(4) *Appropriate staffing.*** The nature and extent of appropriate staffing by licensed professionals is necessarily a fact-based determination dependent on such factors as the nature and volume of professional services offered and performed, the risk of unlicensed practice, the impact of the professional services on the life, health and safety of the public and the public’s property, and the representations made to the public. While the legal nature of the business entity’s relationship (e.g., owner, manager, employee) with a licensed professional engineer or professional land surveyor is not necessarily determinative, licensed professionals must be in responsible charge of all professional services offered and performed.

**8.5(5) *Professional engineering or professional land surveying firms.*** Business entities holding themselves out to the public as professional engineering or professional land surveying firms cannot satisfy the requirements of this rule solely by retaining, through employment or contract, a licensed professional on an as-needed, occasional or consulting basis. Such an arrangement fosters unlicensed practice by the unlicensed owners or managers who place themselves in charge of determining when a licensed professional is needed. When a business entity conveys to the public that it is organized as a firm of licensed professionals, the public has a right to expect that the firm retains the full-time services of one or more licensed professionals. “Full-time” in this context is not measured by hours, but by a licensee’s sustained, meaningful, and effective, direct supervision of all professional services performed, whether the firm performs services, for example, 20 hours per month or 80 hours per week.

**8.5(6) *Restricted services.*** Business entities that do not generally hold themselves out to the public as professional engineering or professional land surveying firms, but that do offer some type of professional engineering or professional land surveying service, shall be appropriately staffed by licensed professionals in a manner that (a) corresponds with the representations made to the public, (b) places licensed professionals in responsible charge of all professional services performed, and (c) guards against the unlicensed practice of professional engineering or professional land surveying.

**8.5(7) *Permitted practices.***

*a.* Nothing in this rule is intended to prevent an individual or business entity from truthfully offering services as a project manager, administrator, or coordinator of a multidisciplinary project.

*b.* Nothing in this rule shall prevent a joint venture arrangement between an engineering or land surveying firm and a business entity that is not owned, managed, or staffed by professional engineers

or professional land surveyors, in which the venturing entities jointly and truthfully offer professional engineering or professional land surveying services on a project-by-project basis. Licensed professional engineers and professional land surveyors who participate in such arrangements shall ensure that the public is accurately informed as to the nature of all professional services to be performed and by whom the services will be performed.

**8.5(8) Remedies against licensees.** Licensed professional engineers or professional land surveyors who aid and abet the unlicensed offering or practice of professional engineering or professional land surveying, or who otherwise knowingly participate in a business entity that does not comply with this rule, are engaging in unethical practices that are harmful or detrimental to the public and are subject to disciplinary action by the board.

**8.5(9) Remedies against business entities and unlicensed individuals.** Pursuant to Iowa Code section 542B.27, the board may by order impose civil penalties against any business entity or unlicensed individual that offers or performs professional services in violation of Iowa Code chapter 542B. The board shall apply the guidelines set forth in this rule in determining whether a violation exists and in establishing an appropriate civil penalty. Civil penalties may not exceed \$1000 for each offense. Each day of a continued violation constitutes a separate offense. In addition to a civil penalty or as an alternative to such remedy, the board may seek an injunction in district court to prevent future violations by business entities or by licensed or unlicensed individuals.

[ARC 0362C, IAB 10/3/12, effective 11/7/12]

These rules are intended to implement Iowa Code sections 542B.6, 542B.21 and 542B.26 and chapter 272C.

[Filed 12/8/78, Notice 8/9/78—published 12/27/78, effective 1/31/79]

[Filed 1/4/79, Notice 10/18/78—published 1/24/79, effective 2/28/79]

[Filed 7/20/79, Notice 4/18/79—published 8/8/79, effective 9/12/79]

[Filed 12/21/84, Notice 7/18/84—published 1/16/85, effective 2/20/85]

[Filed 9/5/85, Notice 7/31/85—published 9/25/85, effective 10/30/85]

[Filed 5/13/88, Notice 3/9/88—published 6/1/88, effective 7/6/88]

[Filed 11/4/91, Notice 8/21/91—published 11/27/91, effective 1/1/92]

[Filed 9/24/93, Notice 8/18/93—published 10/13/93, effective 11/17/93]

[Filed 6/3/94, Notice 3/30/94—published 6/22/94, effective 7/27/94]

[Filed 11/4/94, Notice 6/22/94—published 11/23/94, effective 12/28/94]

[Filed 5/2/96, Notice 1/3/96—published 5/22/96, effective 6/26/96]

[Filed 3/6/97, Notice 11/20/96—published 3/26/97, effective 4/30/97]

[Filed 2/6/98, Notice 12/3/97—published 2/25/98, effective 4/1/98]

[Filed 10/1/98, Notice 8/12/98—published 10/21/98, effective 11/25/98]

[Filed 4/15/99, Notice 3/10/99—published 5/5/99, effective 6/9/99]

[Filed 7/23/99, Notice 6/16/99—published 8/11/99, effective 9/15/99]

[Filed 10/24/01, Notice 8/8/01—published 11/14/01, effective 1/1/02]

[Filed 5/31/06, Notice 3/15/06—published 6/21/06, effective 7/26/06]

[Filed ARC 0362C (Notice ARC 0156C, IAB 6/13/12), IAB 10/3/12, effective 11/7/12]

[Filed ARC 0470C (Notice ARC 0264C, IAB 8/8/12), IAB 11/28/12, effective 1/2/13]

[Filed ARC 1084C (Notice ARC 0928C, IAB 8/7/13), IAB 10/2/13, effective 11/6/13]



**HUMAN SERVICES DEPARTMENT[441]**

Rules transferred from Social Services Department[770] to Human Services Department[498],  
see 1983 Iowa Acts, Senate File 464, effective July 1, 1983.

Rules transferred from agency number [498] to [441] to conform with the reorganization  
numbering scheme in general, IAC Supp. 2/11/87.

## TITLE I

## GENERAL DEPARTMENTAL PROCEDURES

## CHAPTER 1

## DEPARTMENTAL ORGANIZATION AND PROCEDURES

- 1.1(17A) Director
- 1.2(17A) Council
- 1.3(17A) Organization at state level
- 1.4(17A) Field operations structure
- 1.5 Reserved
- 1.6(17A) Mental health and developmental disabilities commission
- 1.7(17A) Governor's developmental disabilities council (governor's DD council)
- 1.8(17A,217) Waivers of administrative rules (hereinafter referred to as exceptions to policy)
- 1.9 Reserved
- 1.10(17A,514I) HAWK-I board

## CHAPTER 2

CONTRACTING OUT DEPARTMENT OF HUMAN SERVICES  
EMPLOYEES AND PROPERTY

- 2.1(23A,225C) Definitions
- 2.2(23A,225C) Contracts for use of the services of department employees
- 2.3(23A,225C) Contract provisions
- 2.4(23A,225C) Leasing of space at state institutions
- 2.5(23A,225C) Requirements prior to leasing

## CHAPTER 3

## DEPARTMENT PROCEDURE FOR RULE MAKING

- 3.1(17A) Applicability
- 3.2(17A) Advice on possible rules before notice of proposed rule adoption
- 3.3(17A) Public rule-making docket
- 3.4(17A) Notice of proposed rule making
- 3.5(17A) Public participation
- 3.6(17A) Regulatory analysis
- 3.7(17A,25B) Fiscal impact statement
- 3.8(17A) Time and manner of rule adoption
- 3.9(17A) Variance between adopted rule and published notice of proposed rule adoption
- 3.10(17A) Exemptions from public rule-making procedures
- 3.11(17A) Concise statement of reasons
- 3.12(17A) Contents, style, and form of rule
- 3.13(17A) Department rule-making record
- 3.14(17A) Filing of rules
- 3.15(17A) Effectiveness of rules prior to publication
- 3.16(17A) Review by department of rules

## CHAPTER 4

## PETITIONS FOR RULE MAKING

- 4.1(17A) Petition for rule making
- 4.2(17A) Briefs

- 4.3(17A) Inquiries
- 4.4(17A) Agency consideration

CHAPTER 5  
DECLARATORY ORDERS

- 5.1(17A) Petition for declaratory order
- 5.2(17A) Notice of petition
- 5.3(17A) Intervention
- 5.4(17A) Briefs
- 5.5(17A) Inquiries
- 5.6(17A) Service and filing of petitions and other papers
- 5.7(17A) Consideration
- 5.8(17A) Action on petition
- 5.9(17A) Refusal to issue order
- 5.10(17A) Contents of declaratory order—effective date
- 5.11(17A) Copies of orders
- 5.12(17A) Effect of a declaratory order

CHAPTER 6  
Reserved

CHAPTER 7  
APPEALS AND HEARINGS

- 7.1(17A) Definitions
- 7.2 Reserved
- 7.3(17A) Presiding officer
- 7.4(17A) Notification of hearing procedures
- 7.5(17A) The right to appeal
- 7.6(17A) Informing persons of their rights
- 7.7(17A) Notice of intent to approve, deny, terminate, reduce, or suspend assistance or deny reinstatement of assistance
- 7.8(17A) Opportunity for hearing
- 7.9(17A) Continuation of assistance pending a final decision on appeal
- 7.10(17A) Procedural considerations
- 7.11(17A) Information and referral for legal services
- 7.12(17A) Subpoenas
- 7.13(17A) Rights of appellants during hearings
- 7.14(17A) Limitation of persons attending
- 7.15(17A) Medical examination
- 7.16(17A) The appeal decision
- 7.17(17A) Exhausting administrative remedies
- 7.18(17A) Ex parte communication
- 7.19(17A) Accessibility of hearing decisions
- 7.20(17A) Right of judicial review and stays of agency action
- 7.21(17A) Food assistance hearings and appeals
- 7.22 Reserved
- 7.23(17A) Contested cases with no factual dispute
- 7.24(17A) Emergency adjudicative proceedings

CHAPTER 8  
PAYMENT OF SMALL CLAIMS

8.1(217) Authorization to reimburse

CHAPTER 9  
PUBLIC RECORDS AND FAIR  
INFORMATION PRACTICES

9.1(17A,22) Definitions  
 9.2(17A,22) Statement of policy  
 9.3(17A,22) Requests for access to records  
 9.4(17A,22) Access to confidential records  
 9.5(17A,22) Requests for treatment of a record as a confidential record and its withholding from examinations  
 9.6(17A,22) Procedure by which additions, dissents, or objections may be entered into certain records  
 9.7(17A,22,228) Consent to disclosure by the subject of a confidential record  
 9.8(17A,22) Notice to suppliers of information  
 9.9(17A,22) Release to subject  
 9.10(17A,22) Use and disclosure without consent of the subject  
 9.11(22) Availability of records  
 9.12(22,252G) Personally identifiable information  
 9.13(217) Distribution of informational materials  
 9.14(17A,22) Special policies and procedures for protected health information  
 9.15(17A,22) Person who may exercise rights of the subject

CHAPTER 10  
Reserved

CHAPTER 11  
COLLECTION OF PUBLIC ASSISTANCE DEBTS

11.1(217) Definitions  
 11.2(217) Establishment of claim  
 11.3(217) Application of payment  
 11.4(217) Setoff against state income tax refund, rebate, or other state payments, including, for example, state employee wages  
 11.5(234) Setoff against federal income tax refund or other federal payments, including, for example, federal employee wages

CHAPTER 12  
VOLUNTEER SERVICES

12.1(234) Definition  
 12.2(234) Allocation of block grant funds  
 12.3(234) Requirements for volunteers  
 12.4(234) Volunteer service programs  
 12.5(234) Services and benefits available to volunteers

CHAPTER 13  
PROGRAM EVALUATION

13.1(234,239B,249A) Definitions  
 13.2(234,239B,249A) Review of public assistance records by the department  
 13.3(234,239B,249A) Who shall be reviewed  
 13.4(234,239B,249A) Notification of review  
 13.5(234,239B,249A) Review procedure

- 13.6(234,239B,249A) Failure to cooperate
- 13.7(234,239B,249A) Report of findings
- 13.8(234,239B,249A) Federal rereview

## CHAPTER 14

## OFFSET OF COUNTY DEBTS OWED DEPARTMENT

- 14.1(217,234) Definitions
- 14.2(217,234) Identifying counties with liabilities
- 14.3(217,234) List of counties with amounts owed
- 14.4(217,234) Notification to county regarding offset
- 14.5(217,234) Implementing the final decision
- 14.6(217,234) Offset completed

## CHAPTER 15

## RESOLUTION OF LEGAL SETTLEMENT DISPUTES

- 15.1(225C) Definitions
- 15.2(225C) Assertion of legal settlement dispute
- 15.3(225C) Response to dispute notification
- 15.4(225C) Contested case hearing
- 15.5(225C) Change in determination

TITLE II  
Reserved

## CHAPTERS 16 to 21

Reserved

TITLE III  
*MENTAL HEALTH*

## CHAPTER 22

STANDARDS FOR SERVICES TO PERSONS WITH MENTAL ILLNESS,  
CHRONIC MENTAL ILLNESS, MENTAL RETARDATION, DEVELOPMENTAL  
DISABILITIES, OR BRAIN INJURY

- 22.1(225C) Definitions
- 22.2(225C) Principles
- 22.3(225C) General guidelines for service delivery
- 22.4(225C) Services
- 22.5(225C) Compliance hearing

## CHAPTER 23

MENTAL HEALTH AND DISABILITY SERVICES  
REDESIGN TRANSITION FUND

- 23.1(225C,84GA,SF2315) Definitions
- 23.2(225C,84GA,SF2315) Eligibility
- 23.3(225C,84GA,SF2315) Application requirements
- 23.4(225C,84GA,SF2315) Guidelines for the management of transition funds
- 23.5(225C,84GA,SF2315) Allocation of transition funds

## CHAPTER 24

ACCREDITATION OF PROVIDERS OF SERVICES TO PERSONS WITH MENTAL ILLNESS,  
MENTAL RETARDATION, AND DEVELOPMENTAL DISABILITIES

- 24.1(225C) Definitions
- 24.2(225C) Standards for policy and procedures
- 24.3(225C) Standards for organizational activities

24.4(225C)	Standards for services
24.5(225C)	Accreditation
24.6(225C)	Deemed status
24.7(225C)	Complaint process
24.8(225C)	Appeal procedure
24.9(225C)	Exceptions to policy

CHAPTER 25  
DISABILITY SERVICES MANAGEMENT

DIVISION I  
DETERMINATION OF STATE PAYMENT AMOUNT

25.1 to 25.10	Reserved
---------------	----------

DIVISION II  
COUNTY MANAGEMENT PLAN

25.11(331)	Definitions
25.12(331)	County management plan—general criteria
25.13(331)	Policies and procedures manual
25.14(331)	Policies and procedures manual review
25.15(331)	Amendments
25.16(331)	Reconsideration
25.17(331)	Management plan annual review
25.18(331)	Strategic plan
25.19(331)	Technical assistance
25.20(331)	Consumer financial eligibility and payment responsibility
25.21 to 25.40	Reserved

DIVISION III  
MINIMUM DATA SET

25.41(331)	Minimum data set
25.42 to 25.50	Reserved

DIVISION IV  
INCENTIVE AND EFFICIENCY POOL FUNDING

25.51(77GA, HF2545)	Desired results areas
25.52(77GA, HF2545)	Methodology for applying for incentive funding
25.53(77GA, HF2545)	Methodology for awarding incentive funding
25.54(77GA, HF2545)	Subsequent year performance factors
25.55(77GA, HF2545)	Phase-in provisions
25.56 to 25.60	Reserved

DIVISION V  
RISK POOL FUNDING

25.61(426B)	Definitions
25.62(426B)	Risk pool board
25.63(426B)	Application process
25.64(426B)	Methodology for awarding risk pool funding
25.65(426B)	Repayment provisions
25.66(426B)	Appeals
25.67 to 25.70	Reserved

DIVISION VI  
TOBACCO SETTLEMENT FUND RISK POOL FUNDING

25.71(78GA, ch1221)	Definitions
25.72(78GA, ch1221)	Risk pool board
25.73(78GA, ch1221)	Rate-setting process
25.74(78GA, ch1221)	Application process

- 25.75(78GA,ch1221) Methodology for awarding tobacco settlement fund risk pool funding
- 25.76(78GA,ch1221) Repayment provisions
- 25.77(78GA,ch1221) Appeals
- 25.78 to 25.80 Reserved

DIVISION VII  
COMMUNITY MENTAL HEALTH CENTER WAIVER REQUEST

- 25.81(225C) Waiver request
- 25.82 to 25.90 Reserved

DIVISION VIII  
CRITERIA FOR EXEMPTING COUNTIES FROM JOINING INTO REGIONS TO ADMINISTER  
MENTAL HEALTH AND DISABILITY SERVICES

- 25.91(331) Exemption from joining into mental health and disability services region

CHAPTERS 26 and 27

Reserved

CHAPTER 28  
POLICIES FOR ALL INSTITUTIONS

- 28.1(218) Definitions
- 28.2(218,222) Selection of facility
- 28.3(222,230) Evidence of legal settlement
- 28.4(225C,229) Grievances
- 28.5(217,218) Photographing and recording of individuals and use of cameras
- 28.6(217,218) Interviews and statements
- 28.7(218) Use of grounds, facilities, or equipment
- 28.8(218) Tours of institution
- 28.9(218) Donations
- 28.10 and 28.11 Reserved
- 28.12(217) Release of confidential information
- 28.13(218) Applying county institutional credit balances

CHAPTER 29  
MENTAL HEALTH INSTITUTES

- 29.1(218) Catchment areas
- 29.2(218,229) Voluntary admissions
- 29.3(229,230) Certification of settlement
- 29.4(218,230) Charges for care
- 29.5(229) Authorization for treatment
- 29.6(217,228,229) Rights of individuals
- 29.7(218) Visiting

CHAPTER 30  
STATE RESOURCE CENTERS

- 30.1(218,222) Catchment areas
- 30.2(218,222) Admission
- 30.3(222) Certification of settlement
- 30.4(222) Liability for support
- 30.5(217,218,225C) Rights of individuals
- 30.6(218) Visiting

CHAPTER 31  
CIVIL COMMITMENT UNIT

31.1(229A)	Definitions
31.2(229A)	Visitation
31.3(229A)	Group visitation
31.4(229A)	Grievances
31.5(229A)	Photographing and recording individuals
31.6(229A)	Release of information
31.7(229A)	Communication with individuals
31.8(229A)	Building and grounds
31.9(8,218)	Gifts and bequests
31.10(229A)	Cost of care

CHAPTERS 32 and 33  
Reserved

CHAPTER 34  
ALTERNATIVE DIAGNOSTIC FACILITIES

34.1(225C)	Definitions
34.2(225C)	Function
34.3(225C)	Standards

CHAPTER 35  
Reserved

CHAPTER 36  
FACILITY ASSESSMENTS

DIVISION I  
ASSESSMENT FEE FOR INTERMEDIATE CARE FACILITIES FOR THE MENTALLY RETARDED

36.1(249A)	Assessment of fee
36.2(249A)	Determination and payment of fee for facilities certified to participate in the Medicaid program
36.3(249A)	Determination and payment of fee for facilities not certified to participate in the Medicaid program
36.4(249A)	Termination of fee assessment
36.5	Reserved

DIVISION II  
QUALITY ASSURANCE ASSESSMENT FOR NURSING FACILITIES

36.6(249L)	Assessment
36.7(249L)	Determination and payment of assessment
36.8 and 36.9	Reserved

DIVISION III  
HEALTH CARE ACCESS ASSESSMENT FOR HOSPITALS

36.10(249M)	Application of assessment
36.11(249M)	Determination and payment of assessment
36.12(249M)	Termination of health care access assessment

CHAPTER 37  
Reserved

## CHAPTER 38

## DEVELOPMENTAL DISABILITIES BASIC STATE GRANT

38.1(225C,217)	Definitions
38.2(225C,217)	Program eligibility
38.3(225C,217)	Application under competitive process
38.4(225C,217)	Competitive project awards
38.5(225C,217)	Sole source or emergency selection project awards
38.6(225C,217)	Field-initiated proposals
38.7(225C,217)	Notification
38.8(225C,217)	Request for reconsideration
38.9(225C,217)	Contracts
38.10	Reserved
38.11(225C,217)	Reallocation of funds
38.12(225C,217)	Conflict of interest policy

## CHAPTER 39

Reserved

## TITLE IV

*FAMILY INVESTMENT PROGRAM*

## CHAPTER 40

## APPLICATION FOR AID

## DIVISION I

## FAMILY INVESTMENT PROGRAM—CONTROL GROUP

40.1 to 40.20 Reserved

## DIVISION II

## FAMILY INVESTMENT PROGRAM—TREATMENT GROUP

40.21(239B)	Definitions
40.22(239B)	Application
40.23(239B)	Date of application
40.24(239B)	Procedure with application
40.25(239B)	Time limit for decision
40.26(239B)	Effective date of grant
40.27(239B)	Continuing eligibility
40.28(239B)	Referral for investigation

## CHAPTER 41

## GRANTING ASSISTANCE

## DIVISION I

FAMILY INVESTMENT PROGRAM—  
CONTROL GROUP

41.1 to 41.20 Reserved

## DIVISION II

## FAMILY INVESTMENT PROGRAM—TREATMENT GROUP

41.21(239B)	Eligibility factors specific to child
41.22(239B)	Eligibility factors specific to payee
41.23(239B)	Home, residence, citizenship, and alienage
41.24(239B)	Promoting independence and self-sufficiency through employment job opportunities and basic skills (PROMISE JOBS) program
41.25(239B)	Uncategorized factors of eligibility
41.26(239B)	Resources
41.27(239B)	Income
41.28(239B)	Need standards

41.29(239B) Composite FIP/SSI cases  
 41.30(239B) Time limits

## CHAPTER 42

Reserved

## CHAPTER 43 ALTERNATE PAYEES

### DIVISION I

#### FAMILY INVESTMENT PROGRAM—CONTROL GROUP

43.1 to 43.20 Reserved

### DIVISION II

#### FAMILY INVESTMENT PROGRAM—TREATMENT GROUP

43.21(239B) Conservatorship or guardianship

43.22 and 43.23 Reserved

43.24(239B) Emergency payee

## CHAPTER 44

Reserved

## CHAPTER 45

### PAYMENT

#### DIVISION I

#### FAMILY INVESTMENT PROGRAM—CONTROL GROUP

45.1 to 45.20 Reserved

#### DIVISION II

#### FAMILY INVESTMENT PROGRAM—TREATMENT GROUP

45.21(239B) Issuing payment

45.22(239B) Return

45.23(239B) Held warrants

45.24(239B) Underpayment

45.25(239B) Deceased payees

45.26(239B) Limitation on payment

45.27(239B) Rounding of need standard and payment amount

## CHAPTER 46

### OVERPAYMENT RECOVERY

#### DIVISION I

#### FAMILY INVESTMENT PROGRAM—CONTROL GROUP

46.1 to 46.20 Reserved

#### DIVISION II

#### FAMILY INVESTMENT PROGRAM—TREATMENT GROUP

46.21(239B) Definitions

46.22(239B) Monetary standards

46.23(239B) Notification and appeals

46.24(239B) Determination of overpayments

46.25(239B) Source of recoupment

46.26 Reserved

46.27(239B) Procedures for recoupment

46.28 Reserved

46.29(239B) Fraudulent misrepresentation of residence

CHAPTER 47  
DIVERSION INITIATIVES

DIVISION I  
PROMOTING AWARENESS OF THE BENEFITS OF A HEALTHY MARRIAGE

- 47.1(234) Eligibility criteria  
47.2(234) Notice and eligibility period  
47.3 to 47.20 Reserved

DIVISION II  
FAMILY SELF-SUFFICIENCY GRANTS PROGRAM

- 47.21(239B) Definitions  
47.22(239B) Availability of the family self-sufficiency grants program  
47.23(239B) General criteria  
47.24(239B) Assistance available in family self-sufficiency grants  
47.25(239B) Application, notification, and appeals  
47.26(239B) Approved local plans for family self-sufficiency grants

CHAPTERS 48 and 49  
Reserved

TITLE V  
*STATE SUPPLEMENTARY ASSISTANCE*

CHAPTER 50  
APPLICATION FOR ASSISTANCE

- 50.1(249) Definitions  
50.2(249) Application procedures  
50.3(249) Approval of application and effective date of eligibility  
50.4(249) Reviews  
50.5(249) Application under conditional benefits

CHAPTER 51  
ELIGIBILITY

- 51.1(249) Application for other benefits  
51.2(249) Supplementation  
51.3(249) Eligibility for residential care  
51.4(249) Dependent relatives  
51.5(249) Residence  
51.6(249) Eligibility for supplement for Medicare and Medicaid eligibles  
51.7(249) Income from providing room and board  
51.8(249) Furnishing of social security number  
51.9(249) Recovery

CHAPTER 52  
PAYMENT

- 52.1(249) Assistance standards

CHAPTER 53  
Reserved

CHAPTER 54  
FACILITY PARTICIPATION

- 54.1(249) Application and contract agreement  
54.2(249) Maintenance of case records  
54.3(249) Financial and statistical report

54.4(249)	Goods and services provided
54.5(249)	Personal needs account
54.6(249)	Case activity report
54.7(249)	Billing procedures
54.8(249)	Audits

TITLE VI  
*GENERAL PUBLIC ASSISTANCE PROVISIONS*

CHAPTERS 55 and 56  
Reserved

CHAPTER 57  
INTERIM ASSISTANCE REIMBURSEMENT

57.1(249)	Definitions
57.2(249)	Requirements for reimbursement
57.3(249)	Certificate of authority

CHAPTER 58  
EMERGENCY ASSISTANCE

DIVISION I  
IOWA DISASTER AID INDIVIDUAL ASSISTANCE GRANT PROGRAM

58.1(29C)	Definitions
58.2(29C)	Program implementation
58.3(29C)	Application for assistance
58.4(29C)	Eligibility criteria
58.5(29C)	Eligible categories of assistance
58.6(29C)	Eligibility determination and payment
58.7(29C)	Contested cases
58.8(29C)	Discontinuance of program
58.9 to 58.20	Reserved

DIVISION II  
FAMILY INVESTMENT PROGRAM—EMERGENCY ASSISTANCE

58.21 to 58.40	Reserved
----------------	----------

DIVISION III  
TEMPORARY MEASURES RELATED TO DISASTERS

58.41(217)	Purpose
58.42(234,237A,239B,249,249A,249J,514I)	Extension of scheduled reporting and review requirements
58.43(237A)	Need for child care services
58.44(249A,249J,514I)	Premium payments
58.45(249A)	Citizenship and identity
58.46 to 58.50	Reserved

DIVISION IV  
IOWANS HELPING IOWANS UNMET NEEDS DISASTER ASSISTANCE PROGRAM

58.51(234)	Definitions
58.52(234)	Program implementation
58.53(234)	Application for assistance
58.54(234)	Eligibility criteria
58.55(234)	Eligible categories of assistance
58.56(234)	Eligibility determination and payment
58.57(234)	Contested cases
58.58(234)	Discontinuance of program
58.59 and 58.60	Reserved

DIVISION V  
TICKET TO HOPE PROGRAM

58.61(234)	Definitions
58.62(234)	Application process
58.63(234)	Eligibility criteria
58.64(234)	Provider participation
58.65(234)	Provider reimbursement
58.66(234)	Reconsideration
58.67(234)	Appeal
58.68(234)	Discontinuance of program

CHAPTER 59  
Reserved

CHAPTER 60  
REFUGEE CASH ASSISTANCE

60.1(217)	Alienage requirements
60.2(217)	Application procedures
60.3(217)	Effective date of grant
60.4(217)	Accepting other assistance
60.5(217)	Eligibility factors
60.6(217)	Students in institutions of higher education
60.7(217)	Time limit for eligibility
60.8(217)	Criteria for exemption from registration for employment services, registration, and refusal to register
60.9(217)	Work and training requirements
60.10(217)	Uncategorized factors of eligibility
60.11(217)	Temporary absence from home
60.12(217)	Application
60.13(217)	Continuing eligibility
60.14(217)	Alternate payees
60.15(217)	Payment
60.16(217)	Overpayment recovery

CHAPTER 61  
REFUGEE SERVICES PROGRAM

61.1(217)	Definitions
61.2(217)	Authority
61.3(217)	Eligibility for refugee services
61.4(217)	Planning and coordinating the placement of refugees in advance of their arrival
61.5(217)	Services of the department available for refugees
61.6(217)	Provision of services
61.7(217)	Application for services
61.8(217)	Adverse service actions
61.9(217)	Client appeals
61.10(217)	Refugee sponsors
61.11(217)	Adverse actions regarding sponsor applications
61.12(217)	Administrative review of denial of sponsorship application
61.13(217)	Refugee resettlement moneys
61.14(217)	Unaccompanied refugee minors program
61.15(217,622A)	Interpreters and translators for legal proceedings
61.16(217)	Pilot recredentialing services

- 61.17(217) Targeted assistance grants
- 61.18(217) Iowa refugee services foundation

## CHAPTERS 62 to 64

Reserved

## TITLE VII

*FOOD PROGRAMS*

## CHAPTER 65

## FOOD ASSISTANCE PROGRAM ADMINISTRATION

## DIVISION I

- 65.1(234) Definitions
- 65.2(234) Application
- 65.3(234) Administration of program
- 65.4(234) Issuance
- 65.5(234) Simplified reporting
- 65.6(234) Delays in certification
- 65.7 Reserved
- 65.8(234) Deductions
- 65.9(234) Treatment centers and group living arrangements
- 65.10 Reserved
- 65.11(234) Discrimination complaint
- 65.12(234) Appeals
- 65.13(234) Joint processing
- 65.14 Reserved
- 65.15(234) Proration of benefits
- 65.16(234) Complaint system
- 65.17(234) Involvement in a strike
- 65.18 and 65.19 Reserved
- 65.20(234) Notice of expiration issuance
- 65.21(234) Claims
- 65.22(234) Verification
- 65.23(234) Prospective budgeting
- 65.24(234) Inclusion of foster children in household
- 65.25(234) Effective date of change
- 65.26(234) Eligible students
- 65.27(234) Voluntary quit or reduction in hours of work
- 65.28(234) Work requirements
- 65.29(234) Income
- 65.30(234) Resources
- 65.31(234) Homeless meal providers
- 65.32(234) Basis for allotment
- 65.33(234) Dependent care deduction
- 65.34 to 65.36 Reserved
- 65.37(234) Eligibility of noncitizens
- 65.38(234) Income deductions
- 65.39(234) Categorical eligibility
- 65.40 Reserved
- 65.41(234) Actions on changes increasing benefits
- 65.42 and 65.43 Reserved
- 65.44(234) Reinstatement
- 65.45 Reserved

65.46(234)	Disqualifications
65.47 to 65.49	Reserved
65.50(234)	No increase in benefits
65.51(234)	State income and eligibility verification system
65.52(234)	Systematic alien verification for entitlements (SAVE) program

#### CHAPTER 66

##### EMERGENCY FOOD ASSISTANCE PROGRAM

66.1(234)	Definitions
66.2(234)	Application to be a TEFAP contractor
66.3(234)	Contracts
66.4(234)	Distribution
66.5(234)	Household eligibility
66.6(234)	Reimbursement for allowable costs
66.7(234)	Commodity losses and claims
66.8(234)	State monitoring
66.9(234)	Limits on unrelated activities
66.10(234)	Complaints

#### CHAPTERS 67 to 74

##### Reserved

#### TITLE VIII

##### *MEDICAL ASSISTANCE*

#### CHAPTER 75

##### CONDITIONS OF ELIGIBILITY

#### DIVISION I

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

75.1(249A)	Persons covered
75.2(249A)	Medical resources
75.3(249A)	Acceptance of other financial benefits
75.4(249A)	Medical assistance lien
75.5(249A)	Determination of countable income and resources for persons in a medical institution
75.6(249A)	Entrance fee for continuing care retirement community or life care community
75.7(249A)	Furnishing of social security number
75.8(249A)	Medical assistance corrective payments
75.9(249A)	Treatment of Medicaid qualifying trusts
75.10(249A)	Residency requirements
75.11(249A)	Citizenship or alienage requirements
75.12(249A)	Inmates of public institutions
75.13(249A)	Categorical relatedness
75.14(249A)	Establishing paternity and obtaining support
75.15(249A)	Disqualification for long-term care assistance due to substantial home equity
75.16(249A)	Client participation in payment for medical institution care
75.17(249A)	Verification of pregnancy
75.18(249A)	Continuous eligibility for pregnant women
75.19(249A)	Continuous eligibility for children
75.20(249A)	Disability requirements for SSI-related Medicaid
75.21(249A)	Health insurance premium payment (HIPP) program
75.22(249A)	AIDS/HIV health insurance premium payment program
75.23(249A)	Disposal of assets for less than fair market value after August 10, 1993
75.24(249A)	Treatment of trusts established after August 10, 1993

75.25(249A)	Definitions
75.26	Reserved
75.27(249A)	AIDS/HIV settlement payments
75.28 to 75.49	Reserved

DIVISION II  
ELIGIBILITY FACTORS SPECIFIC TO COVERAGE GROUPS RELATED TO  
THE FAMILY MEDICAL ASSISTANCE PROGRAM (FMAP)

75.50(249A)	Definitions
75.51	Reserved
75.52(249A)	Continuing eligibility
75.53(249A)	Iowa residency policies specific to FMAP and FMAP-related coverage groups
75.54(249A)	Eligibility factors specific to child
75.55(249A)	Eligibility factors specific to specified relatives
75.56(249A)	Resources
75.57(249A)	Income
75.58(249A)	Need standards
75.59(249A)	Persons who may be voluntarily excluded from the eligible group when determining eligibility for the family medical assistance program (FMAP) and FMAP-related coverage groups
75.60(249A)	Pending SSI approval

CHAPTER 76  
ENROLLMENT AND REENROLLMENT

76.1(249A)	Definitions
76.2(249A)	Application with the department
76.3(249A)	Referrals from a health insurance marketplace
76.4(249A)	Express lane eligibility
76.5(249A)	Enrollment through SSI
76.6(249A)	Referral for Medicare savings program
76.7(249A)	Presumptive eligibility
76.8(249A)	Applicant responsibilities
76.9(249A)	Responsible persons and authorized representatives
76.10(249A)	Right to withdraw the application
76.11(249A)	Choice of electronic notifications
76.12(249A)	Application not required
76.13(249A)	Initial enrollment
76.14(249A)	Reenrollment
76.15(249A)	Report of changes
76.16(249A)	Action on information received
76.17(249A)	Automatic redetermination of eligibility

CHAPTER 77  
CONDITIONS OF PARTICIPATION FOR PROVIDERS  
OF MEDICAL AND REMEDIAL CARE

77.1(249A)	Physicians
77.2(249A)	Retail pharmacies
77.3(249A)	Hospitals
77.4(249A)	Dentists
77.5(249A)	Podiatrists
77.6(249A)	Optometrists
77.7(249A)	Opticians
77.8(249A)	Chiropractors
77.9(249A)	Home health agencies

77.10(249A)	Medical equipment and appliances, prosthetic devices and medical supplies
77.11(249A)	Ambulance service
77.12(249A)	Behavioral health intervention
77.13(249A)	Hearing aid dispensers
77.14(249A)	Audiologists
77.15(249A)	Community mental health centers
77.16(249A)	Screening centers
77.17(249A)	Physical therapists
77.18(249A)	Orthopedic shoe dealers and repair shops
77.19(249A)	Rehabilitation agencies
77.20(249A)	Independent laboratories
77.21(249A)	Rural health clinics
77.22(249A)	Psychologists
77.23(249A)	Maternal health centers
77.24(249A)	Ambulatory surgical centers
77.25(249A)	Home- and community-based habilitation services
77.26(249A)	Behavioral health services
77.27(249A)	Birth centers
77.28(249A)	Area education agencies
77.29(249A)	Case management provider organizations
77.30(249A)	HCBS health and disability waiver service providers
77.31(249A)	Occupational therapists
77.32(249A)	Hospice providers
77.33(249A)	HCBS elderly waiver service providers
77.34(249A)	HCBS AIDS/HIV waiver service providers
77.35(249A)	Federally qualified health centers
77.36(249A)	Advanced registered nurse practitioners
77.37(249A)	Home- and community-based services intellectual disability waiver service providers
77.38(249A)	Assertive community treatment
77.39(249A)	HCBS brain injury waiver service providers
77.40(249A)	Lead inspection agencies
77.41(249A)	HCBS physical disability waiver service providers
77.42(249A)	Public health agencies
77.43(249A)	Infant and toddler program providers
77.44(249A)	Local education agency services providers
77.45(249A)	Indian health service 638 facilities
77.46(249A)	HCBS children's mental health waiver service providers
77.47(249A)	Health home services providers
77.48(249A)	Speech-language pathologists
77.49(249A)	Physician assistants
77.50(249A)	Ordering and referring providers

## CHAPTER 78

AMOUNT, DURATION AND SCOPE OF  
MEDICAL AND REMEDIAL SERVICES

78.1(249A)	Physicians' services
78.2(249A)	Prescribed outpatient drugs
78.3(249A)	Inpatient hospital services
78.4(249A)	Dentists
78.5(249A)	Podiatrists
78.6(249A)	Optometrists

78.7(249A)	Opticians
78.8(249A)	Chiropractors
78.9(249A)	Home health agencies
78.10(249A)	Durable medical equipment (DME), prosthetic devices and medical supplies
78.11(249A)	Ambulance service
78.12(249A)	Behavioral health intervention
78.13(249A)	Nonemergency medical transportation
78.14(249A)	Hearing aids
78.15(249A)	Orthopedic shoes
78.16(249A)	Community mental health centers
78.17(249A)	Physical therapists
78.18(249A)	Screening centers
78.19(249A)	Rehabilitation agencies
78.20(249A)	Independent laboratories
78.21(249A)	Rural health clinics
78.22(249A)	Family planning clinics
78.23(249A)	Other clinic services
78.24(249A)	Psychologists
78.25(249A)	Maternal health centers
78.26(249A)	Ambulatory surgical center services
78.27(249A)	Home- and community-based habilitation services
78.28(249A)	List of medical services and equipment requiring prior authorization, preprocedure review or preadmission review
78.29(249A)	Behavioral health services
78.30(249A)	Birth centers
78.31(249A)	Hospital outpatient services
78.32(249A)	Area education agencies
78.33(249A)	Case management services
78.34(249A)	HCBS ill and handicapped waiver services
78.35(249A)	Occupational therapist services
78.36(249A)	Hospice services
78.37(249A)	HCBS elderly waiver services
78.38(249A)	HCBS AIDS/HIV waiver services
78.39(249A)	Federally qualified health centers
78.40(249A)	Advanced registered nurse practitioners
78.41(249A)	HCBS intellectual disability waiver services
78.42(249A)	Pharmacies administering influenza vaccine to children
78.43(249A)	HCBS brain injury waiver services
78.44(249A)	Lead inspection services
78.45(249A)	Assertive community treatment
78.46(249A)	Physical disability waiver service
78.47(249A)	Pharmaceutical case management services
78.48(249A)	Public health agencies
78.49(249A)	Infant and toddler program services
78.50(249A)	Local education agency services
78.51(249A)	Indian health service 638 facility services
78.52(249A)	HCBS children's mental health waiver services
78.53(249A)	Health home services
78.54(249A)	Speech-language pathology services

CHAPTER 79  
OTHER POLICIES RELATING TO PROVIDERS OF  
MEDICAL AND REMEDIAL CARE

79.1(249A)	Principles governing reimbursement of providers of medical and health services
79.2(249A)	Sanctions against provider of care
79.3(249A)	Maintenance of records by providers of service
79.4(249A)	Reviews and audits
79.5(249A)	Nondiscrimination on the basis of handicap
79.6(249A)	Provider participation agreement
79.7(249A)	Medical assistance advisory council
79.8(249A)	Requests for prior authorization
79.9(249A)	General provisions for Medicaid coverage applicable to all Medicaid providers and services
79.10(249A)	Requests for preadmission review
79.11(249A)	Requests for preprocedure surgical review
79.12(249A)	Advance directives
79.13(249A)	Requirements for enrolled Medicaid providers supplying laboratory services
79.14(249A)	Provider enrollment
79.15(249A)	Education about false claims recovery
79.16(249A)	Electronic health record incentive program

CHAPTER 80  
PROCEDURE AND METHOD OF PAYMENT

80.1	Reserved
80.2(249A)	Submission of claims
80.3(249A)	Payment from other sources
80.4(249A)	Time limit for submission of claims and claim adjustments
80.5(249A)	Authorization process
80.6(249A)	Payment to provider—exception
80.7(249A)	Health care data match program

CHAPTER 81  
NURSING FACILITIES

DIVISION I  
GENERAL POLICIES

81.1(249A)	Definitions
81.2	Reserved
81.3(249A)	Initial approval for nursing facility care
81.4(249A)	Arrangements with residents
81.5(249A)	Discharge and transfer
81.6(249A)	Financial and statistical report and determination of payment rate
81.7(249A)	Continued review
81.8	Reserved
81.9(249A)	Records
81.10(249A)	Payment procedures
81.11(249A)	Billing procedures
81.12(249A)	Closing of facility
81.13(249A)	Conditions of participation for nursing facilities
81.14(249A)	Audits
81.15	Reserved
81.16(249A)	Nurse aide requirements and training and testing programs
81.17	Reserved

81.18(249A)	Sanctions
81.19	Reserved
81.20(249A)	Out-of-state facilities
81.21(249A)	Outpatient services
81.22(249A)	Rates for Medicaid eligibles
81.23(249A)	State-funded personal needs supplement
81.24 to 81.30	Reserved

DIVISION II  
ENFORCEMENT OF COMPLIANCE

81.31(249A)	Definitions
81.32(249A)	General provisions
81.33(249A)	Factors to be considered in selecting remedies
81.34(249A)	Available remedies
81.35(249A)	Selection of remedies
81.36(249A)	Action when there is immediate jeopardy
81.37(249A)	Action when there is no immediate jeopardy
81.38(249A)	Action when there is repeated substandard quality of care
81.39(249A)	Temporary management
81.40(249A)	Denial of payment for all new admissions
81.41(249A)	Secretarial authority to deny all payments
81.42(249A)	State monitoring
81.43(249A)	Directed plan of correction
81.44(249A)	Directed in-service training
81.45(249A)	Closure of a facility or transfer of residents, or both
81.46(249A)	Civil money penalties—basis for imposing penalty
81.47(249A)	Civil money penalties—when penalty is collected
81.48(249A)	Civil money penalties—notice of penalty
81.49(249A)	Civil money penalties—waiver of hearing, reduction of penalty amount
81.50(249A)	Civil money penalties—amount of penalty
81.51(249A)	Civil money penalties—effective date and duration of penalty
81.52(249A)	Civil money penalties—due date for payment of penalty
81.53(249A)	Use of penalties collected by the department
81.54(249A)	Continuation of payments to a facility with deficiencies
81.55(249A)	State and federal disagreements involving findings not in agreement when there is no immediate jeopardy
81.56(249A)	Duration of remedies
81.57(249A)	Termination of provider agreement

CHAPTER 82  
INTERMEDIATE CARE FACILITIES FOR PERSONS  
WITH AN INTELLECTUAL DISABILITY

82.1(249A)	Definition
82.2(249A)	Licensing and certification
82.3(249A)	Conditions of participation for intermediate care facilities for persons with an intellectual disability
82.4	Reserved
82.5(249A)	Financial and statistical report
82.6(249A)	Eligibility for services
82.7(249A)	Initial approval for ICF/ID care
82.8(249A)	Determination of need for continued stay
82.9(249A)	Arrangements with residents
82.10(249A)	Discharge and transfer

82.11(249A)	Continued stay review
82.12(249A)	Quality of care review
82.13(249A)	Records
82.14(249A)	Payment procedures
82.15(249A)	Billing procedures
82.16(249A)	Closing of facility
82.17(249A)	Audits
82.18(249A)	Out-of-state facilities
82.19(249A)	State-funded personal needs supplement

## CHAPTER 83 MEDICAID WAIVER SERVICES

### DIVISION I—HCBS HEALTH AND DISABILITY WAIVER SERVICES

83.1(249A)	Definitions
83.2(249A)	Eligibility
83.3(249A)	Application
83.4(249A)	Financial participation
83.5(249A)	Redetermination
83.6(249A)	Allowable services
83.7(249A)	Service plan
83.8(249A)	Adverse service actions
83.9(249A)	Appeal rights
83.10 to 83.20	Reserved

### DIVISION II—HCBS ELDERLY WAIVER SERVICES

83.21(249A)	Definitions
83.22(249A)	Eligibility
83.23(249A)	Application
83.24(249A)	Client participation
83.25(249A)	Redetermination
83.26(249A)	Allowable services
83.27(249A)	Service plan
83.28(249A)	Adverse service actions
83.29(249A)	Appeal rights
83.30(249A)	Enhanced services
83.31 to 83.40	Reserved

### DIVISION III—HCBS AIDS/HIV WAIVER SERVICES

83.41(249A)	Definitions
83.42(249A)	Eligibility
83.43(249A)	Application
83.44(249A)	Financial participation
83.45(249A)	Redetermination
83.46(249A)	Allowable services
83.47(249A)	Service plan
83.48(249A)	Adverse service actions
83.49(249A)	Appeal rights
83.50 to 83.59	Reserved

### DIVISION IV—HCBS INTELLECTUAL DISABILITY WAIVER SERVICES

83.60(249A)	Definitions
83.61(249A)	Eligibility
83.62(249A)	Application
83.63(249A)	Client participation

83.64(249A)	Redetermination
83.65	Reserved
83.66(249A)	Allowable services
83.67(249A)	Service plan
83.68(249A)	Adverse service actions
83.69(249A)	Appeal rights
83.70 and 83.71	Reserved
83.72(249A)	Rent subsidy program
83.73 to 83.80	Reserved

DIVISION V—BRAIN INJURY WAIVER SERVICES

83.81(249A)	Definitions
83.82(249A)	Eligibility
83.83(249A)	Application
83.84(249A)	Client participation
83.85(249A)	Redetermination
83.86(249A)	Allowable services
83.87(249A)	Service plan
83.88(249A)	Adverse service actions
83.89(249A)	Appeal rights
83.90 to 83.100	Reserved

DIVISION VI—PHYSICAL DISABILITY WAIVER SERVICES

83.101(249A)	Definitions
83.102(249A)	Eligibility
83.103(249A)	Application
83.104(249A)	Client participation
83.105(249A)	Redetermination
83.106(249A)	Allowable services
83.107(249A)	Individual service plan
83.108(249A)	Adverse service actions
83.109(249A)	Appeal rights
83.110 to 83.120	Reserved

DIVISION VII—HCBS CHILDREN'S MENTAL HEALTH WAIVER SERVICES

83.121(249A)	Definitions
83.122(249A)	Eligibility
83.123(249A)	Application
83.124(249A)	Financial participation
83.125(249A)	Redetermination
83.126(249A)	Allowable services
83.127(249A)	Service plan
83.128(249A)	Adverse service actions
83.129(249A)	Appeal rights

CHAPTER 84

EARLY AND PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT

84.1(249A)	Definitions
84.2(249A)	Eligibility
84.3(249A)	Screening services
84.4(249A)	Referral
84.5(249A)	Follow up

CHAPTER 85  
SERVICES IN PSYCHIATRIC INSTITUTIONS

DIVISION I  
PSYCHIATRIC HOSPITALS

- 85.1(249A) Acute care in psychiatric hospitals
- 85.2(249A) Out-of-state placement
- 85.3(249A) Eligibility of persons under the age of 21
- 85.4(249A) Eligibility of persons aged 65 and over
- 85.5(249A) Client participation
- 85.6(249A) Responsibilities of hospitals
- 85.7(249A) Psychiatric hospital reimbursement
- 85.8(249A,81GA,ch167) Eligibility of persons aged 21 through 64
- 85.9 to 85.20 Reserved

DIVISION II  
PSYCHIATRIC MEDICAL INSTITUTIONS FOR CHILDREN

- 85.21(249A) Conditions for participation
- 85.22(249A) Eligibility of persons under the age of 21
- 85.23(249A) Client participation
- 85.24(249A) Responsibilities of facilities
- 85.25(249A) Reimbursement to psychiatric medical institutions for children
- 85.26(249A) Outpatient day treatment for persons aged 20 or under
- 85.27 to 85.40 Reserved

DIVISION III  
NURSING FACILITIES FOR PERSONS WITH MENTAL ILLNESS

- 85.41(249A) Conditions of participation
- 85.42(249A) Out-of-state placement
- 85.43(249A) Eligibility of persons aged 65 and over
- 85.44(249A) Client participation
- 85.45(249A) Responsibilities of nursing facility
- 85.46(249A) Policies governing reimbursement
- 85.47(249A) State-funded personal needs supplement

CHAPTER 86  
HEALTHY AND WELL KIDS IN IOWA (HAWK-I) PROGRAM

- 86.1(514I) Definitions
- 86.2(514I) Eligibility factors
- 86.3(514I) Application process
- 86.4(514I) Coordination with Medicaid
- 86.5(514I) Effective date of coverage
- 86.6(514I) Selection of a plan
- 86.7(514I) Cancellation
- 86.8(514I) Premiums and copayments
- 86.9(514I) Annual reviews of eligibility
- 86.10(514I) Reporting changes
- 86.11(514I) Notice requirements
- 86.12(514I) Appeals and fair hearings
- 86.13(514I) Third-party administrator
- 86.14(514I) Covered services
- 86.15(514I) Participating health and dental plans
- 86.16(514I) Clinical advisory committee
- 86.17(514I) Use of donations to the HAWK-I program
- 86.18(505) Health insurance data match program

- 86.19(514I) Recovery
- 86.20(514I) Supplemental dental-only coverage

## CHAPTER 87

## STATE-FUNDED FAMILY PLANNING PROGRAM

- 87.1(82GA,ch1187) Definitions
- 87.2(82GA,ch1187) Eligibility
- 87.3(82GA,ch1187) Application
- 87.4(82GA,ch1187) Effective date
- 87.5(82GA,ch1187) Period of eligibility and reapplication
- 87.6(82GA,ch1187) Reporting changes
- 87.7(82GA,ch1187) Allocation of funds
- 87.8(82GA,ch1187) Availability of services
- 87.9(82GA,ch1187) Payment of covered services
- 87.10(82GA,ch1187) Submission of claims

## CHAPTER 88

## MANAGED HEALTH CARE PROVIDERS

## DIVISION I

## HEALTH MAINTENANCE ORGANIZATION

- 88.1(249A) Definitions
- 88.2(249A) Participation
- 88.3(249A) Enrollment
- 88.4(249A) Disenrollment
- 88.5(249A) Covered services
- 88.6(249A) Emergency and urgent care services
- 88.7(249A) Access to service
- 88.8(249A) Grievance procedures
- 88.9(249A) Records and reports
- 88.10(249A) Marketing
- 88.11(249A) Patient education
- 88.12(249A) Reimbursement
- 88.13(249A) Quality assurance
- 88.14(249A) Contracts with federally qualified health centers (FQHCs) and rural health clinics (RHCs)
- 88.15 to 88.20 Reserved

## DIVISION II

## PREPAID HEALTH PLANS

- 88.21(249A) Definitions
- 88.22(249A) Participation
- 88.23(249A) Enrollment
- 88.24(249A) Disenrollment
- 88.25(249A) Covered services
- 88.26(249A) Emergency services
- 88.27(249A) Access to service
- 88.28(249A) Grievance procedures
- 88.29(249A) Records and reports
- 88.30(249A) Marketing
- 88.31(249A) Patient education
- 88.32(249A) Payment to the PHP
- 88.33(249A) Quality assurance
- 88.34 to 88.40 Reserved

DIVISION III  
MEDICAID PATIENT MANAGEMENT

88.41(249A)	Definitions
88.42(249A)	Eligible recipients
88.43(249A)	Project area
88.44(249A)	Eligible providers
88.45(249A)	Contracting for the provision of patient management
88.46(249A)	Enrollment and changes in enrollment
88.47(249A)	Disenrollment
88.48(249A)	Services
88.49(249A)	Grievance procedure
88.50(249A)	Payment
88.51(249A)	Utilization review and quality assessment
88.52(249A)	Marketing
88.53 to 88.60	Reserved

DIVISION IV  
IOWA PLAN FOR BEHAVIORAL HEALTH

88.61(249A)	Definitions
88.62(249A)	Participation
88.63(249A)	Enrollment
88.64(249A)	Disenrollment
88.65(249A)	Covered services
88.66(249A)	Emergency services
88.67(249A)	Access to service
88.68(249A)	Review of contractor decisions and actions
88.69(249A)	Records and reports
88.70(249A)	Marketing
88.71(249A)	Enrollee education
88.72(249A)	Payment to the contractor
88.73(249A)	Claims payment
88.74(249A)	Quality assurance
88.75(249A)	Iowa Plan advisory committee
88.76 to 88.80	Reserved

DIVISION V  
PROGRAMS OF ALL-INCLUSIVE CARE FOR THE ELDERLY

88.81(249A)	Scope and definitions
88.82(249A)	PACE organization application and waiver process
88.83(249A)	PACE program agreement
88.84(249A)	Enrollment and disenrollment
88.85(249A)	Program services
88.86(249A)	Access to PACE services
88.87(249A)	Program administrative requirements
88.88(249A)	Payment

CHAPTER 89  
DEBTS DUE FROM TRANSFERS OF ASSETS

89.1(249F)	Definitions
89.2(249F)	Creation of debt
89.3(249F)	Exceptions
89.4(249F)	Presumption of intent
89.5(249F)	Notice of debt
89.6(249F)	No timely request of a hearing

- 89.7(249F) Timely request for a hearing
- 89.8(249F) Department-requested hearing
- 89.9(249F) Filing and docketing of the order
- 89.10(249F) Exemption from Iowa Code chapter 17A

CHAPTER 90  
TARGETED CASE MANAGEMENT

- 90.1(249A) Definitions
- 90.2(249A) Eligibility
- 90.3(249A) Determination of need for service
- 90.4(249A) Application
- 90.5(249A) Service provision
- 90.6(249A) Terminating services
- 90.7(249A) Appeal rights
- 90.8(249A) Provider requirements

CHAPTER 91  
MEDICARE DRUG SUBSIDY

- 91.1(249A) Definitions
- 91.2(249A) Application
- 91.3(249A) Eligibility determination
- 91.4(249A) Notice of decision
- 91.5(249A) Effective date
- 91.6(249A) Changes in circumstances
- 91.7(249A) Reinvestigation
- 91.8(249A) Appeals

CHAPTER 92  
IOWACARE

- 92.1(249A,249J) Definitions
- 92.2(249A,249J) Eligibility
- 92.3(249A,249J) Application
- 92.4(249A,249J) Application processing
- 92.5(249A,249J) Determining income eligibility
- 92.6(249A,249J) Effective date
- 92.7(249A,249J) Financial participation
- 92.8(249A,249J) Benefits
- 92.9(249A,249J) Claims and reimbursement methodologies
- 92.10(249A,249J) Reporting changes
- 92.11(249A,249J) Reapplication
- 92.12(249A,249J) Terminating eligibility
- 92.13(249A,249J) Recovery
- 92.14(249A,249J) Discontinuance of the program
- 92.15(249A,249J) Right to appeal

TITLE IX  
*WORK INCENTIVE DEMONSTRATION*

CHAPTER 93  
PROMISE JOBS PROGRAM

- 93.1(239B) Definitions
- 93.2(239B) Program administration
- 93.3(239B) Registration and referral
- 93.4(239B) The family investment agreement (FIA)

93.5(239B)	Assessment
93.6(239B)	Job readiness and job search activities
93.7(239B)	Work activities
93.8(239B)	Education and training activities
93.9(239B)	Other FIA activities
93.10(239B)	Required documentation and verification
93.11(239B)	Supportive payments
93.12(239B)	Recovery of PROMISE JOBS expense payments
93.13(239B)	Resolution of participation issues
93.14(239B)	Problems that may provide good cause for participation issues
93.15(239B)	Right of appeal
93.16(239B)	Resolution of a limited benefit plan
93.17(239B)	Worker displacement grievance procedure

## CHAPTER 94

Reserved

## TITLE X

*SUPPORT RECOVERY*

## CHAPTER 95

## COLLECTIONS

95.1(252B)	Definitions
95.2(252B)	Child support recovery eligibility and services
95.3(252B)	Crediting of current and delinquent support
95.4(252B)	Prepayment of support
95.5(252B)	Lump sum settlement
95.6(252B)	Offset against state income tax refund or rebate
95.7(252B)	Offset against federal income tax refund and federal nontax payment
95.8(96)	Child support offset of unemployment insurance benefits
95.9 to 95.11	Reserved
95.12(252B)	Procedures for providing information to consumer reporting agencies
95.13(17A)	Appeals
95.14(252B)	Termination of services
95.15(252B)	Child support recovery unit attorney
95.16(252B)	Handling and use of federal 1099 information
95.17(252B)	Effective date of support
95.18(252B)	Continued services available to canceled family investment program (FIP) or Medicaid recipients
95.19(252B)	Cooperation of public assistance recipients in establishing and obtaining support
95.20(252B)	Cooperation of public assistance applicants in establishing and obtaining support
95.21(252B)	Cooperation in establishing and obtaining support in nonpublic assistance cases
95.22(252B)	Charging pass-through fees
95.23(252B)	Reimbursing assistance with collections of assigned support
95.24(252B)	Child support account
95.25(252B)	Emancipation verification

## CHAPTER 96

## INFORMATION AND RECORDS

96.1(252B)	Access to information and records from other sources
96.2(252B)	Refusal to comply with written request or subpoena
96.3(252B)	Procedure for refusal
96.4(252B)	Conference conducted

- 96.5(252B) Fine assessed  
 96.6(252B) Objection to fine or failure to pay

CHAPTER 97  
 COLLECTION SERVICES CENTER

- 97.1(252B) Definitions  
 97.2(252B) Transfer of records and payments  
 97.3(252B) Support payment records  
 97.4(252B) Method of payment  
 97.5(252D) Electronic transmission of payments  
 97.6(252B) Authorization of payment  
 97.7(252B) Processing misdirected payments

CHAPTER 98  
 SUPPORT ENFORCEMENT SERVICES

DIVISION I  
 MEDICAL SUPPORT ENFORCEMENT

- 98.1(252E) Definitions  
 98.2(252E) Provision of services  
 98.3(252E) Establishing medical support  
 98.4(252E) Accessibility of the health benefit plan  
 98.5(252E) Health benefit plan information  
 98.6(252E) Insurer authorization  
 98.7(252E) Enforcement  
 98.8(252E) Contesting the order  
 98.9 to 98.20 Reserved

DIVISION II  
 INCOME WITHHOLDING  
 PART A  
 DELINQUENT SUPPORT PAYMENTS

- 98.21(252D) When applicable  
 98.22 and 98.23 Reserved  
 98.24(252D) Amount of withholding  
 98.25 to 98.30 Reserved

PART B  
 IMMEDIATE INCOME WITHHOLDING

- 98.31(252D) Effective date  
 98.32(252D) Withholding automatic  
 98.33 Reserved  
 98.34(252D) Approval of request for immediate income withholding  
 98.35(252D) Modification or termination of withholding  
 98.36(252D) Immediate income withholding amounts  
 98.37(252D) Immediate income withholding amounts when current support has ended  
 98.38 Reserved

PART C  
 INCOME WITHHOLDING—GENERAL PROVISIONS

- 98.39(252D,252E) Provisions for medical support  
 98.40(252D,252E) Maximum amounts to be withheld  
 98.41(252D) Multiple obligations  
 98.42(252D) Notice to employer and obligor  
 98.43(252D) Contesting the withholding  
 98.44(252D) Termination of order  
 98.45(252D) Modification of income withholding

98.46(252D) Refunds of amounts improperly withheld  
 98.47(252D) Additional information about hardship  
 98.48 to 98.50 Reserved

DIVISION III  
 REVIEW AND ADJUSTMENT OF CHILD SUPPORT OBLIGATIONS

98.51 to 98.60 Reserved

DIVISION IV  
 PUBLICATION OF NAMES

98.61(252B) List for publication  
 98.62(252B) Releasing the list  
 98.63 to 98.70 Reserved

DIVISION V  
 ADMINISTRATIVE SEEK EMPLOYMENT ORDERS

98.71(252B) Seek employment order  
 98.72(252B) Effective date of order  
 98.73(252B) Method and requirements of reporting  
 98.74(252B) Reasons for noncompliance  
 98.75(252B) Method of service  
 98.76(252B) Duration of order  
 98.77 to 98.80 Reserved

DIVISION VI  
 DEBTOR OFFSET

98.81(252B) Offset against payment owed to a person by a state agency  
 98.82 to 98.90 Reserved

DIVISION VII  
 ADMINISTRATIVE LEVY

98.91(252I) Administrative levy  
 98.92 Reserved  
 98.93(252I) Verification of accounts  
 98.94(252I) Notice to financial institution  
 98.95(252I) Notice to support obligor  
 98.96(252I) Responsibilities of financial institution  
 98.97(252I) Challenging the administrative levy  
 98.98 to 98.100 Reserved

DIVISION VIII  
 LICENSE SANCTION

98.101(252J) Referral for license sanction  
 98.102(252J) Reasons for exemption  
 98.103(252J) Notice of potential sanction of license  
 98.104(252J) Conference  
 98.105(252J) Payment agreement  
 98.106(252J) Staying the process due to full payment of support  
 98.107(252J) Duration of license sanction  
 98.108 to 98.120 Reserved

DIVISION IX  
 EXTERNAL ENFORCEMENT

98.121(252B) Difficult-to-collect arrearages  
 98.122(252B) Enforcement services by private attorney entitled to state compensation

CHAPTER 99  
SUPPORT ESTABLISHMENT AND ADJUSTMENT SERVICES

DIVISION I  
CHILD SUPPORT GUIDELINES

- 99.1(234,252B,252H) Income considered  
 99.2(234,252B) Allowable deductions  
 99.3(234,252B) Determining net income  
 99.4(234,252B) Applying the guidelines  
 99.5(234,252B) Deviation from guidelines  
 99.6 to 99.9 Reserved

DIVISION II  
PATERNITY ESTABLISHMENT  
PART A  
JUDICIAL PATERNITY ESTABLISHMENT

- 99.10(252A) Temporary support  
 99.11 to 99.20 Reserved

PART B  
ADMINISTRATIVE PATERNITY ESTABLISHMENT

- 99.21(252F) When paternity may be established administratively  
 99.22(252F) Mother's certified statement  
 99.23(252F) Notice of alleged paternity and support debt  
 99.24(252F) Conference to discuss paternity and support issues  
 99.25(252F) Amount of support obligation  
 99.26(252F) Court hearing  
 99.27(252F) Paternity contested  
 99.28(252F) Paternity test results challenge  
 99.29(252F) Agreement to entry of paternity and support order  
 99.30(252F) Entry of order establishing paternity only  
 99.31(252F) Exception to time limit  
 99.32(252F) Genetic test costs assessed  
 99.33 to 99.35 Reserved

PART C  
PATERNITY DISESTABLISHMENT

- 99.36(598,600B) Definitions  
 99.37(598,600B) Communication between parents  
 99.38(598,600B) Continuation of enforcement  
 99.39(598,600B) Satisfaction of accrued support  
 99.40 Reserved

DIVISION III  
ADMINISTRATIVE ESTABLISHMENT OF SUPPORT

- 99.41(252C) Establishment of an administrative order  
 99.42 to 99.60 Reserved

DIVISION IV  
REVIEW AND ADJUSTMENT OF CHILD SUPPORT OBLIGATIONS

- 99.61(252B,252H) Definitions  
 99.62(252B,252H) Review of permanent child support obligations  
 99.63(252B,252H) Notice requirements  
 99.64(252B,252H) Financial information  
 99.65(252B,252H) Review and adjustment of a child support obligation  
 99.66(252B,252H) Medical support  
 99.67(252B,252H) Confidentiality of financial information  
 99.68(252B,252H) Payment of service fees and other court costs

- 99.69(252B,252H) Denying requests
- 99.70(252B,252H) Withdrawing requests
- 99.71(252H) Effective date of adjustment
- 99.72 to 99.80 Reserved

DIVISION V  
ADMINISTRATIVE MODIFICATION

- 99.81(252H) Definitions
- 99.82(252H) Availability of service
- 99.83(252H) Modification of child support obligations
- 99.84(252H) Notice requirements
- 99.85(252H) Financial information
- 99.86(252H) Challenges to the proposed modification action
- 99.87(252H) Voluntary reduction of income
- 99.88(252H) Effective date of modification
- 99.89(252H) Confidentiality of financial information
- 99.90(252H) Payment of fees
- 99.91(252H) Denying requests
- 99.92(252H) Withdrawing requests
- 99.93 to 99.100 Reserved

DIVISION VI  
SUSPENSION AND REINSTATEMENT OF SUPPORT

- 99.101(252B) Definitions
- 99.102(252B) Availability of service
- 99.103(252B) Basis for suspension of support
- 99.104(252B) Request for assistance to suspend
- 99.105(252B) Order suspending support
- 99.106(252B) Suspension of enforcement of current support
- 99.107(252B) Request for reinstatement
- 99.108(252B) Reinstatement
- 99.109(252B) Reinstatement of enforcement of support
- 99.110(252B) Temporary suspension becomes final

CHAPTER 100  
CHILD SUPPORT PARENTAL OBLIGATION PILOT PROJECTS

- 100.1(17A,80GA,HF667) Definitions
- 100.2(17A,80GA,HF667) Incentives
- 100.3(17A,80GA,HF667) Application to be a funded pilot project
- 100.4(17A,80GA,HF667) Selection of projects
- 100.5(17A,80GA,HF667) Termination of pilot projects
- 100.6(17A,80GA,HF667) Reports and records
- 100.7(17A,80GA,HF667) Appeals
- 100.8(17A,80GA,HF667) Continued application of rules and sunset provisions

TITLE XI  
*CHILDREN'S INSTITUTIONS*

CHAPTER 101  
IOWA JUVENILE HOME

- 101.1(218) Definitions
- 101.2(218) Standards
- 101.3(218) Admission
- 101.4(218) Plan of care
- 101.5(218) Communication with individuals

101.6(218)	Photographing and recording of individuals
101.7(218)	Employment of individual
101.8(218)	Temporary home visits
101.9(218)	Grievances
101.10(218)	Alleged child abuse
101.11(233B)	Cost of care
101.12(218)	Buildings and grounds
101.13(8,218)	Gifts and bequests

## CHAPTER 102

Reserved

## CHAPTER 103

## STATE TRAINING SCHOOL

103.1(218)	Definitions
103.2(218)	Admission
103.3(218)	Plan of care
103.4(218)	Communication with individuals
103.5(218)	Photographing and recording of individuals
103.6(218)	Employment of individual
103.7(218)	Temporary home visits
103.8(218)	Grievances
103.9(692A)	Sex offender registration
103.10(218)	Alleged child abuse
103.11(233A)	Cost of care
103.12(218)	Buildings and grounds
103.13(8,218)	Gifts and bequests

## CHAPTER 104

Reserved

## TITLE XII

*LICENSING AND APPROVED STANDARDS*

## CHAPTER 105

JUVENILE DETENTION  
AND SHELTER CARE HOMES

105.1(232)	Definitions
105.2(232)	Buildings and grounds
105.3(232)	Personnel policies
105.4(232)	Procedures manual
105.5(232)	Staff
105.6(232)	Intake procedures
105.7(232)	Assessments
105.8(232)	Program services
105.9(232)	Medication management and administration
105.10(232)	Control room—juvenile detention home only
105.11(232)	Clothing
105.12(232)	Staffings
105.13(232)	Child abuse
105.14(232)	Daily log
105.15(232)	Children's rights
105.16(232)	Discipline
105.17(232)	Case files

105.18(232)	Discharge
105.19(232)	Approval
105.20(232)	Provisional approval
105.21(232)	Mechanical restraint—juvenile detention only
105.22(232)	Chemical restraint

#### CHAPTER 106

##### SAFETY STANDARDS FOR CHILDREN'S CENTERS

106.1(237B)	Definitions
106.2(237B)	Application of the standards
106.3(237B)	Providing for basic needs
106.4(237B)	Protection from mistreatment, physical abuse, sexual abuse, and neglect
106.5(237B)	Record checks
106.6(237B)	Seclusion and restraints
106.7(237B)	Health
106.8(237B)	Safety
106.9(237B)	Emergencies
106.10(237B)	Buildings

#### CHAPTER 107

##### CERTIFICATION OF ADOPTION INVESTIGATORS

107.1(600)	Introduction
107.2(600)	Definitions
107.3(600)	Application
107.4(600)	Requirements for certification
107.5(600)	Granting, denial, or revocation of certification
107.6(600)	Certificate
107.7(600)	Renewal of certification
107.8(600)	Investigative services
107.9(600)	Retention of adoption records
107.10(600)	Reporting of violations
107.11(600)	Appeals

#### CHAPTER 108

##### LICENSING AND REGULATION OF CHILD-PLACING AGENCIES

108.1(238)	Definitions
108.2(238)	Licensing procedure
108.3(238)	Administration and organization
108.4(238)	Staff qualifications
108.5(238)	Staffing requirements
108.6(238)	Personnel administration
108.7(238)	Foster care services
108.8(238)	Foster home studies
108.9(238)	Adoption services
108.10(238)	Supervised apartment living placement services

#### CHAPTER 109

##### CHILD CARE CENTERS

109.1(237A)	Definitions
109.2(237A)	Licensure procedures
109.3(237A)	Inspection and evaluation
109.4(237A)	Administration
109.5(237A)	Parental participation

109.6(237A)	Personnel
109.7(237A)	Professional growth and development
109.8(237A)	Staff ratio requirements
109.9(237A)	Records
109.10(237A)	Health and safety policies
109.11(237A)	Physical facilities
109.12(237A)	Activity program requirements
109.13(237A)	Extended evening care
109.14(237A)	Get-well center
109.15(237A)	Food services

#### CHAPTER 110 CHILD DEVELOPMENT HOMES

110.1(237A)	Definitions
110.2(237A)	Application for registration
110.3(237A)	Renewal
110.4(237A)	Number of children
110.5(237A)	Standards
110.6(237A)	Compliance checks
110.7(234)	Registration decision
110.8(237A)	Additional requirements for child development home category A
110.9(237A)	Additional requirements for child development home category B
110.10(237A)	Additional requirements for child development home category C
110.11(237A)	Complaints
110.12(237A)	Registration actions for nonpayment of child support
110.13(237A)	Transition exception
110.14(237A)	Prohibition from involvement with child care

#### CHAPTER 111 FAMILY-LIFE HOMES

111.1(249)	Definitions
111.2(249)	Application for certification
111.3(249)	Provisions pertaining to the certificate
111.4(249)	Physical standards
111.5(249)	Personal characteristics of family-life home family
111.6(249)	Health of family
111.7(249)	Planned activities and personal effects
111.8(249)	Client eligibility
111.9(249)	Medical examinations, records, and care of a client
111.10(249)	Placement agreement
111.11(249)	Legal liabilities
111.12(249)	Emergency care and release of client
111.13(249)	Information about client to be confidential

#### CHAPTER 112 LICENSING AND REGULATION OF CHILD FOSTER CARE FACILITIES

112.1(237)	Applicability
112.2(237)	Definitions
112.3(237)	Application for license
112.4(237)	License
112.5(237)	Denial
112.6(237)	Revocation
112.7(237)	Provisional license

- 112.8(237) Adverse actions
- 112.9(237) Suspension
- 112.10(232) Mandatory reporting of child abuse

#### CHAPTER 113

#### LICENSING AND REGULATION OF FOSTER FAMILY HOMES

- 113.1(237) Applicability
- 113.2(237) Definitions
- 113.3(237) Licensing procedure
- 113.4(237) Provisions pertaining to the license
- 113.5(237) Physical standards
- 113.6(237) Sanitation, water, and waste disposal
- 113.7(237) Safety
- 113.8(237) Foster parent training
- 113.9(237) Involvement of kin
- 113.10(237) Information on the foster child
- 113.11(237) Health of foster family
- 113.12(237) Characteristics of foster parents
- 113.13(237) Record checks
- 113.14(237) Reference checks
- 113.15(237) Unannounced visits
- 113.16(237) Planned activities and personal effects
- 113.17(237) Medical examinations and health care of the child
- 113.18(237) Training and discipline of foster children
- 113.19(237) Emergency care and release of children
- 113.20(237) Changes in foster family home

#### CHAPTER 114

#### LICENSING AND REGULATION OF ALL GROUP LIVING FOSTER CARE FACILITIES FOR CHILDREN

- 114.1(237) Applicability
- 114.2(237) Definitions
- 114.3(237) Physical standards
- 114.4(237) Sanitation, water, and waste disposal
- 114.5(237) Safety
- 114.6(237) Organization and administration
- 114.7(237) Policies and record-keeping requirements
- 114.8(237) Staff
- 114.9(237) Intake procedures
- 114.10(237) Program services
- 114.11(237) Case files
- 114.12(237) Drug utilization and control
- 114.13(237) Children's rights
- 114.14(237) Personal possessions
- 114.15(237) Religion—culture
- 114.16(237) Work or vocational experiences
- 114.17(237) Family involvement
- 114.18(237) Children's money
- 114.19(237) Child abuse
- 114.20(237) Discipline
- 114.21(237) Illness, accident, death, or absence from the facility
- 114.22(237) Records

- 114.23(237) Unannounced visits
- 114.24(237) Standards for private juvenile shelter care and detention homes

#### CHAPTER 115

#### LICENSING AND REGULATION OF COMPREHENSIVE RESIDENTIAL FACILITIES FOR CHILDREN

- 115.1(237) Applicability
- 115.2(237) Definitions
- 115.3(237) Information upon admission
- 115.4(237) Staff
- 115.5(237) Program services
- 115.6(237) Restraints
- 115.7(237) Control room
- 115.8(237) Locked cottages
- 115.9(237) Mechanical restraint
- 115.10(237) Chemical restraint

#### CHAPTER 116

#### LICENSING AND REGULATION OF RESIDENTIAL FACILITIES FOR MENTALLY RETARDED CHILDREN

- 116.1(237) Applicability
- 116.2(237) Definitions
- 116.3(237) Qualifications of staff
- 116.4(237) Staff to client ratio
- 116.5(237) Program components
- 116.6(237) Restraint

#### CHAPTER 117

#### FOSTER PARENT TRAINING

- 117.1(237) Required preservice training
- 117.2(237) Required orientation
- 117.3(237) Application materials for in-service training
- 117.4(237) Application process for in-service training
- 117.5(237) Application decisions
- 117.6(237) Application conference available
- 117.7(237) Required in-service training
- 117.8(237) Specific in-service training required
- 117.9(237) Foster parent training expenses

#### CHAPTER 118

#### CHILD CARE QUALITY RATING SYSTEM

- 118.1(237A) Definitions
- 118.2(237A) Application for quality rating
- 118.3(237A) Rating standards for child care centers and preschools (sunsetting on July 31, 2011)
- 118.4(237A) Rating criteria for child development homes (sunsetting on July 31, 2011)
- 118.5(237A) Rating standards for child care centers, preschools, and programs operating under the authority of an accredited school district or nonpublic school
- 118.6(237A) Rating criteria for child development homes
- 118.7(237A) Award of quality rating
- 118.8(237A) Adverse actions

CHAPTER 119  
RECORD CHECK EVALUATIONS FOR  
CERTAIN EMPLOYERS AND EDUCATIONAL TRAINING PROGRAMS

- 119.1(135C) Definitions
- 119.2(135C) When record check evaluations are requested
- 119.3(135C) Request for evaluation
- 119.4(135C) Completion of evaluation
- 119.5(135C) Appeal rights

CHAPTERS 120 to 129  
Reserved

TITLE XIII  
*SERVICE ADMINISTRATION*

CHAPTER 130  
GENERAL PROVISIONS

- 130.1(234) Definitions
- 130.2(234) Application
- 130.3(234) Eligibility
- 130.4(234) Fees
- 130.5(234) Adverse service actions
- 130.6(234) Social casework
- 130.7(234) Case plan
- 130.8 Reserved
- 130.9(234) Entitlement

CHAPTER 131  
SOCIAL CASEWORK

- 131.1(234) Definitions
- 131.2(234) Eligibility
- 131.3(234) Service provision
- 131.4 Reserved
- 131.5(234) Adverse actions

CHAPTER 132  
Reserved

CHAPTER 133  
IV-A EMERGENCY ASSISTANCE PROGRAM

- 133.1(235) Definitions
- 133.2(235) Application
- 133.3(235) Eligibility
- 133.4(235) Method of service provision
- 133.5(235) Duration of services
- 133.6(235) Discontinuance of the program

CHAPTERS 134 to 141  
Reserved

CHAPTER 142  
INTERSTATE COMPACT ON THE PLACEMENT OF CHILDREN

- 142.1(238) Compact agreement
- 142.2(238) Compact administrator
- 142.3(238) Article II(d)

142.4(238)	Article III(a)
142.5(238)	Article III(a) procedures
142.6(238)	Article III(c)
142.7(238)	Article VIII(a)
142.8(238)	Applicability

#### CHAPTER 143

##### INTERSTATE COMPACT ON JUVENILES

143.1(232)	Compact agreement
143.2(232)	Compact administrator
143.3(232)	Sending a juvenile out of Iowa under the compact
143.4(232)	Receiving cases in Iowa under the interstate compact
143.5(232)	Runaways

#### CHAPTERS 144 to 149

Reserved

#### TITLE XIV

##### *GRANT/CONTRACT/PAYMENT ADMINISTRATION*

#### CHAPTER 150

##### PURCHASE OF SERVICE

#### DIVISION I

TERMS AND CONDITIONS FOR IOWA PURCHASE OF SOCIAL SERVICES AGENCY AND  
INDIVIDUAL CONTRACTS, IOWA PURCHASE OF ADMINISTRATIVE SUPPORT, AND  
IOWA DONATIONS OF FUNDS CONTRACT AND PROVISIONS FOR PUBLIC ACCESS TO CONTRACTS

150.1(234)	Definitions
150.2(234)	Categories of contracts
150.3(234)	Iowa purchase of social services agency contract
150.4(234)	Iowa purchase of social services contract—individual providers
150.5(234)	Iowa purchase of administrative support
150.6 to 150.8	Reserved
150.9(234)	Public access to contracts

#### CHAPTER 151

##### JUVENILE COURT SERVICES DIRECTED PROGRAMS

#### DIVISION I

##### GENERAL PROVISIONS

151.1(232)	Definitions
151.2(232)	Administration of funds for court-ordered services and graduated sanction services
151.3(232)	Administration of juvenile court services programs within each judicial district
151.4(232)	Billing and payment
151.5(232)	Appeals
151.6(232)	District program reviews and audits
151.7 to 151.19	Reserved

#### DIVISION II

##### COURT-ORDERED SERVICES

151.20(232)	Juvenile court services responsibilities
151.21(232)	Certification process
151.22(232)	Expenses
151.23 to 151.29	Reserved

DIVISION III  
GRADUATED SANCTION SERVICES

151.30(232)	Life skills
151.31(232)	School-based supervision
151.32(232)	Supervised community treatment
151.33(232)	Tracking, monitoring, and outreach
151.34(232)	Administration of graduated sanction services
151.35(232)	Contract development for graduated sanction services

CHAPTER 152  
FOSTER GROUP CARE CONTRACTING

152.1(234)	Definitions
152.2(234)	Conditions of participation
152.3(234)	Determination of rates
152.4(234)	Initiation of contract proposal
152.5(234)	Contract
152.6(234)	Client eligibility and referral
152.7(234)	Billing procedures
152.8(234)	Contract management
152.9(234)	Provider reviews
152.10(234)	Sanctions against providers
152.11(234)	Appeals of departmental actions

CHAPTER 153  
FUNDING FOR LOCAL SERVICES

DIVISION I  
SOCIAL SERVICES BLOCK GRANT

153.1(234)	Definitions
153.2(234)	Development of preexpenditure report
153.3(234)	Amendment to preexpenditure report
153.4(234)	Service availability
153.5(234)	Allocation of block grant funds
153.6 and 153.7	Reserved
153.8(234)	Expenditure of supplemental funds
153.9 and 153.10	Reserved

DIVISION II  
DECATEGORIZATION OF CHILD WELFARE AND JUVENILE JUSTICE FUNDING

153.11(232)	Definitions
153.12(232)	Implementation requirements
153.13(232)	Role and responsibilities of decategorization project governance boards
153.14(232)	Realignment of decategorization project boundaries
153.15(232)	Decategorization services funding pool
153.16(232)	Relationship of decategorization funding pool to other department child welfare funding
153.17(232)	Relationship of decategorization funding pool to juvenile court services funding streams
153.18(232)	Requirements for annual services plan
153.19(232)	Requirements for annual progress report
153.20 to 153.30	Reserved

DIVISION III  
MENTAL ILLNESS, MENTAL RETARDATION, AND  
DEVELOPMENTAL DISABILITIES—LOCAL SERVICES

153.31 to 153.50	Reserved
------------------	----------

DIVISION IV  
STATE PAYMENT PROGRAM FOR LOCAL MENTAL HEALTH, MENTAL RETARDATION, AND  
DEVELOPMENTAL DISABILITIES SERVICES TO ADULTS WITHOUT LEGAL SETTLEMENT

153.51(331)	Definitions
153.52(331)	Eligibility requirements
153.53(331)	Application procedure
153.54(331)	Eligibility determination
153.55(331)	Eligible services
153.56(331)	Program administration
153.57(331)	Reduction, denial, or termination of benefits
153.58(331)	Appeals

CHAPTER 154

Reserved

CHAPTER 155

CHILD ABUSE PREVENTION PROGRAM

155.1(235A)	Definitions
155.2(235A)	Contract for program administration
155.3(235A)	Awarding of grants

CHAPTER 156

PAYMENTS FOR FOSTER CARE

156.1(234)	Definitions
156.2(234)	Foster care recovery
156.3 to 156.5	Reserved
156.6(234)	Rate of maintenance payment for foster family care
156.7	Reserved
156.8(234)	Additional payments
156.9(234)	Rate of payment for foster group care
156.10(234)	Payment for reserve bed days
156.11(234)	Emergency care
156.12(234)	Supervised apartment living
156.13	Reserved
156.14(234,252C)	Voluntary placements
156.15(234)	Child's earnings
156.16(234)	Trust funds and investments
156.17(234)	Preadoptive homes
156.18	Reserved
156.19(237)	Rate of payment for care in a residential care facility
156.20(234)	Eligibility for foster care payment

CHAPTER 157

Reserved

CHAPTER 158

FOSTER HOME INSURANCE FUND

158.1(237)	Payments from the foster home insurance fund
158.2(237)	Payment limits
158.3(237)	Claim procedures
158.4(237)	Time frames for filing claims
158.5(237)	Appeals

## CHAPTER 159

## CHILD CARE RESOURCE AND REFERRAL SERVICES

- 159.1(237A) Definitions
- 159.2(237A) Availability of funds
- 159.3(237A) Participation requirements
- 159.4(237A) Request for proposals for project grants
- 159.5(237A) Selection of proposals

## CHAPTER 160

## ADOPTION OPPORTUNITY GRANT PROGRAM

- 160.1(234) Definitions
- 160.2(234) Availability of grant funds
- 160.3(234) Project eligibility
- 160.4(234) Request for proposals for project grants
- 160.5(234) Selection of proposals
- 160.6(234) Project contracts
- 160.7(234) Records
- 160.8(234) Evaluation of projects
- 160.9(234) Termination
- 160.10(234) Appeals

## CHAPTER 161

## IOWA SENIOR LIVING TRUST FUND

- 161.1(249H) Definitions
- 161.2(249H) Funding and operation of trust fund
- 161.3(249H) Allocations from the senior living trust fund
- 161.4(249H) Participation by government-owned nursing facilities

## CHAPTER 162

NURSING FACILITY CONVERSION  
AND LONG-TERM CARE SERVICES  
DEVELOPMENT GRANTS

- 162.1(249H) Definitions
- 162.2(249H) Availability of grants
- 162.3(249H) Grant eligibility
- 162.4(249H) Grant application process
- 162.5(249H) Grant dispersal stages
- 162.6(249H) Project contracts
- 162.7(249H) Grantee responsibilities
- 162.8(249H) Offset
- 162.9(249H) Appeals

## CHAPTER 163

ADOLESCENT PREGNANCY PREVENTION AND SERVICES  
TO PREGNANT AND PARENTING ADOLESCENTS  
PROGRAMS

- 163.1(234) Definitions
- 163.2(234) Availability of grants for projects
- 163.3(234) Project eligibility
- 163.4(234) Request for proposals for pilot project grants
- 163.5(234) Selection of proposals
- 163.6(234) Project contracts
- 163.7(234) Records

- 163.8(234) Evaluation
- 163.9(234) Termination of contract
- 163.10(234) Appeals

CHAPTER 164  
IOWA HOSPITAL TRUST FUND

- 164.1(249I) Definitions
- 164.2(249I) Funding and operation of trust fund
- 164.3(249I) Allocations from the hospital trust fund
- 164.4(249I) Participation by public hospitals

CHAPTER 165  
Reserved

CHAPTER 166  
QUALITY IMPROVEMENT INITIATIVE GRANTS

- 166.1(249A) Definitions
- 166.2(249A) Availability of grants
- 166.3(249A) Requirements for applicants
- 166.4(249A) Requirements for initiatives
- 166.5(249A) Applications
- 166.6(249A) Awarding of grants
- 166.7(249A) Grant requirements

CHAPTER 167  
JUVENILE DETENTION REIMBURSEMENT

DIVISION I  
ANNUAL REIMBURSEMENT PROGRAM

- 167.1(232) Definitions
- 167.2(232) Availability of funds
- 167.3(232) Eligible facilities
- 167.4(232) Available reimbursement
- 167.5(232) Submission of voucher
- 167.6(232) Reimbursement by the department

CHAPTER 168  
CHILD CARE EXPANSION PROGRAMS

- 168.1(234) Definitions
- 168.2(234) Availability of funds
- 168.3(234) Eligibility requirements
- 168.4(234) Request for proposals
- 168.5(234) Selection of proposals
- 168.6(234) Appeals
- 168.7(234) Contracts
- 168.8(234) Reporting requirements
- 168.9(234) Termination of contract

CHAPTER 169  
FUNDING FOR EMPOWERMENT AREAS

- 169.1(7I) Definitions
- 169.2(7I) Use of funds
- 169.3(7I) Eligibility for funding
- 169.4(7I) Funding availability
- 169.5(7I) Community empowerment areas' responsibilities

- 169.6(7I) Iowa empowerment board's responsibilities
- 169.7(7I) Department of human services' responsibilities
- 169.8(7I) Revocation of funding
- 169.9(7I) Appeals

TITLE XV  
*INDIVIDUAL AND FAMILY SUPPORT  
AND PROTECTIVE SERVICES*

CHAPTER 170  
CHILD CARE SERVICES

- 170.1(237A) Definitions
- 170.2(237A,239B) Eligibility requirements
- 170.3(237A,239B) Application and determination of eligibility
- 170.4(237A) Elements of service provision
- 170.5(237A) Adverse actions
- 170.6(237A) Appeals
- 170.7(237A) Provider fraud
- 170.8 Reserved
- 170.9(237A) Child care assistance overpayments

CHAPTER 171  
Reserved

CHAPTER 172  
FAMILY-CENTERED CHILD WELFARE SERVICES

DIVISION I  
GENERAL PROVISIONS

- 172.1(234) Definitions
- 172.2(234) Purpose and scope
- 172.3(234) Authorization
- 172.4(234) Reimbursement
- 172.5(234) Client appeals
- 172.6(234) Reviews and audits
- 172.7 to 172.9 Reserved

DIVISION II  
SAFETY PLAN SERVICES

- 172.10(234) Service requirements
- 172.11(234) Contractor selection
- 172.12(234) Service eligibility
- 172.13(234) Service components
- 172.14(234) Monitoring of service delivery
- 172.15(234) Billing and payment
- 172.16 to 172.19 Reserved

DIVISION III  
FAMILY SAFETY, RISK, AND PERMANENCY SERVICES

- 172.20(234) Service requirements
- 172.21(234) Contractor selection
- 172.22(234) Service eligibility
- 172.23(234) Service components
- 172.24(234) Monitoring of service delivery
- 172.25(234) Billing and payment
- 172.26 to 172.29 Reserved

DIVISION IV  
FAMILY-CENTERED SUPPORTIVE SERVICES

172.30(234)	Service components
172.31(234)	Contractor selection
172.32(234)	Service eligibility
172.33(234)	Monitoring of service delivery
172.34(234)	Billing and payment

CHAPTERS 173 and 174  
Reserved

CHAPTER 175  
ABUSE OF CHILDREN

DIVISION I  
CHILD ABUSE

175.1 to 175.20	Reserved
-----------------	----------

DIVISION II  
CHILD ABUSE ASSESSMENT

175.21(232,235A)	Definitions
175.22(232)	Receipt of a report of child abuse
175.23(232)	Sources of report of child abuse
175.24(232)	Child abuse assessment intake process
175.25(232)	Child abuse assessment process
175.26(232)	Completion of a child protective assessment summary
175.27(232)	Contact with juvenile court or the county attorney
175.28(232)	Consultation with health practitioners or mental health professionals
175.29(232)	Consultation with law enforcement
175.30(232)	Information shared with law enforcement
175.31(232)	Completion of required correspondence
175.32(232,235A)	Case records
175.33(232,235A)	Child protection centers
175.34(232)	Department-operated facilities
175.35(232,235A)	Jurisdiction of assessments
175.36(235A)	Multidisciplinary teams
175.37(232)	Community education
175.38(235)	Written authorizations
175.39(232)	Founded child abuse
175.40	Reserved
175.41(235A)	Access to child abuse information
175.42(235A)	Person conducting research
175.43(235A)	Child protection services citizen review panels

CHAPTER 176  
DEPENDENT ADULT ABUSE

176.1(235B)	Definitions
176.2(235B)	Denial of critical care
176.3(235B)	Appropriate evaluation
176.4(235B)	Reporters
176.5(235B)	Reporting procedure
176.6(235B)	Duties of the department upon receipt of report
176.7(235B)	Appropriate evaluation or assessment
176.8(235B)	Immunity from liability for reporters
176.9(235B)	Registry records

176.10(235B)	Adult abuse information disseminated
176.11(235B)	Person conducting research
176.12(235B)	Examination of information
176.13(235B)	Dependent adult abuse information registry
176.14	Reserved
176.15(235B)	Multidisciplinary teams
176.16(235B)	Medical and mental health examinations
176.17(235B)	Request for correction or expungement

## CHAPTER 177

## IN-HOME HEALTH RELATED CARE

177.1(249)	In-home health related care
177.2(249)	Own home
177.3(249)	Service criteria
177.4(249)	Eligibility
177.5(249)	Providers of health care services
177.6(249)	Health care plan
177.7(249)	Client participation
177.8(249)	Determination of reasonable charges
177.9(249)	Written agreements
177.10(249)	Emergency services
177.11(249)	Termination

## CHAPTERS 178 to 183

Reserved

## CHAPTER 184

## INDIVIDUAL AND FAMILY DIRECT SUPPORT

## DIVISION I

## FAMILY SUPPORT SUBSIDY PROGRAM

184.1(225C)	Definitions
184.2(225C)	Eligibility requirements
184.3(225C)	Application process
184.4(225C)	Family support services plan
184.5	Reserved
184.6(225C)	Amount of subsidy payment
184.7(225C)	Redetermination of eligibility
184.8(225C)	Termination of subsidy payments
184.9(225C)	Appeals
184.10 to 184.20	Reserved

## DIVISION II

## COMPREHENSIVE FAMILY SUPPORT PROGRAM

184.21(225C)	Definitions
184.22(225C)	Eligibility
184.23(225C)	Application
184.24(225C)	Contractor selection and duties
184.25(225C)	Direct assistance
184.26(225C)	Appeals
184.27(225C)	Parent advisory council

## CHAPTER 185

Reserved

CHAPTER 186  
COMMUNITY CARE

186.1(234)	Definitions
186.2(234)	Eligibility
186.3(234)	Services provided
186.4(234)	Appeals

CHAPTER 187  
AFTERCARE SERVICES AND SUPPORTS

DIVISION I  
AFTERCARE SERVICES

187.1(234)	Purpose
187.2(234)	Eligibility
187.3(234)	Services and supports provided
187.4(234)	Termination
187.5(234)	Waiting list
187.6(234)	Administration
187.7 to 187.9	Reserved

DIVISION II  
PREPARATION FOR ADULT LIVING (PAL) PROGRAM

187.10(234)	Purpose
187.11(234)	Eligibility
187.12(234)	Payment
187.13(234)	Termination of stipend
187.14(234)	Waiting list
187.15(234)	Administration

CHAPTERS 188 to 199  
Reserved

TITLE XVI  
*ALTERNATIVE LIVING*

CHAPTER 200  
ADOPTION SERVICES

200.1(600)	Definitions
200.2(600)	Release of custody services
200.3(600)	Application
200.4(600)	Adoption services
200.5(600)	Termination of parental rights
200.6 and 200.7	Reserved
200.8(600)	Interstate placements
200.9	Reserved
200.10(600)	Requests for home studies
200.11(600)	Reasons for denial
200.12(600)	Removal of child from preadoptive family
200.13(600)	Consents
200.14(600)	Requests for access to information for research or treatment
200.15(600)	Requests for information for purposes other than research or treatment
200.16(600)	Appeals

CHAPTER 201  
SUBSIDIZED ADOPTIONS

201.1(600)	Administration
201.2(600)	Definitions
201.3(600)	Conditions of eligibility or ineligibility
201.4(600)	Application
201.5(600)	Negotiation of amount of presubsidy or subsidy
201.6(600)	Types of subsidy
201.7(600)	Termination of subsidy
201.8(600)	Reinstatement of subsidy
201.9(600)	New application
201.10(600)	Medical assistance based on residency
201.11(600)	Presubsidy recovery

CHAPTER 202  
FOSTER CARE PLACEMENT AND SERVICES

202.1(234)	Definitions
202.2(234)	Eligibility
202.3(234)	Voluntary placements
202.4(234)	Selection of facility
202.5(234)	Preplacement
202.6(234)	Placement
202.7(234)	Out-of-area placements
202.8(234)	Out-of-state placements
202.9(234)	Supervised apartment living
202.10(234)	Services to foster parents
202.11(234)	Services to the child
202.12(234)	Services to parents
202.13(234)	Removal of the child
202.14(234)	Termination
202.15(234)	Case permanency plan
202.16(135H)	Department approval of need for a psychiatric medical institution for children
202.17(232)	Area group care targets
202.18(235)	Local transition committees

CHAPTER 203  
IOWA ADOPTION EXCHANGE

203.1(232)	Definitions
203.2(232)	Children to be registered on the exchange system
203.3(232)	Families to be registered on the exchange system
203.4(232)	Matching process

CHAPTER 204  
SUBSIDIZED GUARDIANSHIP PROGRAM

204.1(234)	Definitions
204.2(234)	Eligibility
204.3(234)	Application
204.4(234)	Negotiation of amount of subsidy
204.5(234)	Parental liability
204.6(234)	Termination of subsidy
204.7(234)	Reinstatement of subsidy
204.8(234)	Appeals
204.9(234)	Medical assistance

CHAPTER 76  
ENROLLMENT AND REENROLLMENT

[Ch 76, 1973 IDR, renumbered as Ch 911]

[Prior to 7/1/83, Social Services[770] Ch 76]

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

PREAMBLE

This chapter specifies the process for enrolling and reenrolling in the Iowa Medical Assistance or “Medicaid” program and addresses related matters.

Eligible individuals must be enrolled for the date on which services are provided in order for payment to be made for the services received.

Initial enrollment must be based on an application submitted to the department, a referral from a health insurance marketplace, an express lane eligibility determination, a Social Security Income eligibility determination, a transmittal from the federal Social Security Administration for Medicare savings programs, or a presumptive eligibility determination, as described in rules 441—76.2(249A) through 441—76.7(249A).

Reenrollment is based on a review, as described in rule 441—76.14(249A), of all eligibility factors under 441—Chapter 75.

Applicants and members are required to report changes pursuant to rule 441—76.15(249A).

Department action on information received will occur as described in rules 441—76.15(249A) and 441—76.16(249A).

Automatic redeterminations of eligibility will occur as described in rule 441—76.17(249A).

This chapter shall be construed to comply with all requirements for federal funding under Title XIX of the Social Security Act or under the terms of any applicable waiver of Title XIX requirements granted by the Secretary of the U.S. Department of Health and Human Services. To the extent this chapter is inconsistent with any applicable federal funding requirement under Title XIX or the terms of any applicable waiver, the requirements of Title XIX or the terms of the waiver shall prevail.

[ARC 1069C, IAB 10/2/13, effective 10/1/13]

**441—76.1(249A) Definitions.**

“*Authorized representative*” means an individual or organization authorized by a competent applicant or member, authorized by a responsible person acting for an incompetent applicant or member pursuant to subrule 76.9(2), or with other legal authority to represent the applicant or member in the application process, renewal of eligibility and other ongoing communications with the department.

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

“*Electronic case record*” means an electronic file that includes all information collected and generated by the department regarding each individual’s Medicaid eligibility and enrollment.

“*Health insurance marketplace*” means an American health benefit exchange established pursuant to 42 U.S.C. § 18031.

“*Medicare savings program*” refers to the limited Medicaid coverage groups that provide payment of Medicare premiums, coinsurance, and deductibles for low-income elderly or disabled individuals. Those groups are qualified disabled and working people (QDWP) pursuant to 42 U.S.C. § 1396a(a)(10)(E)(ii), qualified Medicare beneficiaries (QMB) pursuant to 42 U.S.C. § 1396a(a)(10)(E)(i), specified low-income Medicare beneficiaries (SLMB) pursuant to 42 U.S.C. § 1396a(a)(10)(E)(iii), and expanded specified low-income Medicare beneficiaries (ESLMB) pursuant to 42 U.S.C. § 1396a(a)(10)(E)(iv).

“*Member*” means an individual who has been determined eligible for medical assistance pursuant to 441—Chapter 75 and has been enrolled to receive assistance. For the medically needy program, “member” shall mean an individual who has been determined eligible for medical assistance under the medically needy program, has been enrolled, and has countable income at or below the medically needy income level (MNIL) or has reduced countable income to the MNIL during the certification period through spenddown.

“*Modified adjusted gross income*” means the methodology to determine income eligibility prescribed by 1902(e)(14) of the Social Security Act (42 U.S.C. § 1396a(e)(14)).

“*Presumptive eligibility*” means that a person is presumed to be eligible on a temporary basis based on information provided.

“*Qualified entity*” is an entity that is described in Paragraphs (1) through (10) of 42 CFR 435.1101 relating to coverage groups for children, 42 CFR 435.1110b relating to hospitals determining eligibility, U.S.C. § 1396r-1 relating to coverage groups for pregnant women, or 42 U.S.C. § 1396r-1b relating to the breast and cervical cancer coverage group, that has been determined by the department to be capable of making presumptive Medicaid eligibility determinations, and that has signed an agreement with the department as a qualified entity.

“*Responsible person*” means an individual recognized by the department pursuant to subrule 76.9(1) as acting for an applicant or member who is unable to act on the applicant’s or member’s own behalf because the applicant or member is a minor or is incompetent, incapacitated, or deceased.

“*Supplemental security income*” or “*SSI*” is a federally administered program established by Title XVI of the Social Security Act to provide supplemental income to individuals who have attained the age of 65 or are blind or disabled.

“*WIC*” is the Special Supplemental Nutrition Program for Women, Infants, and Children established by 42 U.S.C. § 1786.

[ARC 1069C, IAB 10/2/13, effective 10/1/13]

**441—76.2(249A) Application with the department.** This rule describes the process of applying for medical assistance directly with the department of human services.

**76.2(1) Application for eligibility effective prior to January 1, 2014.** Application for the Medicaid or HAWK-I program to be initially effective prior to January 1, 2014, must be made as provided in this subrule.

*a. Forms.*

(1) An application for family medical assistance-related Medicaid programs shall be submitted on Health and Financial Support Application, Form 470-0462 or Form 470-0462(S); Health Services Application, Form 470-2927 or Form 470-2927(S); HAWK-I Application, Comm. 156; or HAWK-I Electronic Application Summary and Signature Page, Form 470-4016.

(2) An application for SSI-related Medicaid shall be submitted on Health Services Application, Form 470-2927 or Form 470-2927(S), or Health and Financial Support Application, Form 470-0462 or Form 470-0462(S).

(3) An application for Medicaid for persons in foster care shall be submitted on Health Services Application, Form 470-2927 or Form 470-2927(S).

*b. Who can file.* An application may be filed by the applicant, an adult in the applicant’s household or family, an authorized representative recognized pursuant to subrule 76.9(2), or a responsible person recognized pursuant to subrule 76.9(1).

*c. How and where to file.*

(1) An application may be filed over the Internet at [www.dhs.iowa.gov](http://www.dhs.iowa.gov), by submission to any local office of the department, or by submission to a department outstation at a disproportionate share hospital, federally qualified health center or other facility where outstationing activities are provided. Applications may be submitted in person, by mail, by fax or by e-mail.

(2) Health Services Application, Form 470-2927 or Form 470-2927(S), may also be filed at the office of a qualified entity for presumptive Medicaid eligibility determinations, a WIC office, a maternal health clinic, or a well child clinic.

(3) Individuals applying for medical assistance for family planning services under 441—subrule 75.1(41) or 441—Chapter 87 may also apply at any family planning agency as defined in rule 441—87.1(82GA,ch1187).

(4) An application for HAWK-I may be filed with the third-party administrator as provided at 441—subrule 86.3(3).

*d. Minimum application requirements.* A valid application is an application containing a legible name, a legible address, and a signature. An authorized representative or responsible person recognized pursuant to rule 441—76.9(249A) may sign on an applicant's behalf. Electronic and handwritten signatures transmitted via electronic transmissions are acceptable. An application that does not include a legible name, a legible address, and a signature will be rejected without a determination of eligibility.

*e. Interviews.*

(1) The department may require a face-to-face or telephone interview with adult applicants, authorized representatives, or responsible persons.

(2) The department shall notify the applicant, authorized representative, or responsible person of the date, time and method of an interview. This notice shall be provided to the applicant, authorized representative, or responsible person personally, by telephone, by e-mail, by mail or by fax.

(3) Failure of the applicant, authorized representative, or responsible person to attend a scheduled interview shall be a basis for denial of an application or cancellation of assistance for adults. Failure to attend an interview shall not serve as a basis for denial of an application or cancellation of assistance for children.

*f. Additional information or verification needed to determine eligibility.* The department shall notify the applicant, authorized representative, or responsible person in writing that additional information or verification is required to establish eligibility. This notice shall be provided to the applicant, authorized representative, or responsible person personally or by mail or fax.

(1) The department shall allow the applicant, authorized representative, or responsible person ten calendar days to supply the information or verification requested.

(2) The department may extend the deadline for a reasonable period of time when the applicant, authorized representative, or responsible person is making every effort but is unable to secure the required information or verification.

(3) The application shall be denied if the department does not receive one of the following by the due date:

1. The information or verification,
2. An authorization for the department to obtain the information or verification, or
3. A request for an extension of the due date.

(4) If benefits are denied for failure to provide information or verification and the information or verification is provided within 14 calendar days of the effective date of the denial, the department shall complete the eligibility determination as though the information or verification were received timely. If the fourteenth calendar day falls on a weekend or state holiday, the applicant, authorized representative, or responsible person shall have until the next business day to provide the information.

**76.2(2)** *Application for eligibility effective on or after January 1, 2014.* Application for the Medicaid or HAWK-I program to be initially effective on or after January 1, 2014, must be made as provided in this subrule.

*a. Form.* Application for the Medicaid or HAWK-I program shall be submitted on Application for Health Coverage and Help Paying Costs, Form 470-5170 or 470-5170(S).

*b. Who can file.* An application may be filed by the applicant, an adult in the applicant's household or family, an authorized representative recognized pursuant to subrule 76.9(2), or a responsible person recognized pursuant to subrule 76.9(1).

*c. How and where to file.*

(1) An application may be filed over the Internet at [www.dhs.iowa.gov](http://www.dhs.iowa.gov) or at [www.dhsservices.iowa.gov](http://www.dhsservices.iowa.gov) or at the health insurance marketplace Web site at [www.healthcare.gov](http://www.healthcare.gov), by submission to any local office of the department, or by submission to a department outstation at a disproportionate share hospital, federally qualified health center, or other facility where outstationing activities are provided. Applications may be submitted in person, by mail, by telephone at 1-855-889-7985, or by e-mail or fax. Addresses, e-mail addresses and fax numbers of local offices of the department are available at [www.dhs.state.ia.us/Consumers/Find\\_Help/MapLocations.html](http://www.dhs.state.ia.us/Consumers/Find_Help/MapLocations.html).

(2) An application may also be filed at the office of a qualified entity for presumptive Medicaid eligibility determinations, a WIC office, a maternal health clinic, or a well child clinic.

(3) Individuals applying for medical assistance for family planning services under 441—subrule 75.1(41) or 441—Chapter 87 may also apply at any family planning agency as defined in rule 441—87.1(82GA,ch1187).

*d. Minimum application requirements.* Initial applications must be signed under penalty of perjury. An authorized representative or responsible person recognized pursuant to rule 441—76.9(249A) may sign on an applicant's behalf. Electronic, including telephonically recorded, signatures and handwritten signatures transmitted via any electronic transmission are acceptable. An application that does not include a signature under penalty of perjury will be rejected without a determination of eligibility.

*e. Additional information or verification needed to determine eligibility.* The applicant must provide additional information or verification as requested by the department, including information or verification necessary to determine SSI-related Medicaid eligibility, as requested on SSI Medicaid Information, Form 470-0364, 470-0364(S), 470-0364(M), or 470-0364(MS).

*f. Interviews.* The applicant, authorized representative, or responsible person may be required to attend a face-to-face or telephone interview to clarify information or to resolve conflicting information. Failure to attend a required interview will result in denial of the application.

**76.2(3) Date of filing.**

*a.* An application is considered filed on the date a valid application is received in any place of filing specified in paragraph 76.2(1) "c" or 76.2(2) "c." When an application is delivered after business hours, it will be considered received on the next business day.

*b.* A valid application for Medicaid which is filed at a WIC office, a well child clinic, a maternal health clinic, an outstationed office, or the office of a qualified entity for presumptive Medicaid eligibility determinations shall be considered filed on the date it is received and date-stamped in one of those offices. When the application is received while the office is closed, it will be considered received on the next business day.

[ARC 1069C, IAB 10/2/13, effective 10/1/13]

**441—76.3(249A) Referrals from a health insurance marketplace.** Upon receipt of a referral from a health insurance marketplace indicating that an application filed with the health insurance marketplace has been screened and that the applicant has been found to be potentially eligible for Medicaid or HAWK-I, the department will treat the referral as an application for medical assistance and will process the application as if received directly by the department. The applicant is required to cooperate as described in this chapter for applications received directly by the department.

[ARC 1069C, IAB 10/2/13, effective 10/1/13]

**441—76.4(249A) Express lane eligibility.** For purposes of the initial enrollment of a child in medical assistance, the department will use express lane procedures as allowed by 42 U.S.C. § 1396a(e)(13) and as described in this rule.

**76.4(1)** For purposes of initial enrollment, the department shall rely on a determination of the child's eligibility for food assistance pursuant to 441—Chapter 65 as establishing that a child under the age of 19 meets all eligibility requirements established in 441—subrule 75.1(28) except for citizenship or alienage requirements, unless:

*a.* The child's household already includes other persons receiving Medicaid based on the use of the modified adjusted gross income methodology, or

*b.* The child was previously granted express lane eligibility and the household has not had at least a two-month break in food assistance eligibility since that time, or

*c.* The household's income as calculated by the food assistance program exceeds the income limit for the mothers and children coverage group found at 441—subparagraph 75.1(28) "a"(1).

**76.4(2)** To obtain express lane enrollment for a child, the child's household must request medical assistance for the child on Express Lane Medicaid for Children, Form 470-4851 or Form 470-4851(S). The department shall send Form 470-4851 or Form 470-4851(S) to the household when a child eligible for express lane enrollment is approved for food assistance pursuant to 441—Chapter 65. An adult

member of the child's household or a child receiving food assistance as head of household must sign Form 470-4851 or Form 470-4851(S) and return it to the department within 30 calendar days of issuance.

**76.4(3)** As a condition of express lane enrollment, the child must meet the citizenship or alienage requirements of rule 441—75.11(249A).

**76.4(4)** The month of application for express lane enrollment is the month of the child's food assistance effective date. Express lane eligibility begins on the first day of the month of the child's food assistance effective date.

**76.4(5)** Retroactive enrollment is available for any of the three months before the month of the child's food assistance effective date when the child:

- a. Has medical bills for covered services that were received in that period, and
- b. Would have been eligible for medical assistance benefits in the month services were received if the application for medical assistance had been made in that month and the eligibility determination was made without regard to food assistance eligibility.

**76.4(6)** After the initial express lane enrollment, all redeterminations of medical assistance eligibility shall be made without reliance on any food assistance eligibility determination.

[ARC 1069C, IAB 10/2/13, effective 10/1/13]

**441—76.5(249A) Enrollment through SSI.** Upon receipt of a referral from the Social Security Administration indicating that an individual has been approved for SSI, the department will treat the referral as an application for medical assistance and will process the application as if received directly by the department. The SSI recipient shall be required to complete SSI Medicaid Information, Form 470-0364, 470-0364(S), 470-0364(M), or 470-0364(MS), when additional information is necessary to determine Medicaid eligibility. The SSI recipient may be required to attend an interview to clarify information on this form.

[ARC 1069C, IAB 10/2/13, effective 10/1/13]

**441—76.6(249A) Referral for Medicare savings program.** Referrals received from the federal Social Security Administration pursuant to 42 U.S.C. 1320b-14(c)(3) when the individual has indicated that the individual wants to apply for the Medicare savings program will be treated by the department as an application for the Medicare savings program and will be processed as if the application were received directly by the department. The date on which the referral is transmitted by the Social Security Administration shall be treated as the date of application. When requested to do so, the applicant must complete Medicare Savings Programs Additional Information Request, Form 470-4846, to provide additional information needed to determine Medicare savings program eligibility.

[ARC 1069C, IAB 10/2/13, effective 10/1/13]

**441—76.7(249A) Presumptive eligibility.** Individuals may be temporarily enrolled in Medicaid based on a presumptive eligibility determination by a qualified entity pursuant to this rule.

**76.7(1)** *For eligibility effective prior to January 1, 2014.*

a. Applicants for presumptive eligibility for children will complete Application: Presumptive Health Care Coverage for Children, Form 470-4855 or 470-4855(S).

b. Applicants for presumptive eligibility for pregnant women or for presumptive eligibility for breast and cervical cancer coverage group shall complete Health Services Application, Form 470-2927 or Form 470-2927(S).

**76.7(2)** *For eligibility effective on or after January 1, 2014.* Applicants for presumptive eligibility will complete Application for Health Coverage and Help Paying Costs, Form 470-5170 or 470-5170(S).

**76.7(3)** *How and where to file.* Applications for presumptive eligibility are filed at the office of a qualified entity for presumptive Medicaid eligibility determinations.

**76.7(4)** *Enrollment.* An individual is enrolled on the date that presumptive eligibility is determined by the qualified entity.

**76.7(5)** *Notice and appeal rights.* Timely and adequate notice requirements and appeal rights of the Medicaid program shall not apply to presumptive eligibility decisions made by a qualified entity.

**76.7(6) Full medical assistance eligibility determination.** All presumptive eligibility applications shall receive a full determination of eligibility for Medicaid or HAWK-I except for breast and cervical cancer and pregnant women coverage groups.  
[ARC 1069C, IAB 10/2/13, effective 10/1/13]

**441—76.8(249A) Applicant responsibilities.**

**76.8(1) Accurate information.** Applicants are responsible to give complete and accurate information needed to establish eligibility.

**76.8(2) Time frames for providing information or verification.** Applicants shall have ten calendar days to supply the information or verification requested by the department.

**76.8(3) Extensions.** The applicant may request an extension of a reasonable period of time when the applicant is making every effort but is unable to secure the required information or verification.

**76.8(4) Failure to comply.** An application shall be denied if the applicant does not attend a required interview, if applicable under subrule 76.2(1) or 76.2(2), or if the department does not receive one of the following by the due date:

- a. The information or verification,
- b. An authorization to obtain the information or verification, or
- c. A request for an extension of the due date.

**76.8(5) Grace period.** If benefits are denied for failure to provide information or verification and the information or verification is provided within 14 calendar days of the effective date of the denial, the department shall complete the eligibility determination as though the information were received timely. If the fourteenth calendar day falls on a weekend or state holiday, the applicant shall have until the next business day to provide the information.

**76.8(6) Referrals to the Social Security Administration.** When an applicant or member may be eligible for benefits from the Social Security Administration and is directed by the department to apply for such benefits, the applicant or member must make application for such benefits as described in rule 441—75.3(249A).

[ARC 1069C, IAB 10/2/13, effective 10/1/13]

**441—76.9(249A) Responsible persons and authorized representatives.**

**76.9(1) Responsible person.** If an applicant or member is unable to act on the applicant's or member's own behalf because the applicant or member is a minor or is incompetent, incapacitated, or deceased, a responsible person may act for the applicant or member. Except as provided in paragraph 76.9(1) "a" below, the responsible person shall be a family member, friend or other person who has knowledge of the applicant's or member's financial affairs and circumstances and has a personal interest in the applicant's or member's welfare. The responsible person shall assume the applicant's or member's position and responsibilities during the application process or for ongoing eligibility. The responsible person may designate an authorized representative as provided for in subrule 76.9(2) to represent the applicant or member. However, the designation of an authorized representative does not relieve the responsible person from assuming the applicant's or member's position and responsibilities during the application process or for ongoing eligibility.

a. When there is no person as described above to act on behalf of the minor, incompetent, incapacitated, or deceased applicant or member, any individual or organization may be allowed to act as the responsible person if the individual or organization conducts a diligent search and completes Inability to Find a Responsible Person, Form 470-3356, attesting to the individual's or organization's inability to find a responsible person to act on behalf of the minor, incompetent, incapacitated, or deceased applicant or member.

b. The department may require verification of the applicant's or member's incompetence or death and of the responsible person's relationship to the applicant or member.

c. Copies of all departmental correspondence with the applicant or member shall be provided to the recognized responsible person.

**76.9(2) Authorized representative.** An individual or organization designated by a competent applicant or member, designated by a responsible person recognized pursuant to subrule 76.9(1), or

with other legal authority to do so may act on behalf of the applicant or member in the application process, renewal of eligibility, or for ongoing eligibility.

*a.* The designation of an authorized representative by an applicant, member, or responsible person must be in writing and must be signed and dated by the applicant or member or the responsible person. The applicant, member, or responsible person may authorize the representative to complete and sign an application on the applicant's behalf, complete and submit a renewal form, receive copies of the applicant's or member's notices and other communications from the department, and act on behalf of the applicant or member in all other matters with the department.

*b.* Legal documentation of authority to act on behalf of the applicant or member under state law, such as a court order establishing legal guardianship or a power of attorney, shall serve in place of a written authorization by the applicant or member.

*c.* Designations of authorized representatives, legal documentation of authority to act on behalf of the applicant or member, and modifications or terminations of designations or legal authority may be submitted via the Internet Web site, [www.dhsservices.iowa.gov](http://www.dhsservices.iowa.gov), by mail, by e-mail, by fax, or in person.

*d.* For purposes of this rule, the department shall accept electronic, including telephonically recorded, signatures and handwritten signatures transmitted by fax or other electronic transmission.

*e.* If the authorization indicates the time period or dates the authorization is to cover, the stated period or dates shall be honored and may include subsequent applications, if necessary, that relate to the time period or dates indicated on the authorization. If the authorization does not indicate the time period or dates it is to cover, the authorization shall be valid for any applications filed within 120 days from the date the authorization was signed and for all subsequent actions pertaining to the applications filed within the 120-day period.

*f.* The power to act as an authorized representative based on a designation by an applicant, member, or responsible person is valid until the applicant, member, or responsible person modifies the authorization or notifies the department that the representative is no longer authorized to act on behalf of the applicant or member or until the authorized representative informs the department that the representative no longer is acting in such capacity. Such notice must be in writing and should include the applicant's, member's, responsible person's, or authorized representative's signature as appropriate.

*g.* Copies of all departmental correspondence shall be provided to the applicant or member and the authorized representative.

**76.9(3)** *Additional requirements applicable to all authorized representatives and responsible persons.*

*a.* An authorized representative or responsible person must agree to maintain, or be legally bound to maintain, the confidentiality of any information regarding an applicant or member provided by the department.

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

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

[ARC 1069C, IAB 10/2/13, effective 10/1/13]

**441—76.10(249A) Right to withdraw the application.** The applicant may withdraw the application at any time before the eligibility determination has been made. The applicant may request that the application be withdrawn entirely or request withdrawal for any month covered by the application process

except as provided in the medically needy program in accordance with the provisions of 441—subrule 75.1(35).

[ARC 1069C, IAB 10/2/13, effective 10/1/13]

**441—76.11(249A) Choice of electronic notifications.** The applicant is responsible to indicate if notices and other communications are to be provided by the department in an electronic format through the individual's electronic account, rather than by regular mail. The applicant may change the selection at any time. Notices and other communications provided through the individual's electronic account are deemed to be received upon the sending of an e-mail to the individual notifying the individual of the notice or other communication.

[ARC 1069C, IAB 10/2/13, effective 10/1/13]

**441—76.12(249A) Application not required.**

**76.12(1) Adding a new person.**

*a. Adding an eligible person.* For members whose eligibility is based on the modified adjusted gross income methodology, a new application is not required when an eligible person is added to an existing Medicaid-eligible group. Such a person is considered to be included in the application that established the existing eligible group. However, in these instances, the date of application to add a person is the date the change is reported. When it is reported that a person is anticipated to enter the home, the date of application to add the person shall be no earlier than the date of entry or the date of report, whichever is later.

*b. Adding a person previously ineligible due to a failure to cooperate.* In those instances where a person previously ineligible for Medicaid for failure to cooperate in obtaining medical support or establishing paternity as described at 441—subrule 75.14(2) is to be granted Medicaid benefits, the person shall be granted Medicaid benefits effective the first of the month in which the person becomes eligible by cooperating in obtaining medical support or establishing paternity.

*c. Adding a person previously ineligible due to failure to provide a social security number.* In those instances where a person previously ineligible for Medicaid for failure to provide a social security number or proof of application for a social security number as described at rule 441—75.7(249A) is to be granted Medicaid benefits, the person shall be granted Medicaid benefits effective the first of the month in which the person becomes eligible by providing a social security number.

*d. Adding a person who was voluntarily excluded.* In those instances where a person who has been voluntarily excluded from the eligible group in accordance with the provisions of rule 441—75.59(249A) is being added to the eligible group, the person shall be added effective the first of the month after the month in which the household requests that the person no longer be excluded.

**76.12(2) Reinstatement after cancellation.** Eligibility for medical assistance may be reinstated without a new application when all information necessary to establish eligibility, including verification of any changes, is provided within 14 calendar days of the effective date of the cancellation. If the fourteenth calendar day falls on a weekend or state holiday, the member shall have until the next business day to provide the information.

**76.12(3) Loss of HAWK-I eligibility.** In those instances where a child loses HAWK-I eligibility and has been determined eligible for Medicaid, with no break in coverage, an application for Medicaid is not required.

[ARC 1069C, IAB 10/2/13, effective 10/1/13]

**441—76.13(249A) Initial enrollment.**

**76.13(1) Enrollment date.** Applicants who have been determined to be eligible shall be enrolled by the department in the Medicaid program.

*a. First day of the month.* The effective date of enrollment is the first day of the first month for which eligibility has been determined, with the following exceptions:

(1) Presumptive eligibility is effective on the date that presumptive eligibility was determined by a qualified entity for presumptive Medicaid eligibility determinations.

(2) Eligibility under the qualified Medicare beneficiary coverage group begins on the first day of the month after the month of decision.

(3) Eligibility for individuals approved for supplemental security income, programs related to supplemental security income, state supplementary assistance, or medical assistance benefits shall be effective on the first day of the month when the individual was resource-eligible as of the first moment of the first day of the month and met all other eligibility criteria at any time during the month.

(4) When a request is made to add a new person to the eligible group, medical assistance shall not be effective before the first of the month in which the request was made.

(5) When a request is made prior to January 1, 2014, to add to the eligible group a person who previously was excluded, in accordance with the provisions of rule 441—75.59(249A), medical assistance for the person shall be effective no earlier than the first day of the month following the month in which the request was made.

*b. Care or services prior to enrollment.* No payment shall be made for medical care or services received prior to the effective date of enrollment.

**76.13(2) Retroactive enrollment.**

*a.* Except as provided in paragraphs 76.13(2)“*e*” and “*f*,” medical assistance shall be available for all or any of the three months preceding the month in which an application is filed to persons who:

(1) Have medical bills for covered care or services received during the three-month retroactive period; and

(2) Would have been eligible for medical assistance in the month services were received if application for medical assistance had been made in that month.

*b.* The applicant need not be eligible in the month of application to be eligible in any of the three months prior to the month of application.

*c.* Retroactive medical assistance shall be made available when an application has been made on behalf of a deceased person if the conditions in paragraph 76.13(2)“*a*” are met.

*d.* Persons enrolled in Medicaid based on receipt of supplemental security income benefits who wish to make application for Medicaid benefits for three months preceding the month of application shall complete SSI Medicaid Information, Form 470-0364, 470-0364(S), 470-0364(M), or 470-0364(MS).

*e.* Exceptions to retroactive enrollment. This subrule does not apply to the following individuals:

(1) Individuals whose citizenship or alien status has not been verified even though they are eligible during a 90-day reasonable opportunity period.

(2) Individuals determined eligible only under presumptive Medicaid benefits.

(3) Individuals eligible for Medicaid only under the qualified Medicare beneficiary program.

(4) Individuals eligible only under the home- and community-based waiver services program.

*f.* Exceptions to length of retroactive enrollment. Individuals eligible for Medicaid only on the basis of eligibility for a state supplementary assistance program are only eligible for retroactive enrollment for the 30 days prior to the date of application. All other provisions of this subrule apply.

**76.13(3) Certification for services.** The department shall issue a Medical Assistance Eligibility Card, Form 470-1911, to persons who have been determined to be eligible for the benefits provided under the Medicaid program, with the following exceptions:

*a. Presumptive eligibility.* A person who has been determined only presumptively eligible will be issued a Presumptive Medicaid Eligibility Notice of Action, Form 470-2580 or 470-2580(S), that will include certification information.

*b. Emergency Medicaid for aliens.* An individual who is eligible only for limited emergency Medicaid for aliens pursuant to 441—subrule 75.11(4) will be issued a Notice of Action, Form 470-0485 or Form 470-0485(S), that will include certification information.

[ARC 1069C, IAB 10/2/13, effective 10/1/13]

**441—76.14(249A) Reenrollment.** Reviews of all conditions of eligibility will occur for the purposes of determining continued enrollment in Medicaid.

**76.14(1) Reenrollment frequency.**

*a. Eligibility reviews for eligibility prior to January 1, 2014.*

(1) Eligibility reviews shall be made as often as circumstances indicate, but in no instance shall the period of time between reviews exceed 12 months.

(2) Eligibility reviews will be conducted using information contained in and verification supplied with the review form specified in 441—subrule 75.52(3).

(3) When the review form is issued in the department's regular end-of-month mailing, the member shall return the completed form to the department by the fifth calendar day of the following month.

(4) When the review form is not issued in the department's regular end-of-month mailing, the member shall return the completed form to the department by the seventh day after the date the form is mailed by the department.

*b. Eligibility reviews for eligibility effective on or after January 1, 2014.*

(1) Eligibility reviews for members whose eligibility is based on the modified adjusted gross income methodology, who are eligible for Medicaid related to reciprocity for a subsidized adoption, who are eligible for Medicaid programs that are solely state-funded, who are Medicaid-eligible based upon the receipt of Medicaid related to foster care at the time they aged out of foster care, and who are eligible based on breast or cervical cancer treatment shall be conducted once every 12 months and no more frequently.

(2) Eligibility reviews for other members shall be made as often as circumstances indicate, but in no instance shall the period of time between eligibility reviews exceed 12 months.

**76.14(2) Reenrollment process.**

*a. Reenrollment process prior to January 1, 2014.*

(1) Within ten working days from the date a written request is issued, the member shall supply, insofar as the member is able, additional information needed to establish continued eligibility.

1. The member shall give written permission for the release of information when the member is unable to furnish information needed to reestablish eligibility.

2. Failure to supply the information or verification requested or refusal to request assistance and authorize the department to secure the requested information from other sources shall serve as a basis for cancellation of Medicaid. Signing a general authorization for release of information to the department does not meet this responsibility.

(2) Information for the eligibility review shall be submitted on Review/Recertification Eligibility Document (RRED), Form 470-2881, 470-2881(M), 470-2881(S), or 470-2881(MS), with the following exceptions:

1. Persons whose eligibility for Medicaid is related to the family medical assistance program shall complete Medicaid Review, Form 470-3118 or 470-3118(S).

2. Persons whose eligibility for Medicaid is related to supplemental security income and who are receiving state supplementary assistance shall complete Medicaid Review, Form 470-3118 or 470-3118(S).

3. Persons whose eligibility for Medicaid is based on foster care, subsidized adoption or subsidized guardianship shall have continued eligibility determined by submission of Foster Care, Adoption and Guardianship Medicaid Review, Form 470-2914 or Form 470-2914(S).

4. Individuals whose eligibility is for the medically needy coverage group shall complete Medicaid Review, Form 470-3118 or 470-3118(S).

5. Members eligible for family planning services only shall complete Family Planning Medicaid Review, Form 470-4071. The member must submit the completed review form before the end of the eligibility period to any location specified in subparagraph 76.2(2)“c”(3).

(3) For SSI-related Medicaid for adults, the department may request a face-to-face or telephone interview. Failure of the member to attend a scheduled interview shall serve as a basis for cancellation of assistance for adults. Failure of the member to attend an interview shall not serve as a basis for cancellation of assistance for children.

(4) If the department does not receive a completed form, assistance shall be canceled. A completed form is one that has all questions answered and is signed, dated and accompanied by verification as required in 441—paragraphs 75.57(1)“f” and 75.57(2)“l.”

(5) Reinstatement. When medical assistance has been canceled for failure to return a completed review form, assistance may be reinstated without a new application if the department receives the completed form within 14 calendar days of the effective date of cancellation. If the fourteenth calendar day falls on a weekend or state holiday, the member shall have until the next business day to provide the information. EXCEPTION: Members eligible for family planning services only who fail to submit Family Planning Medicaid Review, Form 470-4071, before the end of the eligibility period must reapply as directed in rule 441—76.2(249A).

*b. Reenrollment process effective on or after January 1, 2014.*

(1) Reenrollment shall be based on information contained in the member's electronic case record or other more current information available through electronic data matches. The member will be notified of the determination of continued eligibility and the basis of the determination on Notice of Action, Form 470-0485 or Form 470-0485(S). If any information contained in Form 470-0485 or Form 470-0485(S) is inaccurate, the member must sign and return the notice with accurate information within 30 days of the date on the notice.

(2) When eligibility cannot be determined based on information in the electronic case record and data matches, the member will be provided with a prepopulated renewal form, MAGI Medicaid Renewal, Form 470-5168 or Form 470-5168(S), and will have 30 days from the date of the renewal form to sign and return the form with necessary information, with the following exceptions:

1. Members eligible for family planning services only shall complete Family Planning Medicaid Review, Form 470-4071.

2. Members whose eligibility for Medicaid is not based on the modified adjusted gross income methodology shall complete and return Medicaid Review, Form 470-3118 or 470-3118(S), when requested to do so by the department. Members whose eligibility has been determined on the basis of age, blindness or disability must sign and return the notice within 30 days of the date on the notice and provide verification of income and resources before a determination of continued eligibility can be made.

(3) Enrollment will end when information or documentation necessary to complete the determination of continued eligibility is not returned within 30 days, with the exception that members eligible for family planning services only who fail to submit the completed Family Planning Medicaid Review, Form 470-4071, before the end of the eligibility period must reapply as directed in rule 441—76.2(249A). The department shall notify the member on Notice of Action, Form 470-0485 or Form 470-0485(S).

(4) Reconsideration period. When medical assistance has been canceled for failure to return a completed prepopulated renewal form or other information necessary to determine continued eligibility, enrollment may be reinstated without a new application if the department receives the completed form within the three calendar months following the effective date of cancellation. Enrollment for up to three months of retroactive benefits is available when the conditions of subrule 76.13(2) are met.

(5) An individual whose eligibility is not based on the modified adjusted gross income methodology must attend a face-to-face or telephone interview if requested to do so by the department.

[ARC 1069C, IAB 10/2/13, effective 10/1/13]

**441—76.15(249A) Report of changes.** As a condition of enrollment and continued enrollment for medical assistance, applicants and members shall report changes in circumstances as required in this rule.

**76.15(1) Report of changes for eligibility prior to January 1, 2014.**

*a.* In coverage groups for which Medicaid eligibility is determined using the family medical assistance program (FMAP) income and resource policies, members shall report changes as follows:

(1) At the annual review or upon the addition of an individual to the eligible group, members shall report any change in the following:

1. Income from all sources, including any change in care expenses.
2. Resources.
3. Members of the household.

4. School attendance.
  5. A stepparent's recovery from an incapacity.
  6. Mailing or living address.
  7. Payment of child support.
  8. Receipt of a social security number.
  9. Payment for child support, alimony, or dependents as defined in 441—paragraph 75.57(8)“b.”
  10. Health insurance premiums or coverage.
- (2) Applicants and members shall report any change in the following within ten calendar days of the change:
1. Members of the household.
  2. Mailing or living address.
  3. Sources of income.
  4. Health insurance premiums or coverage.
- (3) Members described at 441—subrule 75.1(35) shall also report any change in income from any source and any change in care expenses within ten calendar days of the change.
- b.* In coverage groups for which Medicaid eligibility is determined using income and resource policies related to the supplemental security income (SSI) program, members shall report any change in the following to the department within ten calendar days of the change. EXCEPTION: Persons actually receiving SSI benefits are exempted from these reporting requirements unless the persons have a trust or are applying for or are receiving home- and community-based waiver services.
- (1) Income from all sources.
  - (2) Resources.
  - (3) Members of the household.
  - (4) Recovery from disability.
  - (5) Mailing or living address.
  - (6) Health insurance premiums or coverage.
  - (7) Medicare premiums or coverage.
  - (8) Receipt of social security number.
  - (9) Gross income of the community spouse or of the dependent children, parents or siblings of the institutionalized or community spouse living with a community spouse when a diversion is made to the community spouse or family. (See definitions in rule 441—75.25(249A).)
  - (10) Income and resources of parents and spouses when income and resources are used in determining Medicaid eligibility, client participation or spenddown.
  - (11) Residence in a medical institution for other than respite care for more than 15 days for home- and community-based waiver services recipients.
- c.* Individuals in the breast and cervical cancer coverage group are required to report when health insurance coverage begins, or when their living or mailing address changes, within ten calendar days.
- 76.15(2) Report of changes for eligibility on or after January 1, 2014.** A change in circumstance that may affect the eligibility of applicants and members must be reported within ten days of the date the change occurred. Changes required to be reported are described in this subrule.
- a.* In coverage groups for which Medicaid eligibility is determined using the modified adjusted gross income methodology, any change in the following must be reported:
- (1) Income from all sources.
  - (2) Members of the household.
  - (3) School attendance.
  - (4) Mailing or living address.
  - (5) Receipt of a social security number.
  - (6) Health insurance premiums or coverage.
  - (7) Alien or citizenship status.
- b.* In coverage groups for which Medicaid eligibility is not determined using the modified adjusted gross income methodology, any change in the following must be reported. EXCEPTION: Persons actually

receiving SSI benefits are exempted from these reporting requirements unless the persons have a trust or are applying for or are receiving home- and community-based waiver services.

- (1) Income from all sources.
- (2) Resources.
- (3) Members of the household.
- (4) Recovery from disability.
- (5) Mailing or living address.
- (6) Health insurance premiums or coverage.
- (7) Medicare premiums or coverage.
- (8) Receipt of social security number.
- (9) Gross income of the community spouse or of the dependent children, parents, or siblings of the institutionalized or community spouse who are living with a community spouse when a diversion is made to the community spouse or family. (See definitions in rule 441—75.25(249A).)
- (10) Income and resources of parents and spouses when income and resources are used in determining Medicaid eligibility, client participation or spenddown.
- (11) Residence in a medical institution for other than respite care for more than 15 days for home- and community-based waiver services recipients.

*c.* Individuals in the breast and cervical cancer coverage group are required to report changes in their health insurance coverage and changes in their living or mailing address.

*d.* Individuals receiving Medicaid based on the receipt of Title IV-E-funded foster care or based on an adoption assistance agreement are required to report changes in health insurance coverage, when their living or mailing address changes, receipt of a social security number, and termination of the adoption assistance agreement.

*e.* Individuals receiving state-only funded Medicaid are required to report any change in the following:

- (1) Income from all sources.
- (2) Mailing or living address.
- (3) Receipt of a social security number.
- (4) Health insurance coverage.
- (5) Alien or citizenship status.

**76.15(3) Failure to report.** When a change is not reported as required by this rule, any Medicaid expenditures for care or services provided when the member was not eligible shall be considered an overpayment and subject to recovery from the member.

[ARC 1069C, IAB 10/2/13, effective 10/1/13]

**441—76.16(249A) Action on information received.** When a change in circumstance is reported, or when a change in a member's circumstances otherwise comes to the attention of the department, its effect on eligibility shall be evaluated and eligibility shall be redetermined regardless of whether the report of change was required by rule 441—76.15(249A). When the department has information about an anticipated change in a member's circumstances that may affect eligibility, eligibility will be redetermined at the appropriate time based on such change.

**76.16(1)** After assistance has been approved, except as provided in subrule 76.13(1), action based on a change reported during a month shall be effective the first day of the next calendar month unless timely notice of adverse action is required as specified in 441—subrule 7.7(1).

**76.16(2)** When a request is made to add a new person to the eligible group, and that person meets the eligibility requirements, assistance shall be effective the first day of the month in which the request was made unless otherwise specified at rule 441—76.12(249A).

**76.16(3)** When the change creates ineligibility, eligibility under the current coverage group shall be canceled and an automatic redetermination of eligibility shall be completed in accordance with rule 441—76.17(249A).

[ARC 1069C, IAB 10/2/13, effective 10/1/13]

**441—76.17(249A) Automatic redetermination of eligibility.** Whenever a Medicaid member no longer meets the eligibility requirements of the current coverage group, an automatic redetermination of eligibility for other Medicaid coverage groups shall be made. If the reason for ineligibility under the initial coverage group pertained to a condition of eligibility which applies to all coverage groups, such as failure to cooperate, no further redetermination shall be required. When the redetermination is completed, the member shall be notified of the decision in writing. The redetermination process shall be completed as follows:

**76.17(1) Information received by the tenth of the month.** If information that creates ineligibility under the current coverage group is received in the department by the tenth of the month, the redetermination process shall be completed by the end of that month unless the provisions of rule 441—76.14(249A) apply. The effective date of cancellation for the current coverage group shall be the first day of the month following the month in which the information is received.

**76.17(2) Information received after the tenth of the month.** If information that creates ineligibility under the current coverage group is received in the department after the tenth of the month, the redetermination process shall be completed by the end of the following month unless the provisions of rule 441—76.14(249A) apply. The effective date of cancellation for the current coverage group shall be the first day of the second month following the month in which the information is received.

**76.17(3) Change in federal law.** If a change in federal law affects the eligibility of large numbers of Medicaid members and the Secretary of Health and Human Services has extended the redetermination time limits, in accordance with 42 CFR § 435.1003 as amended to January 13, 1997, the redetermination process shall be completed within the extended time limit and the effective date of cancellation for the current coverage group shall be no later than the first day of the month following the month in which the extended time limit expires.

[ARC 1069C, IAB 10/2/13, effective 10/1/13]

These rules are intended to implement Iowa Code sections 249.3, 249.4, 249A.3, and 249A.4.

[Filed 3/11/70]

[Filed 6/25/76, Notice 5/17/76—published 7/12/76, effective 8/16/76]  
 [Filed 11/5/82, Notice 8/18/82—published 11/24/82, effective 1/1/83]  
 [Filed emergency 1/13/84—published 2/1/84, effective 2/8/84]  
 [Filed 5/31/84, Notice 4/11/84—published 6/20/84, effective 8/1/84]  
 [Filed 8/31/84, Notice 6/20/84—published 9/26/84, effective 11/1/84]  
 [Filed 9/28/84, Notice 8/15/84—published 10/24/84, effective 12/1/84]  
 [Filed 10/1/85, Notice 8/14/85—published 10/23/85, effective 12/1/85]  
 [Filed 2/21/86, Notice 1/1/86—published 3/12/86, effective 5/1/86]  
 [Filed 3/21/86, Notice 1/29/86—published 4/9/86, effective 6/1/86]  
 [Filed 4/29/86, Notice 3/12/86—published 5/21/86, effective 8/1/86]  
 [Filed emergency 1/15/87—published 2/11/87, effective 1/15/87]  
 [Filed 8/28/87, Notice 6/17/87—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 3/17/88, Notice 1/13/88—published 4/6/88, effective 6/1/88]  
 [Filed 6/9/88, Notice 4/20/88—published 6/29/88, effective 9/1/88]  
 [Filed 2/16/89, Notice 12/28/88—published 3/8/89, effective 5/1/89]  
 [Filed 4/14/89, Notice 2/22/89—published 5/3/89, effective 7/1/89]  
 [Filed 7/14/89, Notice 5/31/89—published 8/9/89, effective 10/1/89]  
 [Filed 10/10/89, Notice 8/23/89—published 11/1/89, effective 1/1/90]  
 [Filed 11/16/89, Notice 9/20/89—published 12/13/89, effective 2/1/90]  
 [Filed 1/17/90, Notice 8/23/90—published 2/7/90, effective 4/1/90]<sup>1</sup>  
 [Filed 6/14/90, Notice 5/2/90—published 7/11/90, effective 9/1/90]  
 [Filed 11/14/90, Notice 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 4/11/91, Notice 2/20/91—published 5/1/91, effective 7/1/91]  
 [Filed 7/10/91, Notice 5/29/91—published 8/7/91, effective 10/1/91]

- [Filed without Notice 9/18/91—published 10/16/91, effective 11/21/91]
- [Filed emergency 10/10/91—published 10/30/91, effective 11/21/91]
- [Filed 10/10/91, Notice 8/21/91—published 10/30/91, effective 1/1/92]
- [Filed 1/16/92, Notice 9/18/91—published 2/5/92, effective 4/1/92]
- [Filed 1/16/92, Notice 11/27/91—published 2/5/92, effective 4/1/92]
- [Filed 1/29/92, Notice 10/16/91—published 2/19/92, effective 3/25/92]
- [Filed 2/13/92, Notices 12/25/91, 1/8/92—published 3/4/92, effective 5/1/92]
- [Filed emergency 4/16/92 after Notice 2/19/92—published 5/13/92, effective 5/1/92]
- [Filed emergency 6/11/92 after Notice 4/15/92—published 7/8/92, effective 7/1/92]
- [Filed 6/11/92, Notice 4/15/92—published 7/8/92, effective 9/1/92]
- [Filed emergency 7/17/92—published 8/5/92, effective 8/1/92]
- [Filed 9/11/92, Notices 7/22/92, 8/5/92—published 9/30/92, effective 12/1/92]
- [Filed 7/14/93, Notice 5/12/93—published 8/4/93, effective 10/1/93]
- [Filed emergency 9/17/93—published 10/13/93, effective 10/1/93]
- [Filed 11/12/93, Notice 9/29/93—published 12/8/93, effective 2/1/94]
- [Filed 12/16/93, Notice 10/13/93—published 1/5/94, effective 3/1/94]
- [Filed 4/14/94, Notice 2/16/94—published 5/11/94, effective 7/1/94]
- [Filed 10/12/94, Notices 8/17/94—published 11/9/94, effective 1/1/95]
- [Filed 2/16/95, Notice 11/23/94—published 3/15/95, effective 5/1/95]
- [Filed 8/10/95, Notice 6/21/95—published 8/30/95, effective 11/1/95]
- [Filed 12/12/96, Notice 9/11/96—published 1/1/97, effective 3/1/97]
- [Filed emergency 1/15/97 after Notice 12/4/96—published 2/12/97, effective 2/1/97]
- [Filed emergency 3/12/97—published 4/9/97, effective 4/1/97]
- [Filed 9/16/97, Notice 7/16/97—published 10/8/97, effective 12/1/97]
- [Filed 8/12/98, Notice 6/17/98—published 9/9/98, effective 11/1/98]
- [Filed emergency 12/23/98 after Notice 11/4/98—published 1/13/99, effective 1/1/99]
- [Filed emergency 6/10/99—published 6/30/99, effective 7/1/99]
- [Filed 8/11/99, Notices 6/16/99, 6/30/99—published 9/8/99, effective 11/1/99]
- [Filed emergency 9/12/00 after Notice 7/12/00—published 10/4/00, effective 10/1/00]
- [Filed 6/13/01, Notice 4/18/01—published 7/11/01, effective 9/1/01]
- [Filed 10/10/01, Notice 8/22/01—published 10/31/01, effective 1/1/02]
- [Filed emergency 6/13/02—published 7/10/02, effective 6/13/02]
- [Filed emergency 9/12/02 after Notice 7/24/02—published 10/2/02, effective 10/1/02]
- [Filed emergency 5/16/03—published 6/11/03, effective 7/1/03]
- [Filed 9/22/03, Notice 7/9/03—published 10/15/03, effective 12/1/03]
- [Filed emergency 12/16/03 after Notice 10/29/03—published 1/7/04, effective 1/1/04]
- [Filed emergency 7/9/04—published 8/4/04, effective 7/9/04]
- [Filed 9/23/04, Notice 8/4/04—published 10/13/04, effective 11/17/04]
- [Filed emergency 1/13/05 after Notice 12/8/04—published 2/2/05, effective 2/1/05]
- [Filed without Notice 5/4/05—published 5/25/05, effective 7/1/05]
- [Filed emergency 6/17/05 after Notice 8/4/04—published 7/6/05, effective 7/1/05]
- [Filed emergency 11/16/05—published 12/7/05, effective 12/1/05]
- [Filed emergency 6/16/06 after Notice 4/12/06—published 7/5/06, effective 7/1/06]
- [Filed 12/13/06, Notice 8/2/06—published 1/3/07, effective 3/1/07]
- [Filed 5/16/07, Notice 2/14/07—published 6/6/07, effective 8/1/07]
- [Filed emergency 7/12/07 after Notice 5/9/07—published 8/1/07, effective 8/1/07]
- [Filed 11/14/07, Notice 8/29/07—published 12/5/07, effective 2/1/08]
- [Filed emergency 2/13/08 after Notice 12/19/07—published 3/12/08, effective 2/15/08]
- [Filed 7/9/08, Notice 5/7/08—published 7/30/08, effective 10/1/08]
- [Filed emergency 10/14/08 after Notice 8/27/08—published 11/5/08, effective 11/1/08]
- [Filed Emergency After Notice ARC 7544B (Notice ARC 7367B, IAB 11/19/08), IAB 2/11/09, effective 1/14/09]

[Filed ARC 7547B (Notice ARC 7355B, IAB 11/19/08), IAB 2/11/09, effective 3/18/09]  
[Filed ARC 7740B (Notice ARC 7590B, IAB 2/25/09), IAB 5/6/09, effective 6/10/09]  
[Filed ARC 8260B (Notice ARC 8056B, IAB 8/26/09), IAB 11/4/09, effective 1/1/10]  
[Filed ARC 8343B (Notice ARC 8113B, IAB 9/9/09), IAB 12/2/09, effective 1/6/10]  
[Filed ARC 8439B (Notice ARC 8083B, IAB 8/26/09), IAB 1/13/10, effective 3/1/10]  
[Filed Emergency After Notice ARC 8500B (Notice ARC 8272B, IAB 11/4/09), IAB 2/10/10,  
effective 3/1/10]  
[Filed ARC 8642B (Notice ARC 8461B, IAB 1/13/10), IAB 4/7/10, effective 6/1/10]  
[Filed Emergency After Notice ARC 8786B (Notice ARC 8552B, IAB 2/24/10), IAB 6/2/10, effective  
6/1/10]  
[Filed Emergency ARC 9701B, IAB 9/7/11, effective 9/1/11]  
[Filed ARC 0150C (Notice ARC 0039C, IAB 3/21/12), IAB 6/13/12, effective 8/1/12]  
[Filed Emergency After Notice ARC 1069C (Notice ARC 0908C, IAB 8/7/13), IAB 10/2/13, effective  
10/1/13]

<sup>1</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.

CHAPTER 77  
CONDITIONS OF PARTICIPATION FOR PROVIDERS  
OF MEDICAL AND REMEDIAL CARE

[Prior to 7/1/83, Social Services[770] Ch 77]

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

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

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

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

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

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

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

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

[ARC 0485C, IAB 12/12/12, effective 2/1/13]

**441—77.3(249A) Hospitals.**

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

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

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

[ARC 0198C, IAB 7/11/12, effective 7/1/12]

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

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

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

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

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

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

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

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

**77.9(1) Definitions.**

“*Assets*” includes any listing that identifies Medicaid members to whom home health services were furnished by a participating or formerly participating home health agency.

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

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

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

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

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

c. Other good cause.

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

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

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

a. *Effective dates and submission dates.*

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

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

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

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

(5) Home health agencies which continue to participate in Medicaid after the period covered by an initial surety bond shall secure a surety bond for each subsequent fiscal year of the home health agency or a continuous bond which remains in effect from year to year.

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

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

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

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

(3) Provide that the surety's liability to the department is not extinguished by any of the following:

1. Any action by the home health agency or the surety to terminate or limit the scope or term of the bond unless the surety furnishes the department with notice of the action not later than 10 days after the date of notice of the action by the home health agency to the surety and not later than 60 days before the effective date of the action by the surety.

2. The surety's failure to continue to meet the requirements in subrule 77.9(2) or the department's determination that the surety company is an unauthorized surety under subrule 77.9(2).

3. Termination of the home health agency's provider agreement.

4. Any action by the department to suspend, offset, or otherwise recover payments to the home health agency.

5. Any action by the home health agency to cease operations, sell or transfer any assets or ownership interest, file for bankruptcy, or fail to pay the surety.

6. Any fraud, misrepresentation, or negligence by the home health agency in obtaining the surety bond or by the surety (or the surety's agent, if any) in issuing the surety bond; except that any fraud, misrepresentation, or negligence by the home health agency in identifying to the surety (or the surety's agent) the amount of Medicaid payments upon which the amount of the surety bond is determined shall not cause the surety's liability to the department to exceed the amount of the bond.

7. The home health agency's failure to exercise available appeal rights under Medicaid or assign appeal rights to the surety.

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

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

(6) Provide that the surety may appeal department decisions.

**77.9(5)** *Exemption from surety bond requirements for government-operated home health agencies.* A home health agency operated by a federal, state, local, or tribal government agency is exempt from the bonding requirements of this rule if, during the preceding five years, the home health agency has not had any uncollected overpayments. Government-operated home health agencies having uncollected overpayments during the preceding five years shall not be exempted from the bonding requirements of this rule.

**77.9(6)** *Government-operated home health agency that loses its exemption.* A government-operated home health agency which has met the criteria for an exemption under subrule 77.9(6) but is later determined by the department not to meet the criteria shall submit a surety bond within 60 days of the date of the department's written notification to the home health agency that it no longer meets the criteria for an exemption, for the period and in the amount required in the notice from the department.

**441—77.10(249A) Medical equipment and appliances, prosthetic devices and medical supplies.** All dealers in medical equipment and appliances, prosthetic devices and medical supplies in Iowa or in other states are eligible to participate in the program.

**441—77.11(249A) Ambulance service.** Providers of ambulance service are eligible to participate providing they meet the eligibility requirements for participation in the Medicare program (Title XVIII of the Social Security Act).

**441—77.12(249A) Behavioral health intervention.** A provider of behavioral health intervention is eligible to participate in the medical assistance program when the provider is enrolled in the Iowa Plan for Behavioral Health pursuant to 441—Chapter 88, Division IV. Providers must complete child abuse, dependent adult abuse, and criminal background screenings pursuant to Iowa Code section 135C.33(5)“a”(1) before employment of a staff member who will provide direct care.

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

[ARC 7741B, IAB 5/6/09, effective 7/1/09; ARC 9487B, IAB 5/4/11, effective 7/1/11]

**441—77.13(249A) Hearing aid dispensers.** Hearing aid dispensers are eligible to participate if they are duly licensed by the state of Iowa. Hearing aid dispensers in other states will be eligible to participate if they are duly licensed in that state.

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

**441—77.14(249A) Audiologists.** Audiologists are eligible to participate in the program when they are duly licensed by the state of Iowa. Audiologists in other states will be eligible to participate when they are duly licensed in that state. In states having no licensure requirement for audiologists, an audiologist shall obtain a license from the state of Iowa.

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

**441—77.15(249A) Community mental health centers.** Community mental health centers are eligible to participate in the medical assistance program when they comply with the standards for mental health centers in the state of Iowa established by the Iowa mental health authority.

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

**441—77.16(249A) Screening centers.** Public or private health agencies are eligible to participate as screening centers when they have the staff and facilities needed to perform all of the elements of screening specified in 441—78.18(249A) and meet the department of public health's standards for a child health screening center. The staff members must be employed by or under contract with the screening center. Screening centers shall direct applications to participate to the Iowa Medicaid enterprise provider services unit.

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

**441—77.17(249A) Physical therapists.** Physical therapists are eligible to participate when they are licensed, in independent practice; and are eligible to participate in the Medicare program.

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

**441—77.18(249A) Orthopedic shoe dealers and repair shops.** Establishments eligible to participate in the medical assistance program are retail dealers in orthopedic shoes prescribed by physicians or podiatrists and shoe repair shops specializing in orthopedic work as prescribed by physicians or podiatrists.

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

**441—77.19(249A) Rehabilitation agencies.** Rehabilitation agencies are eligible to participate providing they are certified to participate in the Medicare program (Title XVIII of the Social Security Act).

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

**441—77.20(249A) Independent laboratories.** Independent laboratories are eligible to participate providing they are certified to participate as a laboratory in the Medicare program (Title XVIII of the Social Security Act). An independent laboratory is a laboratory that is independent of attending and consulting physicians' offices, hospitals, and critical access hospitals.

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

**441—77.21(249A) Rural health clinics.** Rural health clinics are eligible to participate providing they are certified to participate in the Medicare program (Title XVIII of the Social Security Act).

**441—77.22(249A) Psychologists.** All psychologists licensed to practice in the state of Iowa and meeting the standards of the National Register of Health Service Providers in Psychology, 1981 edition, published by the council for the National Register of Health Service Providers in Psychology, are eligible to participate in the medical assistance program. Psychologists in other states are eligible to participate when they are duly licensed to practice in that state and meet the standards of the National Register of Health Service Providers in Psychology.

This rule is intended to implement Iowa Code sections 249A.4 and 249A.15.

**441—77.23(249A) Maternal health centers.** A maternal health center is eligible to participate in the Medicaid program if the center provides a team of professionals to render prenatal and postpartum care and enhanced perinatal services (see rule 441—78.25(249A)). The prenatal and postpartum care shall be in accordance with the latest edition of the American College of Obstetricians and Gynecologists, Standards for Obstetric Gynecologic Services. The team must have at least a physician, a registered nurse, a licensed dietitian and a person with at least a bachelor's degree in social work, counseling, sociology or psychology. Team members must be employed by or under contract with the center.

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

**441—77.24(249A) Ambulatory surgical centers.** Ambulatory surgical centers that are not part of hospitals are eligible to participate in the medical assistance program if they are certified to participate in the Medicare program (Title XVIII of the Social Security Act). Freestanding ambulatory surgical centers providing only dental services are also eligible to participate in the medical assistance program

if the board of dental examiners has issued a current permit pursuant to 650—Chapter 29 for any dentist to administer deep sedation or general anesthesia at the facility.

**441—77.25(249A) Home- and community-based habilitation services.** To be eligible to participate in the Medicaid program as an approved provider of home- and community-based habilitation services, a provider shall be an enrolled provider of habilitation with the Iowa Plan for Behavioral Health and meet the general requirements in subrules 77.25(2), 77.25(3), and 77.25(4) and shall meet the requirements in the subrules applicable to the individual services being provided.

**77.25(1) Definitions.**

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

*“Major incident”* means an occurrence involving a member during service provision that:

1. Results in a physical injury to or by the member that requires a physician’s treatment or admission to a hospital;
2. Results in the death of any person;
3. Requires emergency mental health treatment for the member;
4. Requires the intervention of law enforcement;
5. Requires a report of child abuse pursuant to Iowa Code section 232.69 or a report of dependent adult abuse pursuant to Iowa Code section 235B.3;
6. Constitutes a prescription medication error or a pattern of medication errors that leads to the outcome in paragraph “1,” “2,” or “3”; or
7. Involves a member’s location being unknown by provider staff who are assigned protective oversight.

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

*“Minor incident”* means an occurrence involving a member during service provision that is not a major incident and that:

1. Results in the application of basic first aid;
2. Results in bruising;
3. Results in seizure activity;
4. Results in injury to self, to others, or to property; or
5. Constitutes a prescription medication error.

**77.25(2) Organization and staff.**

*a.* The prospective provider shall demonstrate the fiscal capacity to initiate and operate the specified programs on an ongoing basis.

*b.* The provider shall complete child abuse, dependent adult abuse, and criminal background screenings pursuant to Iowa Code section 249A.29 before employing a person who will provide direct care.

*c.* A person providing direct care shall be at least 16 years of age.

*d.* A person providing direct care shall not be an immediate family member of the member.

**77.25(3) Incident management and reporting.** As a condition of participation in the medical assistance program, HCBS habilitation service providers must comply with the requirements of Iowa Code sections 232.69 and 235B.3 regarding the reporting of child abuse and dependent adult abuse and with the incident management and reporting requirements in this subrule.

*a. Reporting procedure for minor incidents.* Minor incidents may be reported in any format designated by the provider. When a minor incident occurs or a staff member becomes aware of a minor incident, the staff member involved shall submit the completed incident report to the staff member’s supervisor within 72 hours of the incident. The completed report shall be maintained in a centralized file with a notation in the member’s file.

*b. Reporting procedure for major incidents.* When a major incident occurs or a staff member becomes aware of a major incident:

- (1) The staff member involved shall notify the following persons of the incident by the end of the next calendar day after the incident:

1. The staff member's supervisor.
2. The member or the member's legal guardian. EXCEPTION: Notification to the member is required only if the incident took place outside of the provider's service provision. Notification to the guardian, if any, is always required.

3. The member's case manager.

(2) By the end of the next calendar day after the incident, the staff member who observed or first became aware of the incident shall also report as much information as is known about the incident to the department's bureau of long-term care either:

1. By direct data entry into the Iowa Medicaid Provider Access System, or

2. By faxing or mailing Form 470-4698, Critical Incident Report, according to the directions on the form.

(3) The following information shall be reported:

1. The name of the member involved.

2. The date and time the incident occurred.

3. A description of the incident.

4. The names of all provider staff and others who were present at the time of the incident or who responded after becoming aware of the incident. The confidentiality of other members or nonmembers who were present must be maintained by the use of initials or other means.

5. The action that the provider staff took to manage the incident.

6. The resolution of or follow-up to the incident.

7. The date the report is made and the handwritten or electronic signature of the person making the report.

(4) Submission of the initial report will generate a workflow in the Individualized Services Information System (ISIS) for follow-up by the case manager. When complete information about the incident is not available at the time of the initial report, the provider must submit follow-up reports until the case manager is satisfied with the incident resolution and follow-up. The completed report shall be maintained in a centralized file with a notation in the member's file.

*c. Tracking and analysis.* The provider shall track incident data and analyze trends to assess the health and safety of members served and determine if changes need to be made for service implementation or if staff training is needed to reduce the number or severity of incidents.

**77.25(4) Restraint, restriction, and behavioral intervention.** The provider shall have in place a system for the review, approval, and implementation of ethical, safe, humane, and efficient behavioral intervention procedures. All members receiving home- and community-based habilitation services shall be afforded the protections imposed by these rules when any restraint, restriction, or behavioral intervention is implemented.

*a.* The system shall include procedures to inform the member and the member's legal guardian of the restraint, restriction, and behavioral intervention policy and procedures at the time of service approval and as changes occur.

*b.* Restraint, restriction, and behavioral intervention shall be used only for reducing or eliminating maladaptive target behaviors that are identified in the member's restraint, restriction, or behavioral intervention program.

*c.* Restraint, restriction, and behavioral intervention procedures shall be designed and implemented only for the benefit of the member and shall never be used as punishment, for the convenience of the staff, or as a substitute for a nonaversive program.

*d.* Restraint, restriction, and behavioral intervention programs shall be time-limited and shall be reviewed at least quarterly.

*e.* Corporal punishment and verbal or physical abuse are prohibited.

**77.25(5) Case management.** The department of human services, a county or consortium of counties, or a provider under subcontract to the department or to a county or consortium of counties is eligible to participate in the home- and community-based habilitation services program as a provider of case management services provided that the agency meets the standards in 441—Chapter 24.

**77.25(6) Day habilitation.** The following providers may provide day habilitation:

a. An agency that is accredited by the Commission on Accreditation of Rehabilitation Facilities to provide services that qualify as day habilitation under 441—subrule 78.27(8).

b. An agency that is accredited by the Commission on Accreditation of Rehabilitation Facilities to provide other services and began providing services that qualify as day habilitation under 441—subrule 78.27(8) since the agency's last accreditation survey. The agency may provide day habilitation services until the current accreditation expires. When the current accreditation expires, the agency must qualify under paragraph "a," "d," "g," or "h."

c. An agency that is not accredited by the Commission on Accreditation of Rehabilitation Facilities but has applied to the Commission within the last 12 months for accreditation to provide services that qualify as day habilitation under subrule 441—78.27(8). An agency that has not received accreditation within 12 months after application to the Commission is no longer a qualified provider.

d. An agency that is accredited by the Council on Quality and Leadership in Supports for People with Disabilities.

e. An agency that has applied to the Council on Quality and Leadership in Supports for People with Disabilities for accreditation within the last 12 months. An agency that has not received accreditation within 12 months after application to the Council is no longer a qualified provider.

f. An agency that is accredited under 441—Chapter 24 to provide day treatment or supported community living services.

g. An agency that is certified by the department to provide day habilitation services under the home- and community-based services intellectual disability waiver pursuant to rule 441—77.37(249A).

h. An agency that is accredited by the International Center for Clubhouse Development.

i. An agency that is accredited by the Joint Commission on Accreditation of Healthcare Organizations.

j. A residential care facility of more than 16 beds that is licensed by the Iowa department of inspections and appeals, was enrolled as a provider of rehabilitation services for adults with chronic mental illness before December 31, 2006, and has applied for accreditation through one of the accrediting bodies listed in this subrule.

(1) The facility must have policies in place by June 30, 2007, consistent with the accreditation being sought.

(2) A facility that has not received accreditation within 12 months after application for accreditation is no longer a qualified provider.

**77.25(7) Home-based habilitation.** The following agencies may provide home-based habilitation services:

a. An agency that is certified by the department to provide supported community living services under:

(1) The home- and community-based services intellectual disability waiver pursuant to rule 441—77.37(249A); or

(2) The home- and community-based services brain injury waiver pursuant to rule 441—77.39(249A).

b. An agency that is accredited under 441—Chapter 24 to provide supported community living services.

c. An agency that is accredited by the Commission on Accreditation of Rehabilitation Facilities as a community housing or supported living service provider.

d. An agency that is accredited by the Council on Quality and Leadership in Supports for People with Disabilities.

e. An agency that is accredited by the Council on Accreditation of Services for Families and Children.

f. An agency that is accredited by the Joint Commission on Accreditation of Healthcare Organizations.

g. A residential care facility of 16 or fewer beds that is licensed by the Iowa department of inspections and appeals, was enrolled as a provider of rehabilitation services for adults with chronic

mental illness before December 31, 2006, and has applied for accreditation through one of the accrediting bodies listed in this subrule.

(1) The facility must have policies in place by June 30, 2007, consistent with the accreditation being sought.

(2) A facility that has not received accreditation within 12 months after application for accreditation is no longer a qualified provider.

**77.25(8) *Prevocational habilitation.*** The following providers may provide prevocational services:

a. An agency that is accredited by the Commission on Accreditation of Rehabilitation Facilities as an organizational employment service provider or a community employment service provider.

b. An agency that is accredited by the Council on Quality and Leadership in Supports for People with Disabilities.

c. An agency that is accredited by the International Center for Clubhouse Development.

d. An agency that is certified by the department to provide prevocational services under:

(1) The home- and community-based services intellectual disability waiver pursuant to rule 441—77.37(249A); or

(2) The home- and community-based services brain injury waiver pursuant to rule 441—77.39(249A).

**77.25(9) *Supported employment habilitation.*** The following agencies may provide supported employment services:

a. An agency that is certified by the department to provide supported employment services under:

(1) The home- and community-based services intellectual disability waiver pursuant to rule 441—77.37(249A); or

(2) The home- and community-based services brain injury waiver pursuant to rule 441—77.39(249A).

b. An agency that is accredited by the Commission on Accreditation of Rehabilitation Facilities as an organizational employment service provider or a community employment service provider.

c. An agency that is accredited by the Council on Accreditation of Services for Families and Children.

d. An agency that is accredited by the Joint Commission on Accreditation of Healthcare Organizations.

e. An agency that is accredited by the Council on Quality and Leadership in Supports for People with Disabilities.

f. An agency that is accredited by the International Center for Clubhouse Development.

**77.25(10) *Provider enrollment.*** A prospective provider that meets the criteria in this rule and the provider criteria of the Iowa Plan for Behavioral Health contractor must be enrolled through the Iowa Plan for Behavioral Health contractor as an approved provider of a specific component of home- and community-based habilitation services. Enrollment carries no assurance that the approved provider will receive funding. The Iowa Medicaid enterprise will enroll providers with Medicaid only when the provider is enrolled in the Iowa Plan for Behavioral Health. Payment for services will be made to a provider only when the provider is enrolled in the Iowa Plan for Behavioral Health and the provider is authorized to provide the services. This includes payments made by the Iowa Medicaid enterprise for services provided to members who are not eligible to enroll in the Iowa Plan for Behavioral Health.

a. The Iowa Plan for Behavioral Health contractor shall review compliance with standards for initial enrollment. Review of a provider may occur at any time.

b. The department or the Iowa Plan for Behavioral Health contractor may request any information from the prospective service provider that is pertinent to arriving at an enrollment decision. This information may include:

(1) Current accreditations.

(2) Evaluations.

(3) Inspection reports.

(4) Reviews by regulatory and licensing agencies and associations.

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

[ARC 7936B, IAB 7/1/09, effective 9/1/09; ARC 9314B, IAB 12/29/10, effective 3/1/11; ARC 0848C, IAB 7/24/13, effective 7/1/13; ARC 1051C, IAB 10/2/13, effective 11/6/13]

**441—77.26(249A) Behavioral health services.** The following persons are eligible to participate in the Medicaid program as providers of behavioral health services.

**77.26(1) Licensed marital and family therapists (LMFT).** Any person licensed by the board of behavioral science as a marital and family therapist pursuant to 645—Chapter 31 is eligible to participate. A marital and family therapist in another state is eligible to participate when duly licensed to practice in that state.

**77.26(2) Licensed independent social workers (LISW).** Any person licensed by the board of social work as an independent social worker pursuant to 645—Chapter 280 is eligible to participate. An independent social worker in another state is eligible to participate when duly licensed to practice in that state.

**77.26(3) Licensed master social workers (LMSW).**

*a.* A person licensed by the board of social work as a master social worker pursuant to 645—Chapter 280 is eligible to participate when the person:

(1) Holds a master's or doctoral degree as approved by the board of social work; and

(2) Provides treatment under the supervision of an independent social worker licensed pursuant to 645—Chapter 280.

*b.* A master social worker in another state is eligible to participate when the person:

(1) Is duly licensed to practice in that state; and

(2) Provides treatment under the supervision of an independent social worker duly licensed in that state.

**77.26(4) Licensed mental health counselors (LMC).** Any person licensed by the board of behavioral science as a mental health counselor pursuant to Iowa Code chapter 154D and 645—Chapter 31 is eligible to participate. A mental health counselor in another state is eligible to participate when duly licensed to practice in that state.

**77.26(5) Certified alcohol and drug counselors.** Any person certified by the nongovernmental Iowa board of substance abuse certification as an alcohol and drug counselor is eligible to participate.

This rule is intended to implement Iowa Code chapter 249A as amended by 2011 Iowa Acts, Senate File 233.

[ARC 9649B, IAB 8/10/11, effective 8/1/11]

**441—77.27(249A) Birth centers.** Birth centers are eligible to participate in the Medicaid program if they are licensed or receive reimbursement from at least two third-party payors.

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

**441—77.28(249A) Area education agencies.** An area education agency is eligible to participate in the Medicaid program when it has a plan for providing comprehensive special education programs and services approved by the Iowa department of education. Covered services shall be provided by personnel who are licensed, endorsed, or registered as provided in this rule and shall be within the scope of the applicable license, endorsement, or registration.

**77.28(1)** Personnel providing audiological or speech-language services shall be licensed by the Iowa board of speech pathology and audiology as a speech pathologist or audiologist pursuant to 645—Chapters 299, 300 and 303 through 305.

**77.28(2)** Personnel providing physical therapy shall be licensed by the Iowa board of physical and occupational therapy as a physical therapist pursuant to 645—Chapters 199 through 204.

**77.28(3)** Personnel providing occupational therapy shall be licensed by the Iowa board of physical and occupational therapy as an occupational therapist pursuant to 645—Chapters 205 through 210.

**77.28(4)** Personnel providing psychological evaluations and counseling or psychotherapy services shall be:

- a. Endorsed by the Iowa board of educational examiners as a school psychologist pursuant to rule 282—15.11(272);
- b. Licensed by the Iowa board of psychology as a psychologist pursuant to 645—Chapters 239 through 243;
- c. Licensed by the Iowa board of social work as a social worker pursuant to 645—Chapters 279 through 284;
- d. Licensed by the Iowa board of medicine as a physician pursuant to 653—Chapters 9 through 11; or
- e. Registered by the Iowa nursing board as an advanced registered nurse practitioner pursuant to 655—Chapter 7.

**77.28(5)** Personnel providing nursing services shall be licensed by the Iowa nursing board as a registered or licensed practical nurse pursuant to 655—Chapters 3 through 6.

**77.28(6)** Personnel providing vision services shall be:

- a. Licensed by the Iowa nursing board as a registered or licensed practical nurse pursuant to 655—Chapters 3 through 6;
  - b. Licensed by the Iowa board of medicine as a physician pursuant to 653—Chapters 9 through 11; or
  - c. Licensed by the Iowa board of optometry as an optometrist pursuant to 645—Chapter 180.
- This rule is intended to implement Iowa Code section 249A.4.

**441—77.29(249A) Case management provider organizations.** Case management provider organizations are eligible to participate in the Medicaid program provided that they meet the standards for the populations being served. Providers shall meet the following standards:

**77.29(1) Standards in 441—Chapter 24.** Providers shall meet the standards in 441—Chapter 24 when they are the department of human services, a county or consortium of counties, or an agency or provider under subcontract to the department or a county or consortium of counties providing case management services to persons with mental retardation, developmental disabilities or chronic mental illness.

**77.29(2) Standards in 441—Chapter 186.** Rescinded IAB 10/12/05, effective 10/1/05.

**441—77.30(249A) HCBS health and disability waiver service providers.** HCBS health and disability waiver services shall be rendered by a person who is at least 16 years old (except as otherwise provided in this rule) and is not the spouse of the member served or the parent or stepparent of a member aged 17 or under. People who are 16 or 17 years old must be employed and supervised by an enrolled HCBS provider unless they are employed to provide self-directed personal care services through the consumer choices option. A person hired for self-directed personal care services need not be supervised by an enrolled HCBS provider. A provider hired through the consumer choices option for independent support brokerage, self-directed personal care, individual-directed goods and services, or self-directed community support and employment is not required to enroll as a Medicaid provider. The following providers shall be eligible to participate in the Medicaid HCBS health and disability waiver program if they meet the standards in subrule 77.30(18) and also meet the standards set forth below for the service to be provided:

**77.30(1) Homemaker providers.** Homemaker providers shall be agencies that are:

- a. Certified as a home health agency under Medicare, or
- b. Authorized to provide similar services through a contract with the department of public health (IDPH) for local public health services. The agency must provide a current IDPH local public health services contract number.

**77.30(2) Home health aide providers.** Home health aide providers shall be agencies which are certified to participate in the Medicare program.

**77.30(3) Adult day care providers.** Adult day care providers shall be agencies that are certified by the department of inspections and appeals as being in compliance with the standards for adult day services programs at 481—Chapter 70.

**77.30(4) Nursing care providers.** Nursing care providers shall be agencies which are certified to participate in the Medicare program as home health agencies.

**77.30(5) Respite care providers.**

*a.* The following agencies may provide respite services:

- (1) Home health agencies that are certified to participate in the Medicare program.
- (2) Respite providers certified under the home- and community-based services intellectual disability or brain injury waiver.
- (3) Nursing facilities, intermediate care facilities for the mentally retarded, and hospitals enrolled as providers in the Iowa Medicaid program.
- (4) Group living foster care facilities for children licensed by the department according to 441—Chapters 112 and 114 to 116 and child care centers licensed according to 441—Chapter 109.
- (5) Camps certified by the American Camping Association.
- (6) Home care agencies that meet the conditions of participation set forth in subrule 77.30(1).
- (7) Adult day care providers that meet the conditions of participation set forth in subrule 77.30(3).
- (8) Residential care facilities for persons with mental retardation licensed by the department of inspections and appeals.
- (9) Child care facilities, which are defined as child care centers, preschools, or child development homes registered pursuant to 441—Chapter 110.
- (10) Assisted living programs certified by the department of inspections and appeals.

*b.* Respite providers shall meet the following conditions:

- (1) Providers shall maintain the following information that shall be updated at least annually:
  1. The consumer's name, birth date, age, and address and the telephone number of each parent, guardian or primary caregiver.
  2. An emergency medical care release.
  3. Emergency contact telephone numbers such as the number of the consumer's physician and the parents, guardian, or primary caregiver.
  4. The consumer's medical issues, including allergies.
  5. The consumer's daily schedule which includes the consumer's preferences in activities or foods or any other special concerns.
- (2) Procedures shall be developed for the dispensing, storage, authorization, and recording of all prescription and nonprescription medications administered. Home health agencies must follow Medicare regulations for medication dispensing.

All medications shall be stored in their original containers, with the accompanying physician's or pharmacist's directions and label intact. Medications shall be stored so they are inaccessible to consumers and the public. Nonprescription medications shall be labeled with the consumer's name.

In the case of medications that are administered on an ongoing, long-term basis, authorization shall be obtained for a period not to exceed the duration of the prescription.

(3) Policies shall be developed for:

1. Notifying the parent, guardian or primary caregiver of any injuries or illnesses that occur during respite provision. A parent's, guardian's or primary caregiver's signature is required to verify receipt of notification.
2. Requiring the parent, guardian or primary caregiver to notify the respite provider of any injuries or illnesses that occurred prior to respite provision.
3. Documenting activities and times of respite. This documentation shall be made available to the parent, guardian or primary caregiver upon request.
4. Ensuring the safety and privacy of the individual. Policies shall at a minimum address threat of fire, tornado, or flood and bomb threats.

*c.* A facility providing respite under this subrule shall not exceed the facility's licensed capacity, and services shall be provided in locations consistent with licensure.

*d.* Respite provided outside the consumer's home or the facility covered by the licensure, certification, accreditation, or contract must be approved by the parent, guardian or primary caregiver

and the interdisciplinary team and must be consistent with the way the location is used by the general public. Respite in these locations shall not exceed 72 continuous hours.

**77.30(6) Counseling providers.** Counseling providers shall be:

a. Agencies which are certified under the community mental health center standards established by the mental health and developmental disabilities commission, set forth in 441—Chapter 24, Divisions I and III.

b. Agencies which are licensed as meeting the hospice standards and requirements set forth in department of inspections and appeals rules 481—Chapter 53 or which are certified to meet the standards under the Medicare program for hospice programs.

c. Agencies which are accredited under the mental health service provider standards established by the mental health and developmental disabilities commission, set forth in 441—Chapter 24, Divisions I and IV.

**77.30(7) Consumer-directed attendant care providers.** The following providers may provide consumer-directed attendant care service:

a. An individual who contracts with the member to provide attendant care service and who is:

(1) At least 18 years of age.

(2) Qualified by training or experience to carry out the member's plan of care pursuant to the department-approved case plan or individual comprehensive plan.

(3) Not the spouse of the member or a parent or stepparent of a member aged 17 or under.

(4) Not the recipient of respite services paid through home- and community-based services on behalf of a member who receives home- and community-based services.

b. Agencies authorized to provide similar services through a contract with the department of public health (IDPH) for local public health services. The agency must provide a current IDPH local public health services contract number.

c. Home health agencies which are certified to participate in the Medicare program.

d. Chore providers subcontracting with area agencies on aging or with letters of approval from the area agencies on aging stating that the organization is qualified to provide chore services.

e. Community action agencies as designated in Iowa Code section 216A.93.

f. Providers certified under an HCBS waiver for supported community living.

g. Assisted living programs that are certified by the department of inspections and appeals under 481—Chapter 69.

h. Adult day service providers that are certified by the department of inspections and appeals under 481—Chapter 70.

**77.30(8) Interim medical monitoring and treatment providers.**

a. The following providers may provide interim medical monitoring and treatment services:

(1) Child care facilities, which are defined as child care centers licensed pursuant to 441—Chapter 109, preschools, or child development homes registered pursuant to 441—Chapter 110.

(2) Rescinded IAB 9/1/04, effective 11/1/04.

(3) Rescinded IAB 9/1/04, effective 11/1/04.

(4) Home health agencies certified to participate in the Medicare program.

(5) Supported community living providers certified according to subrule 77.37(14) or 77.39(13).

b. Staff requirements. Staff members providing interim medical monitoring and treatment services to members shall meet all of the following requirements:

(1) Be at least 18 years of age.

(2) Not be the spouse of the member or a parent or stepparent of the member if the member is aged 17 or under.

(3) Not be a usual caregiver of the member.

(4) Be qualified by training or experience to provide medical intervention or intervention in a medical emergency necessary to carry out the member's plan of care. The training or experience required must be determined by the member's usual caregivers and a licensed medical professional on the member's interdisciplinary team and must be documented in the member's service plan.

c. Service documentation. Providers shall maintain clinical and fiscal records necessary to fully disclose the extent of services furnished to members. Records shall specify by service date the procedures performed, together with information concerning progress of treatment.

**77.30(9) Home and vehicle modification providers.** The following providers may provide home and vehicle modification:

- a. Area agencies on aging as designated in 17—4.4(231).
- b. Community action agencies as designated in Iowa Code section 216A.93.
- c. Providers eligible to participate as home and vehicle modification providers under the elderly waiver, enrolled as home and vehicle modification providers under the physical disability waiver, or certified as home and vehicle modification providers under the home- and community-based services intellectual disability or brain injury waiver.
- d. Community businesses that have all necessary licenses and permits to operate in conformity with federal, state, and local laws and regulations, and that submit verification of current liability and workers' compensation coverage.

**77.30(10) Personal emergency response system providers.** Personal emergency response system providers shall be agencies that meet the conditions of participation set forth in subrule 77.33(2).

**77.30(11) Home-delivered meals.** The following providers may provide home-delivered meals:

a. Area agencies on aging as designated in 17—4.4(231). Home-delivered meals providers subcontracting with area agencies on aging or with letters of approval from the area agencies on aging stating the organization is qualified to provide home-delivered meals services may also provide home-delivered meals services.

- b. Community action agencies as designated in Iowa Code section 216A.93.
- c. Nursing facilities licensed pursuant to Iowa Code chapter 135C.
- d. Restaurants licensed and inspected under Iowa Code chapter 137F.
- e. Hospitals enrolled as Medicaid providers.
- f. Home health aide providers meeting the standards set forth in subrule 77.33(3).
- g. Medical equipment and supply dealers certified to participate in the Medicaid program.
- h. Home care providers meeting the standards set forth in subrule 77.33(4).

**77.30(12) Nutritional counseling.** The following providers may provide nutritional counseling by a dietitian licensed under 645—Chapter 81:

- a. Hospitals enrolled as Medicaid providers.
- b. Community action agencies as designated in Iowa Code section 216A.93.
- c. Nursing facilities licensed pursuant to Iowa Code chapter 135C.
- d. Home health agencies certified by Medicare.
- e. Independent licensed dietitians approved by an area agency on aging.

**77.30(13) Financial management service.** Members who elect the consumer choices option shall work with a financial institution that meets the following qualifications.

- a. The financial institution shall either:
  - (1) Be cooperative, nonprofit, member-owned and member-controlled, and federally insured through and chartered by either the National Credit Union Administration (NCUA) or the credit union division of the Iowa department of commerce; or
  - (2) Be chartered by the Office of the Comptroller of the Currency, a bureau of the U.S. Department of the Treasury, and insured by the Federal Deposit Insurance Corporation (FDIC).
- b. The financial institution shall complete a financial management readiness review and certification conducted by the department or its designee.
- c. The financial institution shall obtain an Internal Revenue Service federal employee identification number dedicated to the financial management service.
- d. The financial institution shall enroll as a Medicaid provider.

**77.30(14) Independent support brokerage.** Members who elect the consumer choices option shall work with an independent support broker who meets the following qualifications.

- a. The broker must be at least 18 years of age.

- b. The broker shall not be the member's guardian, conservator, attorney in fact under a durable power of attorney for health care, power of attorney for financial matters, trustee, or representative payee.
- c. The broker shall not provide any other paid service to the member.
- d. The broker shall not work for an individual or entity that is providing services to the member.
- e. The broker must consent to a criminal background check and child and dependent adult abuse checks. The results shall be provided to the member.
- f. The broker must complete independent support brokerage training approved by the department.

**77.30(15) *Self-directed personal care.*** Members who elect the consumer choices option may choose to purchase self-directed personal care services from an individual or business that meets the following requirements.

- a. A business providing self-directed personal care services shall:
  - (1) Have all the necessary licenses and permits to operate in conformity with federal, state, and local laws and regulations; and
  - (2) Have current liability and workers' compensation coverage.
- b. An individual providing self-directed personal care services shall have all the necessary licenses required by federal, state, and local laws, including a valid driver's license if providing transportation.
- c. All personnel providing self-directed personal care services shall:
  - (1) Be at least 16 years of age.
  - (2) Be able to communicate successfully with the member.
  - (3) Not be the recipient of respite services paid through home- and community-based services on behalf of a member who receives home- and community-based services.
  - (4) Not be the recipient of respite services paid through the consumer choices option on behalf of a member who receives the consumer choices option.
  - (5) Not be the parent or stepparent of a minor child member or the spouse of a member.

- d. The provider of self-directed personal care services shall:
  - (1) Prepare timecards or invoices approved by the department that identify what services were provided and the time when services were provided.
  - (2) Submit invoices and timesheets to the financial management service no later than 30 calendar days from the date when the last service in the billing period was provided. Payment shall not be made if invoices and timesheets are received after this 30-day period.

**77.30(16) *Individual-directed goods and services.*** Members who elect the consumer choices option may choose to purchase individual-directed goods and services from an individual or business that meets the following requirements.

- a. A business providing individual-directed goods and services shall:
  - (1) Have all the necessary licenses and permits to operate in conformity with federal, state, and local laws and regulations; and
  - (2) Have current liability and workers' compensation coverage.
- b. An individual providing individual-directed goods and services shall have all the necessary licenses required by federal, state, and local laws, including a valid driver's license if providing transportation.
- c. All personnel providing individual-directed goods and services shall:
  - (1) Be at least 18 years of age.
  - (2) Be able to communicate successfully with the member.
  - (3) Not be the recipient of respite services paid through home- and community-based services on behalf of a member who receives home- and community-based services.
  - (4) Not be the recipient of respite services paid through the consumer choices option on behalf of a member who receives the consumer choices option.
  - (5) Not be the parent or stepparent of a minor child member or the spouse of a member.
- d. The provider of individual-directed goods and services shall:
  - (1) Prepare timecards or invoices approved by the department that identify what services were provided and the time when services were provided.

(2) Submit invoices and timesheets to the financial management service no later than 30 calendar days from the date when the last service in the billing period was provided. Payment shall not be made if invoices and timesheets are received after this 30-day period.

**77.30(17) Self-directed community supports and employment.** Members who elect the consumer choices option may choose to purchase self-directed community supports and employment from an individual or business that meets the following requirements.

*a.* A business providing community supports and employment shall:

(1) Have all the necessary licenses and permits to operate in conformity with federal, state, and local laws and regulations; and

(2) Have current liability and workers' compensation coverage.

*b.* An individual providing self-directed community supports and employment shall have all the necessary licenses required by federal, state, and local laws, including a valid driver's license if providing transportation.

*c.* All personnel providing self-directed community supports and employment shall:

(1) Be at least 18 years of age.

(2) Be able to communicate successfully with the member.

(3) Not be the recipient of respite services paid through home- and community-based services on behalf of a member who receives home- and community-based services.

(4) Not be the recipient of respite services paid through the consumer choices option on behalf of a member who receives the consumer choices option.

(5) Not be the parent or stepparent of a minor child member or the spouse of a member.

*d.* The provider of self-directed community supports and employment shall:

(1) Prepare timecards or invoices approved by the department that identify what services were provided and the time when services were provided.

(2) Submit invoices and timesheets to the financial management service no later than 30 calendar days from the date when the last service in the billing period was provided. Payment shall not be made if invoices and timesheets are received after this 30-day period.

**77.30(18) Incident management and reporting.** As a condition of participation in the medical assistance program, HCBS health and disability waiver service providers must comply with the requirements of Iowa Code sections 232.69 and 235B.3 regarding the reporting of child abuse and dependent adult abuse and with the incident management and reporting requirements in this subrule. EXCEPTION: The conditions in this subrule do not apply to providers of goods and services purchased under the consumer choices option or providers of home and vehicle modification, home-delivered meals, or personal emergency response.

*a. Definitions.*

"Major incident" means an occurrence involving a consumer during service provision that:

1. Results in a physical injury to or by the consumer that requires a physician's treatment or admission to a hospital;

2. Results in the death of any person;

3. Requires emergency mental health treatment for the consumer;

4. Requires the intervention of law enforcement;

5. Requires a report of child abuse pursuant to Iowa Code section 232.69 or a report of dependent adult abuse pursuant to Iowa Code section 235B.3;

6. Constitutes a prescription medication error or a pattern of medication errors that leads to the outcome in paragraph "1," "2," or "3"; or

7. Involves a consumer's location being unknown by provider staff who are assigned protective oversight.

"Minor incident" means an occurrence involving a consumer during service provision that is not a major incident and that:

1. Results in the application of basic first aid;

2. Results in bruising;

3. Results in seizure activity;

4. Results in injury to self, to others, or to property; or
  5. Constitutes a prescription medication error.
- b. Reporting procedure for minor incidents.* Minor incidents may be reported in any format designated by the provider. When a minor incident occurs or a staff member becomes aware of a minor incident, the staff member involved shall submit the completed incident report to the staff member's supervisor within 72 hours of the incident. The completed report shall be maintained in a centralized file with a notation in the consumer's file.
- c. Reporting procedure for major incidents.* When a major incident occurs or a staff member becomes aware of a major incident:
- (1) The staff member involved shall notify the following persons of the incident by the end of the next calendar day after the incident:
    1. The staff member's supervisor.
    2. The consumer or the consumer's legal guardian. EXCEPTION: Notification to the consumer is required only if the incident took place outside of the provider's service provision. Notification to the guardian, if any, is always required.
    3. The consumer's case manager.
  - (2) By the end of the next calendar day after the incident, the staff member who observed or first became aware of the incident shall also report as much information as is known about the incident to the department's bureau of long-term care either:
    1. By direct data entry into the Iowa Medicaid Provider Access System, or
    2. By faxing or mailing Form 470-4698, Critical Incident Report, according to the directions on the form.
  - (3) The following information shall be reported:
    1. The name of the consumer involved.
    2. The date and time the incident occurred.
    3. A description of the incident.
    4. The names of all provider staff and others who were present at the time of the incident or who responded after becoming aware of the incident. The confidentiality of other waiver-eligible or non-waiver-eligible consumers who were present must be maintained by the use of initials or other means.
    5. The action that the provider staff took to manage the incident.
    6. The resolution of or follow-up to the incident.
    7. The date the report is made and the handwritten or electronic signature of the person making the report.
  - (4) Submission of the initial report will generate a workflow in the Individualized Services Information System (ISIS) for follow-up by the case manager. When complete information about the incident is not available at the time of the initial report, the provider must submit follow-up reports until the case manager is satisfied with the incident resolution and follow-up. The completed report shall be maintained in a centralized file with a notation in the consumer's file.
- d. Tracking and analysis.* The provider shall track incident data and analyze trends to assess the health and safety of consumers served and determine if changes need to be made for service implementation or if staff training is needed to reduce the number or severity of incidents.

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

[ARC 7936B, IAB 7/1/09, effective 9/1/09; ARC 9314B, IAB 12/29/10, effective 3/1/11; ARC 0757C, IAB 5/29/13, effective 8/1/13]

**441—77.31(249A) Occupational therapists.** Occupational therapists are eligible to participate if they are licensed and in private practice independent of the administrative and professional control of an employer such as a physician, institution, or rehabilitation agency. Licensed occupational therapists in an independent group practice are eligible to enroll.

**77.31(1)** Occupational therapists in other states are eligible to participate if they are licensed in that state and meet the Medicare criteria for enrollment.

**77.31(2)** Occupational therapists who provide services to Medicaid members who are also Medicare beneficiaries must be enrolled in the Medicare program.

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

**441—77.32(249A) Hospice providers.** Hospice providers are eligible to participate in the Medicaid program providing they are certified to participate in the Medicare program.

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

**441—77.33(249A) HCBS elderly waiver service providers.** HCBS elderly waiver services shall be rendered by a person who is at least 16 years old (except as otherwise provided in this rule) and is not the spouse of the consumer served or the parent or stepparent of a consumer aged 17 or under. People who are 16 or 17 years old must be employed and supervised by an enrolled HCBS provider unless they are employed to provide self-directed personal care services through the consumer choices option. A person hired for self-directed personal care services need not be supervised by an enrolled HCBS provider. A person hired through the consumer choices option for independent support brokerage, self-directed personal care, individual-directed goods and services, or self-directed community support and employment is not required to enroll as a Medicaid provider. The following providers shall be eligible to participate in the Medicaid HCBS elderly waiver program if they meet the standards in subrule 77.33(22) and also meet the standards set forth below for the service to be provided:

**77.33(1) Adult day care providers.** Adult day care providers shall be agencies that are certified by the department of inspections and appeals as being in compliance with the standards for adult day services programs at 481—Chapter 70.

**77.33(2) Emergency response system providers.** Emergency response system providers must meet the following standards:

*a.* The agency shall provide an electronic component to transmit a coded signal via digital equipment over telephone lines to a central monitoring station. The central monitoring station must operate receiving equipment and be fully staffed by trained attendants, 24 hours a day, seven days per week. The attendants must process emergency calls and ensure the timely notification of appropriate emergency resources to be dispatched to the person in need.

*b.* The agency, parent agency, institution or corporation shall have the necessary legal authority to operate in conformity with federal, state and local laws and regulations.

*c.* There shall be a governing authority which is responsible for establishing policy and ensuring effective control of services and finances. The governing authority shall employ or contract for an agency administrator to whom authority and responsibility for overall agency administration are delegated.

*d.* The agency or institution shall be in compliance with all legislation relating to prohibition of discriminatory practices.

*e.* There shall be written policies and procedures established to explain how the service operates, agency responsibilities, client responsibilities and cost information.

**77.33(3) Home health aide providers.** Home health aide providers shall be agencies certified to participate in the Medicare program as home health agencies.

**77.33(4) Homemaker providers.** Homemaker providers shall be agencies that are:

*a.* Certified as a home health agency under Medicare, or

*b.* Authorized to provide similar services through a contract with the department of public health (IDPH) for local public health services. The agency must provide a current IDPH local public health services contract number.

**77.33(5) Nursing care.** Nursing care providers shall be agencies which are certified to participate in the Medicare program as home health agencies.

**77.33(6) Respite care providers.**

*a.* The following agencies may provide respite services:

(1) Home health agencies that are certified to participate in the Medicare program.

(2) Nursing facilities and hospitals enrolled as providers in the Iowa Medicaid program.

(3) Camps certified by the American Camping Association.

(4) Respite providers certified under the home- and community-based services intellectual disability waiver.

(5) Home care agencies that meet the conditions of participation set forth in subrule 77.33(4).

(6) Adult day care providers that meet the conditions set forth in subrule 77.33(1).

(7) Assisted living programs certified by the department of inspections and appeals.

*b.* Respite providers shall meet the following conditions:

(1) Providers shall maintain the following information that shall be updated at least annually:

1. The consumer's name, birth date, age, and address and the telephone number of the spouse, guardian or primary caregiver.

2. An emergency medical care release.

3. Emergency contact telephone numbers such as the number of the consumer's physician and the spouse, guardian, or primary caregiver.

4. The consumer's medical issues, including allergies.

5. The consumer's daily schedule which includes the consumer's preferences in activities or foods or any other special concerns.

(2) Procedures shall be developed for the dispensing, storage, authorization, and recording of all prescription and nonprescription medications administered. Home health agencies must follow Medicare regulations for medication dispensing.

All medications shall be stored in their original containers, with the accompanying physician's or pharmacist's directions and label intact. Medications shall be stored so they are inaccessible to consumers and the public. Nonprescription medications shall be labeled with the consumer's name.

In the case of medications that are administered on an ongoing, long-term basis, authorization shall be obtained for a period not to exceed the duration of the prescription.

(3) Policies shall be developed for:

1. Notifying the spouse, guardian, or primary caregiver of any injuries or illnesses that occur during respite provision. A spouse's, guardian's or primary caregiver's signature is required to verify receipt of notification.

2. Requiring the spouse, guardian or primary caregiver to notify the respite provider of any injuries or illnesses that occurred prior to respite provision.

3. Documenting activities and times of respite. This documentation shall be made available to the spouse, guardian or primary caregiver upon request.

4. Ensuring the safety and privacy of the individual. Policies shall at a minimum address threat of fire, tornado, or flood and bomb threats.

*c.* A facility providing respite under this subrule shall not exceed the facility's licensed capacity, and services shall be provided in locations consistent with licensure.

*d.* Respite provided outside the consumer's home or the facility covered by the licensure, certification, accreditation, or contract must be approved by the spouse, guardian or primary caregiver and the interdisciplinary team and must be consistent with the way the location is used by the general public. Respite in these locations shall not exceed 72 continuous hours.

**77.33(7) *Chore providers.*** The following providers may provide chore services:

*a.* Home health agencies certified under Medicare.

*b.* Community action agencies as designated in Iowa Code section 216A.93.

*c.* Agencies authorized to provide similar services through a contract with the department of public health (IDPH) for local public health services. The agency must provide a current IDPH local public health services contract number.

*d.* Nursing facilities licensed pursuant to Iowa Code chapter 135C.

*e.* Providers that were enrolled as chore providers as of June 30, 2010, based on a subcontract with or letter of approval from an area agency on aging.

*f.* Community businesses that are engaged in the provision of chore services and that:

(1) Have all necessary licenses and permits to operate in conformity with federal, state, and local laws and regulations, and

(2) Submit verification of current liability and workers' compensation coverage.

**77.33(8) Home-delivered meals.** The following providers may provide home-delivered meals:

a. Area agencies on aging as designated in 17—4.4(231). Home-delivered meals providers subcontracting with area agencies on aging or with letters of approval from the area agencies on aging stating the organization is qualified to provide home-delivered meals services may also provide home-delivered meals services.

b. Community action agencies as designated in Iowa Code section 216A.93.

c. Nursing facilities licensed pursuant to Iowa Code chapter 135C.

d. Restaurants licensed and inspected under Iowa Code chapter 137F.

e. Hospitals enrolled as Medicaid providers.

f. Home health aide providers meeting the standards set forth in subrule 77.33(3).

g. Medical equipment and supply dealers certified to participate in the Medicaid program.

h. Home care providers meeting the standards set forth in subrule 77.33(4).

**77.33(9) Home and vehicle modification providers.** The following providers may provide home and vehicle modification:

a. Area agencies on aging as designated in 17—4.4(231).

b. Community action agencies as designated in Iowa Code section 216A.93.

c. Providers eligible to participate as home and vehicle modification providers under the health and disability waiver, enrolled as home and vehicle modification providers under the physical disability waiver, or certified as home and vehicle modification providers under the home- and community-based services intellectual disability or brain injury waiver.

d. Community businesses that have all necessary licenses and permits to operate in conformity with federal, state, and local laws and regulations, and that submit verification of current liability and workers' compensation coverage.

**77.33(10) Mental health outreach providers.** Community mental health centers or other mental health providers accredited by the mental health and developmental disabilities commission pursuant to 441—Chapter 24 may provide mental health outreach services.

**77.33(11) Transportation providers.** The following providers may provide transportation:

a. Area agencies on aging as designated in 17—4.4(231). Transportation providers subcontracting with area agencies on aging or with letters of approval from the area agencies on aging stating the organization is qualified to provide transportation services may also provide transportation services.

b. Community action agencies as designated in Iowa Code section 216A.93.

c. Regional transit agencies as recognized by the Iowa department of transportation.

d. Rescinded IAB 3/10/99, effective 5/1/99.

e. Nursing facilities licensed pursuant to Iowa Code chapter 135C.

f. Transportation providers contracting with the nonemergency medical transportation contractor.

**77.33(12) Nutritional counseling.** The following providers may provide nutritional counseling by a dietitian licensed under 645—Chapter 81:

a. Hospitals enrolled as Medicaid providers.

b. Community action agencies as designated in Iowa Code section 216A.93.

c. Nursing facilities licensed pursuant to Iowa Code chapter 135C.

d. Home health agencies certified by Medicare.

e. Independent licensed dietitians.

**77.33(13) Assistive device providers.** The following providers may provide assistive devices:

a. Medicaid-enrolled medical equipment and supply dealers.

b. Area agencies on aging as designated according to department on aging rules 17—4.4(231) and 17—4.9(231).

c. Providers that were enrolled as assistive device providers as of June 30, 2010, based on a contract with or letter of approval from an area agency on aging.

d. Community businesses that are engaged in the provision of assistive devices and that:

(1) Have all necessary licenses and permits to operate in conformity with federal, state, and local laws and regulations, and

(2) Submit verification of current liability and workers' compensation coverage.

**77.33(14) Senior companions.** Senior companion programs designated by the Corporation for National and Community Service may provide senior companion service.

**77.33(15) Consumer-directed attendant care providers.** The following providers may provide consumer-directed attendant care service:

- a.* An individual who contracts with the member to provide attendant care service and who is:
- (1) At least 18 years of age.
  - (2) Qualified by training or experience to carry out the member's plan of care pursuant to the department-approved case plan or individual comprehensive plan.
  - (3) Not the spouse of the member or a parent or stepparent of a member aged 17 or under.
  - (4) Not the recipient of respite services paid through home- and community-based services on behalf of a member who receives home- and community-based services.
- b.* Agencies authorized to provide similar services through a contract with the department of public health (IDPH) for local public health services. The agency must provide a current IDPH local public health services contract number.
- c.* Home health agencies which are certified to participate in the Medicare program.
- d.* Chore providers subcontracting with area agencies on aging or with letters of approval from the area agencies on aging stating that the organization is qualified to provide chore services.
- e.* Community action agencies as designated in Iowa Code section 216A.93.
- f.* Providers certified under an HCBS waiver for supported community living.
- g.* Assisted living programs that are certified by the department of inspections and appeals under 481—Chapter 69.
- h.* Adult day service providers that are certified by the department of inspections and appeals under 481—Chapter 70.

**77.33(16) Financial management service.** Consumers who elect the consumer choices option shall work with a financial institution that meets the qualifications in subrule 77.30(13).

**77.33(17) Independent support brokerage.** Consumers who elect the consumer choices option shall work with an independent support broker who meets the qualifications in subrule 77.30(14).

**77.33(18) Self-directed personal care.** Consumers who elect the consumer choices option may choose to purchase self-directed personal care services from an individual or business that meets the requirements in subrule 77.30(15).

**77.33(19) Individual-directed goods and services.** Consumers who elect the consumer choices option may choose to purchase individual-directed goods and services from an individual or business that meets the requirements in subrule 77.30(16).

**77.33(20) Self-directed community supports and employment.** Consumers who elect the consumer choices option may choose to purchase self-directed community supports and employment from an individual or business that meets the requirements in subrule 77.30(17).

**77.33(21) Case management providers.** A case management provider organization is eligible to participate in the Medicaid HCBS elderly waiver program if the organization meets the following standards:

- a.* The case management provider shall be an agency or individual that:
- (1) Is accredited by the mental health, mental retardation, developmental disabilities, and brain injury commission as meeting the standards for case management services in 441—Chapter 24; or
  - (2) Is accredited through the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) to provide case management; or
  - (3) Is accredited through the Council on Accreditation of Rehabilitation Facilities (CARF) to provide case management; or
  - (4) Is accredited through the Council on Quality and Leadership in Supports for People with Disabilities (CQL) to provide case management; or
  - (5) Is approved by the department on aging as meeting the standards for case management services in 17—Chapter 21; or
  - (6) Is authorized to provide similar services through a contract with the department of public health (IDPH) for local public health services and that:

1. Meets the qualifications for case managers in 641—subrule 80.6(1); and
  2. Provides a current IDPH local public health services contract number.
- b.* A case management provider shall not provide direct services to the consumer. The department and the Centers for Medicare and Medicaid Services deem the provision of direct services to case management consumers to be a conflict of interest. A person cannot be the first-line supervisor of both case managers and direct service staff who are providing services to elderly waiver consumers. The provider must have written conflict of interest policies that include, but are not limited to:
- (1) Specific procedures to identify conflicts of interest.
  - (2) Procedures to eliminate any conflict of interest that is identified.
  - (3) Procedures for handling complaints of conflict of interest, including written documentation.
- c.* If the case management provider organization subcontracts case management services to another entity:
- (1) That entity must also meet the provider qualifications in this subrule; and
  - (2) The contractor is responsible for verification of compliance.

**77.33(22) Incident management and reporting.** As a condition of participation in the medical assistance program, HCBS elderly waiver service providers must comply with the requirements of Iowa Code sections 232.69 and 235B.3 regarding the reporting of child abuse and dependent adult abuse and with the incident management and reporting requirements in this subrule. EXCEPTION: The conditions in this subrule do not apply to providers of assistive devices, chore service, goods and services purchased under the consumer choices option, home and vehicle modification, home-delivered meals, personal emergency response, or transportation.

*a. Definitions.*

“*Major incident*” means an occurrence involving a consumer during service provision that:

1. Results in a physical injury to or by the consumer that requires a physician’s treatment or admission to a hospital;
2. Results in the death of any person;
3. Requires emergency mental health treatment for the consumer;
4. Requires the intervention of law enforcement;
5. Requires a report of child abuse pursuant to Iowa Code section 232.69 or a report of dependent adult abuse pursuant to Iowa Code section 235B.3;
6. Constitutes a prescription medication error or a pattern of medication errors that leads to the outcome in paragraph “1,” “2,” or “3”; or
7. Involves a consumer’s location being unknown by provider staff who are assigned protective oversight.

“*Minor incident*” means an occurrence involving a consumer during service provision that is not a major incident and that:

1. Results in the application of basic first aid;
2. Results in bruising;
3. Results in seizure activity;
4. Results in injury to self, to others, or to property; or
5. Constitutes a prescription medication error.

*b. Reporting procedure for minor incidents.* Minor incidents may be reported in any format designated by the provider. When a minor incident occurs or a staff member becomes aware of a minor incident, the staff member involved shall submit the completed incident report to the staff member’s supervisor within 72 hours of the incident. The completed report shall be maintained in a centralized file with a notation in the consumer’s file.

*c. Reporting procedure for major incidents.* When a major incident occurs or a staff member becomes aware of a major incident:

- (1) The staff member involved shall notify the following persons of the incident by the end of the next calendar day after the incident:
  1. The staff member’s supervisor.

2. The consumer or the consumer's legal guardian. EXCEPTION: Notification to the consumer is required only if the incident took place outside of the provider's service provision. Notification to the guardian, if any, is always required.

3. The consumer's case manager.

(2) By the end of the next calendar day after the incident, the staff member who observed or first became aware of the incident shall also report as much information as is known about the incident to the department's bureau of long-term care either:

1. By direct data entry into the Iowa Medicaid Provider Access System, or

2. By faxing or mailing Form 470-4698, Critical Incident Report, according to the directions on the form.

(3) The following information shall be reported:

1. The name of the consumer involved.

2. The date and time the incident occurred.

3. A description of the incident.

4. The names of all provider staff and others who were present at the time of the incident or who responded after becoming aware of the incident. The confidentiality of other waiver-eligible or non-waiver-eligible consumers who were present must be maintained by the use of initials or other means.

5. The action that the provider staff took to manage the incident.

6. The resolution of or follow-up to the incident.

7. The date the report is made and the handwritten or electronic signature of the person making the report.

(4) Submission of the initial report will generate a workflow in the Individualized Services Information System (ISIS) for follow-up by the case manager. When complete information about the incident is not available at the time of the initial report, the provider must submit follow-up reports until the case manager is satisfied with the incident resolution and follow-up. The completed report shall be maintained in a centralized file with a notation in the consumer's file.

*d. Tracking and analysis.* The provider shall track incident data and analyze trends to assess the health and safety of consumers served and determine if changes need to be made for service implementation or if staff training is needed to reduce the number or severity of incidents.

**77.33(23) Assisted living on-call service.** Assisted living on-call service providers shall be assisted living programs that are certified by the department of inspections and appeals under 481—Chapter 69.

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

[ARC 7936B, IAB 7/1/09, effective 9/1/09; ARC 9314B, IAB 12/29/10, effective 3/1/11; ARC 0545C, IAB 1/9/13, effective 3/1/13; ARC 0757C, IAB 5/29/13, effective 8/1/13; ARC 1071C, IAB 10/2/13, effective 10/1/13]

**441—77.34(249A) HCBS AIDS/HIV waiver service providers.** HCBS AIDS/HIV waiver services shall be rendered by a person who is at least 16 years old (except as otherwise provided in this rule) and is not the spouse of the consumer served or the parent or stepparent of a consumer aged 17 or under. People who are 16 or 17 years old must be employed and supervised by an enrolled HCBS provider unless they are employed to provide self-directed personal care services through the consumer choices option. A person hired for self-directed personal care services need not be supervised by an enrolled HCBS provider. A person hired through the consumer choices option for independent support brokerage, self-directed personal care, individual-directed goods and services, or self-directed community support and employment is not required to enroll as a Medicaid provider. The following providers shall be eligible to participate in the Medicaid HCBS AIDS/HIV waiver program if they meet the standards in subrule 77.34(14) and also meet the standards set forth below for the service to be provided:

**77.34(1) Counseling providers.** Counseling providers shall be:

*a.* Agencies which are certified under the community mental health center standards established by the mental health and developmental disabilities commission, set forth in 441—Chapter 24, Divisions I and III.

b. Agencies which are licensed as meeting the hospice standards and requirements set forth in department of inspections and appeals rules 481—Chapter 53 or which are certified to meet the standards under the Medicare program for hospice programs.

c. Agencies which are accredited under the mental health service provider standards established by the mental health and developmental disabilities commission, set forth in 441—Chapter 24, Divisions I and IV.

**77.34(2) Home health aide providers.** Home health aide providers shall be agencies which are certified to participate in the Medicare program.

**77.34(3) Homemaker providers.** Homemaker providers shall be agencies that are:

- a. Certified as a home health agency under Medicare, or
- b. Authorized to provide similar services through a contract with the department of public health (IDPH) for local public health services. The agency must provide a current IDPH local public health services contract number.

**77.34(4) Nursing care providers.** Nursing care providers shall be agencies which are certified to meet the standards under the Medicare program for home health agencies.

**77.34(5) Respite care providers.**

- a. The following agencies may provide respite services:
  - (1) Home health agencies that are certified to participate in the Medicare program.
  - (2) Nursing facilities, intermediate care facilities for the mentally retarded, or hospitals enrolled as providers in the Iowa Medicaid program.
  - (3) Respite providers certified under the home- and community-based services intellectual disability or brain injury waiver.
  - (4) Group living foster care facilities for children licensed by the department according to 441—Chapters 112 and 114 to 116 and child care centers licensed according to 441—Chapter 109.
  - (5) Camps certified by the American Camping Association.
  - (6) Home care agencies that meet the conditions of participation set forth in subrule 77.34(3).
  - (7) Adult day care providers that meet the conditions of participation set forth in subrule 77.34(7).
  - (8) Child care facilities, which are defined as child care centers, preschools, or child development homes registered pursuant to 441—Chapter 110.
  - (9) Assisted living programs certified by the department of inspections and appeals.
- b. Respite providers shall meet the following conditions:
  - (1) Providers shall maintain the following information that shall be updated at least annually:
    1. The consumer's name, birth date, age, and address and the telephone number of each parent, guardian or primary caregiver.
    2. An emergency medical care release.
    3. Emergency contact telephone numbers such as the number of the consumer's physician and the parents, guardian, or primary caregiver.
    4. The consumer's medical issues, including allergies.
    5. The consumer's daily schedule which includes the consumer's preferences in activities or foods or any other special concerns.
  - (2) Procedures shall be developed for the dispensing, storage, authorization, and recording of all prescription and nonprescription medications administered. Home health agencies must follow Medicare regulations for medication dispensing.

All medications shall be stored in their original containers, with the accompanying physician's or pharmacist's directions and label intact. Medications shall be stored so they are inaccessible to consumers and the public. Nonprescription medications shall be labeled with the consumer's name.

In the case of medications that are administered on an ongoing, long-term basis, authorization shall be obtained for a period not to exceed the duration of the prescription.

(3) Policies shall be developed for:

1. Notifying the parent, guardian or primary caregiver of any injuries or illnesses that occur during respite provision. A parent's, guardian's or primary caregiver's signature is required to verify receipt of notification.

2. Requiring the parent, guardian, or primary caregiver to notify the respite provider of any injuries or illnesses that occurred prior to respite provision.

3. Documenting activities and times of respite. This documentation shall be made available to the parent, guardian or primary caregiver upon request.

4. Ensuring the safety and privacy of the individual. Policies shall at a minimum address threat of fire, tornado, or flood and bomb threats.

c. A facility providing respite under this subrule shall not exceed the facility's licensed capacity, and services shall be provided in locations consistent with licensure.

d. Respite provided outside the consumer's home or the facility covered by the licensure, certification, accreditation, or contract must be approved by the parent, guardian or primary caregiver and the interdisciplinary team and must be consistent with the way the location is used by the general public. Respite in these locations shall not exceed 72 continuous hours.

**77.34(6) Home-delivered meals.** The following providers may provide home-delivered meals:

a. Home health aide providers meeting the standards set forth in subrule 77.34(2).

b. Home care providers meeting the standards set forth in subrule 77.34(3).

c. Hospitals enrolled as Medicaid providers.

d. Nursing facilities licensed pursuant to Iowa Code chapter 135C.

e. Restaurants licensed and inspected under Iowa Code chapter 137F.

f. Community action agencies as designated in Iowa Code section 216A.93. Home-delivered meals providers subcontracting with community action agencies or with letters of approval from the community action agencies stating the organization is qualified to provide home-delivered meals services may also provide home-delivered meals services.

g. Area agencies on aging as designated in 17—4.4(231). Home-delivered meals providers subcontracting with area agencies on aging or with letters of approval from the area agencies on aging stating the organization is qualified to provide home-delivered meals services may also provide home-delivered meals services.

h. Medical equipment and supply dealers certified to participate in the Medicaid program.

**77.34(7) Adult day care providers.** Adult day care providers shall be agencies that are certified by the department of inspections and appeals as being in compliance with the standards for adult day services programs at 481—Chapter 70.

**77.34(8) Consumer-directed attendant care providers.** The following providers may provide consumer-directed attendant care service:

a. An individual who contracts with the member to provide attendant care service and who is:

(1) At least 18 years of age.

(2) Qualified by training or experience to carry out the member's plan of care pursuant to the department-approved case plan or individual comprehensive plan.

(3) Not the spouse of the member or a parent or stepparent of a member aged 17 or under.

(4) Not the recipient of respite services paid through home- and community-based services on behalf of a member who receives home- and community-based services.

b. Agencies authorized to provide similar services through a contract with the department of public health (IDPH) for local public health services. The agency must provide a current IDPH local public health services contract number.

c. Home health agencies which are certified to participate in the Medicare program.

d. Chore providers subcontracting with area agencies on aging or with letters of approval from the area agencies on aging stating that the organization is qualified to provide chore services.

e. Community action agencies as designated in Iowa Code section 216A.93.

f. Providers certified under an HCBS waiver for supported community living.

g. Assisted living programs that are certified by the department of inspections and appeals under 481—Chapter 69.

h. Adult day service providers that are certified by the department of inspections and appeals under 481—Chapter 70.

**77.34(9) *Financial management service.*** Consumers who elect the consumer choices option shall work with a financial institution that meets the qualifications in subrule 77.30(13).

**77.34(10) *Independent support brokerage.*** Consumers who elect the consumer choices option shall work with an independent support broker who meets the qualifications in subrule 77.30(14).

**77.34(11) *Self-directed personal care.*** Consumers who elect the consumer choices option may choose to purchase self-directed personal care services from an individual or business that meets the requirements in subrule 77.30(15).

**77.34(12) *Individual-directed goods and services.*** Consumers who elect the consumer choices option may choose to purchase individual-directed goods and services from an individual or business that meets the requirements in subrule 77.30(16).

**77.34(13) *Self-directed community supports and employment.*** Consumers who elect the consumer choices option may choose to purchase self-directed community supports and employment from an individual or business that meets the requirements in subrule 77.30(17).

**77.34(14) *Incident management and reporting.*** As a condition of participation in the medical assistance program, HCBS AIDS/HIV waiver service providers must comply with the requirements of Iowa Code sections 232.69 and 235B.3 regarding the reporting of child abuse and dependent adult abuse and with the incident management and reporting requirements in this subrule. **EXCEPTION:** The conditions in this subrule do not apply to providers of goods and services purchased under the consumer choices option or to home-delivered meals.

*a. Definitions.*

*“Major incident”* means an occurrence involving a consumer during service provision that:

1. Results in a physical injury to or by the consumer that requires a physician’s treatment or admission to a hospital;
2. Results in the death of any person;
3. Requires emergency mental health treatment for the consumer;
4. Requires the intervention of law enforcement;
5. Requires a report of child abuse pursuant to Iowa Code section 232.69 or a report of dependent adult abuse pursuant to Iowa Code section 235B.3;
6. Constitutes a prescription medication error or a pattern of medication errors that leads to the outcome in paragraph “1,” “2,” or “3”; or
7. Involves a consumer’s location being unknown by provider staff who are assigned protective oversight.

*“Minor incident”* means an occurrence involving a consumer during service provision that is not a major incident and that:

1. Results in the application of basic first aid;
2. Results in bruising;
3. Results in seizure activity;
4. Results in injury to self, to others, or to property; or
5. Constitutes a prescription medication error.

*b. Reporting procedure for minor incidents.* Minor incidents may be reported in any format designated by the provider. When a minor incident occurs or a staff member becomes aware of a minor incident, the staff member involved shall submit the completed incident report to the staff member’s supervisor within 72 hours of the incident. The completed report shall be maintained in a centralized file with a notation in the consumer’s file.

*c. Reporting procedure for major incidents.* When a major incident occurs or a staff member becomes aware of a major incident:

(1) The staff member involved shall notify the following persons of the incident by the end of the next calendar day after the incident:

1. The staff member’s supervisor.
2. The consumer or the consumer’s legal guardian. **EXCEPTION:** Notification to the consumer is required only if the incident took place outside of the provider’s service provision. Notification to the guardian, if any, is always required.

3. The consumer's case manager.
- (2) By the end of the next calendar day after the incident, the staff member who observed or first became aware of the incident shall also report as much information as is known about the incident to the department's bureau of long-term care either:
  1. By direct data entry into the Iowa Medicaid Provider Access System, or
  2. By faxing or mailing Form 470-4698, Critical Incident Report, according to the directions on the form.
- (3) The following information shall be reported:
  1. The name of the consumer involved.
  2. The date and time the incident occurred.
  3. A description of the incident.
  4. The names of all provider staff and others who were present at the time of the incident or who responded after becoming aware of the incident. The confidentiality of other waiver-eligible or non-waiver-eligible consumers who were present must be maintained by the use of initials or other means.
  5. The action that the provider staff took to manage the incident.
  6. The resolution of or follow-up to the incident.
  7. The date the report is made and the handwritten or electronic signature of the person making the report.

(4) Submission of the initial report will generate a workflow in the Individualized Services Information System (ISIS) for follow-up by the case manager. When complete information about the incident is not available at the time of the initial report, the provider must submit follow-up reports until the case manager is satisfied with the incident resolution and follow-up. The completed report shall be maintained in a centralized file with a notation in the consumer's file.

*d. Tracking and analysis.* The provider shall track incident data and analyze trends to assess the health and safety of consumers served and determine if changes need to be made for service implementation or if staff training is needed to reduce the number or severity of incidents.

This rule is intended to implement Iowa Code section 249A.4.  
[ARC 7936B, IAB 7/1/09, effective 9/1/09; ARC 9314B, IAB 12/29/10, effective 3/1/11]

**441—77.35(249A) Federally qualified health centers.** Federally qualified health centers are eligible to participate in the Medicaid program when the Centers for Medicare and Medicaid Services has notified the Medicaid program of their eligibility as allowed by Section 6404(b) of Public Law 101-239.

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

**441—77.36(249A) Advanced registered nurse practitioners.** Advanced registered nurse practitioners are eligible to participate in the Medicaid program if they are duly licensed and registered by the state of Iowa as advanced registered nurse practitioners certified pursuant to board of nursing rules 655—Chapter 7.

**77.36(1)** Advanced registered nurse practitioners in another state shall be eligible to participate if they are duly licensed and registered in that state as advanced registered nurse practitioners with certification in a practice area consistent with board of nursing rules 655—Chapter 7.

**77.36(2)** Advanced registered nurse practitioners who have been certified eligible to participate in Medicare shall be considered as having met these guidelines.

**77.36(3)** Licensed nurse anesthetists who have graduated from a nurse anesthesia program meeting the standards set forth by a national association of nurse anesthetists within the past 18 months and who are awaiting initial certification by a national association of nurse anesthetists approved by the board of nursing shall be considered as having met these guidelines.

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

**441—77.37(249A) Home- and community-based services intellectual disability waiver service providers.** Providers shall be eligible to participate in the Medicaid HCBS intellectual disability waiver program if they meet the requirements in this rule and the subrules applicable to the individual service.

The standards in subrule 77.37(1) apply only to providers of supported employment, respite providers certified according to subparagraph 77.37(15)“a”(8), and providers of supported community living services that are not residential-based. The standards and certification processes in subrules 77.37(2) through 77.37(7) and 77.37(9) through 77.37(12) apply only to supported employment providers and non-residential-based supported community living providers.

The requirements in subrule 77.37(13) apply to all providers. EXCEPTION: A person hired through the consumer choices option for independent support brokerage, self-directed personal care, individual-directed goods and services, or self-directed community support and employment is not required to enroll as a Medicaid provider and is not subject to the review requirements in subrule 77.37(13). Also, services must be rendered by a person who is at least 16 years old (except as otherwise provided in this rule) and is not the spouse of the consumer served or the parent or stepparent of a consumer aged 17 or under. People who are 16 or 17 years old must be employed and supervised by an enrolled HCBS provider unless they are employed to provide self-directed personal care services through the consumer choices option. A person hired for self-directed personal care services need not be supervised by an enrolled HCBS provider. Consumer-directed attendant care and interim medical monitoring and treatment providers must be at least 18 years of age.

**77.37(1) Organizational standards (Outcome 1).** Organizational outcome-based standards for home- and community-based services intellectual disability providers are as follows:

*a.* The organization demonstrates the provision and oversight of high-quality supports and services to consumers.

*b.* The organization demonstrates a defined mission commensurate with consumer’s needs, desires, and abilities.

*c.* The organization establishes and maintains fiscal accountability.

*d.* The organization has qualified staff commensurate with the needs of the consumers they serve. These staff demonstrate competency in performing duties and in all interactions with clients.

*e.* The organization provides needed training and supports to its staff. This training includes at a minimum:

(1) Consumer rights.

(2) Confidentiality.

(3) Provision of consumer medication.

(4) Identification and reporting of child and dependent adult abuse.

(5) Individual consumer support needs.

*f.* The organization has a systematic, organizationwide, planned approach to designing, measuring, evaluating, and improving the level of its performance. The organization:

(1) Measures and assesses organizational activities and services annually.

(2) Gathers information from consumers, family members, and staff.

(3) Conducts an internal review of consumer service records, including all major and minor incident reports according to subrule 77.37(8).

(4) Tracks incident data and analyzes trends annually to assess the health and safety of consumers served by the organization.

(5) Identifies areas in need of improvement.

(6) Develops a plan to address the areas in need of improvement.

(7) Implements the plan and documents the results.

*g.* Consumers and their legal representatives have the right to appeal the provider’s implementation of the 20 outcomes, or staff or contractual person’s action which affects the consumer. The provider shall distribute the policies for consumer appeals and procedures to consumers.

*h.* The provider shall have written policies and procedures and a staff training program for the identification and reporting of child and dependent adult abuse to the department pursuant to 441—Chapters 175 and 176.

- i.* The governing body has an active role in the administration of the agency.
- j.* The governing body receives and uses input from a wide range of local community interests and consumer representation and provides oversight that ensures the provision of high-quality supports and services to consumers.

**77.37(2) *Rights and dignity.*** Outcome-based standards for rights and dignity are as follows:

- a.* (Outcome 2) Consumers are valued.
- b.* (Outcome 3) Consumers live in positive environments.
- c.* (Outcome 4) Consumers work in positive environments.
- d.* (Outcome 5) Consumers exercise their rights and responsibilities.
- e.* (Outcome 6) Consumers have privacy.
- f.* (Outcome 7) When there is a need, consumers have support to exercise and safeguard their rights.
- g.* (Outcome 8) Consumers decide which personal information is shared and with whom.
- h.* (Outcome 9) Consumers make informed choices about where they work.
- i.* (Outcome 10) Consumers make informed choices on how they spend their free time.
- j.* (Outcome 11) Consumers make informed choices about where and with whom they live.
- k.* (Outcome 12) Consumers choose their daily routine.
- l.* (Outcome 13) Consumers are a part of community life and perform varied social roles.
- m.* (Outcome 14) Consumers have a social network and varied relationships.
- n.* (Outcome 15) Consumers develop and accomplish personal goals.
- o.* (Outcome 16) Management of consumers' money is addressed on an individualized basis.
- p.* (Outcome 17) Consumers maintain good health.
- q.* (Outcome 18) The consumer's living environment is reasonably safe in the consumer's home and community.
- r.* (Outcome 19) The consumer's desire for intimacy is respected and supported.
- s.* (Outcome 20) Consumers have an impact on the services they receive.

**77.37(3) *Contracts with consumers.*** The provider shall have written procedures which provide for the establishment of an agreement between the consumer and the provider.

- a.* The agreement shall define the responsibilities of the provider and the consumer, the rights of the consumer, the services to be provided to the consumer by the provider, all room and board and copay fees to be charged to the consumer and the sources of payment.
- b.* Contracts shall be reviewed at least annually.

**77.37(4) *The right to appeal.*** Consumers and their legal representatives have the right to appeal the provider's application of policies or procedures, or any staff or contractual person's action which affects the consumer. The provider shall distribute the policies for consumer appeals and procedures to consumers.

**77.37(5) *Storage and provision of medication.*** If the provider stores, handles, prescribes, dispenses or administers prescription or over-the-counter medications, the provider shall develop procedures for the storage, handling, prescribing, dispensing or administration of medication. For controlled substances, procedures shall be in accordance with department of inspections and appeals rule 481—63.18(135).

If the provider has a physician on staff or under contract, the physician shall review and document the provider's prescribed medication regime at least annually in accordance with current medical practice.

**77.37(6) *Research.*** If the provider conducts research involving human subjects, the provider shall have written policies and procedures for research which ensure the rights of consumers and staff.

**77.37(7) *Abuse reporting requirements.*** The provider shall have written policies and procedures and a staff training program for the identification and reporting of child and dependent adult abuse to the department pursuant to 441—Chapters 175 and 176.

**77.37(8) *Incident management and reporting.*** As a condition of participation in the medical assistance program, HCBS intellectual disability waiver service providers must comply with the requirements of Iowa Code sections 232.69 and 235B.3 regarding the reporting of child abuse and dependent adult abuse and with the incident management and reporting requirements in this subrule. EXCEPTION: The conditions in this subrule do not apply to providers of goods and services purchased

under the consumer choices option or providers of home and vehicle modification, personal emergency response, and transportation.

*a. Definitions.*

“*Major incident*” means an occurrence involving a consumer during service provision that:

1. Results in a physical injury to or by the consumer that requires a physician’s treatment or admission to a hospital;
2. Results in the death of any person;
3. Requires emergency mental health treatment for the consumer;
4. Requires the intervention of law enforcement;
5. Requires a report of child abuse pursuant to Iowa Code section 232.69 or a report of dependent adult abuse pursuant to Iowa Code section 235B.3;
6. Constitutes a prescription medication error or a pattern of medication errors that leads to the outcome in paragraph “1,” “2,” or “3”; or
7. Involves a consumer’s location being unknown by provider staff who are assigned protective oversight.

“*Minor incident*” means an occurrence involving a consumer during service provision that is not a major incident and that:

1. Results in the application of basic first aid;
2. Results in bruising;
3. Results in seizure activity;
4. Results in injury to self, to others, or to property; or
5. Constitutes a prescription medication error.

*b. Reporting procedure for minor incidents.* Minor incidents may be reported in any format designated by the provider. When a minor incident occurs or a staff member becomes aware of a minor incident, the staff member involved shall submit the completed incident report to the staff member’s supervisor within 72 hours of the incident. The completed report shall be maintained in a centralized file with a notation in the consumer’s file.

*c. Reporting procedure for major incidents.* When a major incident occurs or a staff member becomes aware of a major incident:

(1) The staff member involved shall notify the following persons of the incident by the end of the next calendar day after the incident:

1. The staff consumer’s supervisor.
2. The consumer or the consumer’s legal guardian. EXCEPTION: Notification to the consumer is required only if the incident took place outside of the provider’s service provision. Notification to the guardian, if any, is always required.
3. The consumer’s case manager.

(2) By the end of the next calendar day after the incident, the staff member who observed or first became aware of the incident shall also report as much information as is known about the incident to the department’s bureau of long-term care either:

1. By direct data entry into the Iowa Medicaid Provider Access System, or
2. By faxing or mailing Form 470-4698, Critical Incident Report, according to the directions on the form.

(3) The following information shall be reported:

1. The name of the consumer involved.
2. The date and time the incident occurred.
3. A description of the incident.
4. The names of all provider staff and others who were present at the time of the incident or who responded after becoming aware of the incident. The confidentiality of other waiver-eligible or non-waiver-eligible consumers who were present must be maintained by the use of initials or other means.
5. The action that the provider staff took to manage the incident.
6. The resolution of or follow-up to the incident.

7. The date the report is made and the handwritten or electronic signature of the person making the report.

(4) Submission of the initial report will generate a workflow in the Individualized Services Information System (ISIS) for follow-up by the case manager. When complete information about the incident is not available at the time of the initial report, the provider must submit follow-up reports until the case manager is satisfied with the incident resolution and follow-up. The completed report shall be maintained in a centralized file with a notation in the consumer's file.

*d. Tracking and analysis.* The provider shall track incident data and analyze trends to assess the health and safety of consumers served and determine if changes need to be made for service implementation or if staff training is needed to reduce the number or severity of incidents.

**77.37(9) Intake, admission, service coordination, discharge, and referral.**

*a.* The provider shall have written policies and procedures according to state and federal laws for intake, admission, service coordination, discharge and referral. Service coordination means activities designed to help individuals and families locate, access, and coordinate a network of supports and services that will allow them to live a full life in the community.

*b.* The provider shall ensure the rights of persons applying for services.

**77.37(10) Certification process.** Reviews of compliance with standards for initial certification and recertification shall be conducted by the department of human services' bureau of long-term care quality assurance staff. Certification carries no assurance that the approved provider will receive funding.

*a.* Rescinded IAB 9/1/04, effective 11/1/04.

*b.* Rescinded IAB 9/1/04, effective 11/1/04.

*c.* Rescinded IAB 9/1/04, effective 11/1/04.

*d.* The department may request any information from the prospective service provider which is considered pertinent to arriving at a certification decision. This may include, but is not limited to:

(1) Current accreditations, evaluations, inspections and reviews by regulatory and licensing agencies and associations.

(2) Fiscal capacity of the prospective provider to initiate and operate the specified programs on an ongoing basis.

**77.37(11) Initial certification.** The department shall review the application and accompanying information to see if the provider has the necessary framework to provide services in accordance with all applicable requirements and standards.

*a.* The department shall make a determination regarding initial certification within 60 days of receipt of the application and notify the provider in writing of the decision unless extended by mutual consent of the parties involved. Providers shall be responsible for notifying the appropriate county and the appropriate central point of coordination of the determination.

*b.* The decision of the department on initial certification of the providers shall be based on all relevant information, including:

(1) The application for status as an approved provider according to requirements of rules.

(2) A determination of the financial position of the prospective provider in relation to its ability to meet the stated need.

(3) The prospective provider's coordination of service design, development, and application with the applicable region and other interested parties.

(4) The prospective provider's written agreement to work cooperatively with the state, counties and regions to be served by the provider.

*c.* Providers applying for initial certification shall be offered technical assistance.

**77.37(12) Period of certification.** Provider certification shall become effective on the date identified on the certificate of approval and shall terminate in 270 calendar days, one year, or three calendar years from the month of issue. The renewal of certification shall be contingent upon demonstration of continued compliance with certification requirements.

*a.* Initial certification. Providers eligible for initial certification by the department shall be issued an initial certification for 270 calendar days based on documentation provided.

*b.* Recertification. After the initial certification, the level of certification shall be based on an on-site review unless the provider has been accredited for similar services by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), the Commission on Accreditation of Rehabilitation Facilities (CARF), the Council on Quality and Leadership in Supports for People with Disabilities (The Council), or the Council on Accreditation of Services for Families and Children (COA). The on-site reviews for supported community living and supported employment use interviews with consumers and significant people in the consumer's life to determine whether or not the 20 individual value-based outcomes set forth in subrules 77.37(1) and 77.37(2) and corresponding processes are present for the consumer. Respite services are required to meet Outcome 1 and participate in satisfaction surveys.

Once the outcomes and processes have been determined for all the consumers in the sample, a review team then determines which of the 20 outcomes and processes are present for the provider. A specific outcome is present for the provider when the specific outcome is determined to be present for 75 percent or more of the consumers interviewed. A specific process is present for the provider when the process is determined to be present for 75 percent or more of the consumers interviewed. Since the processes are in the control of the provider and the outcomes are more in the control of the consumer, length of certification will be based more heavily on whether or not the processes are in place to help consumers obtain desired outcomes.

An exit conference shall be held with the organization to share preliminary findings of the certification review. A review report shall be written and sent to the provider within 30 calendar days unless the parties mutually agree to extend that time frame.

Provider certification shall become effective on the date identified on the Certificate of Approval, Form 470-3410, and shall terminate in 270 calendar days, one year, or three calendar years from the month of issue. The renewal of certification shall be contingent upon demonstration of continued compliance with certification requirements.

*c.* The department may issue four categories of recertification:

(1) Three-year certification with excellence. An organization is eligible for certification with excellence if the number of processes present is 18 or higher and the number of outcomes and corresponding processes present together is 12 or higher. Both criteria need to be met to receive three-year certification with excellence. Corrective actions may be required which may be monitored through the assignment of follow-up monitoring either by written report, a plan of corrective actions and improvements, an on-site review, or the provision of technical assistance.

(2) Three-year certification with follow-up monitoring. An organization is eligible for this type of certification if the number of processes present is 17 or higher and the number of outcomes and corresponding processes present together are 11 or higher. Both criteria need to be met to receive three-year certification. Corrective actions are required which may be monitored through the assignment of follow-up monitoring either by written report, a plan of corrective actions and improvements, an on-site review, or the provision of technical assistance.

(3) One-year certification. An organization is eligible for this type of certification when the number of processes present is 14 or higher and the number of outcomes and processes together is 9 or higher. Both criteria need to be met to receive one-year certification. One-year certification may also be given in lieu of longer certification when previously required corrective actions have not been implemented or completed. Corrective actions are required which may be monitored through the assignment of follow-up monitoring either by written report, a plan of corrective actions and improvements, an on-site review, or the provision of technical assistance.

(4) Probational certification. A probational certification may be issued to those providers who cannot meet requirements for a one-year certification. This time period shall be granted to the provider to establish and implement corrective actions and improvement activities. During this time period the department may require monitoring of the implementation of the corrective actions through on-site visits, written reports or technical assistance. Probational certification issued for 270 calendar days shall not be renewed or extended, and shall require a full on-site follow-up review to be completed. The provider shall be required to achieve at least a one-year certification status at the time of the follow-up review in order to maintain certification.

*d.* During the course of the review, if a team member encounters a situation that places a member in immediate jeopardy, the team member shall immediately notify the provider, the department, and other team members. "Immediate jeopardy" refers to circumstances where the life, health, or safety of a member will be severely jeopardized if the circumstances are not immediately corrected.

(1) The provider shall correct the situation within 24 to 48 hours. If the situation is not corrected within the prescribed time frame, that portion of the provider's services that was the subject of the notification shall not be certified. The department shall be notified immediately to discontinue funding for that provider's service. If a member is in immediate jeopardy, the case manager or department service worker shall notify the county or region in the event the county or region is funding a service that may assist the member in the situation.

(2) If this action is appealed and the member, legal guardian, or attorney in fact under a durable power of attorney for health care wants to maintain the provider's services, funding can be reinstated. At that time the provider shall take appropriate action to ensure the life, health, and safety of the members deemed to be at risk as a result of the provider's inaction.

*e.* As a mandatory reporter, each team member shall be required to follow appropriate procedure in all cases where a condition reportable to child and adult protective services is observed.

*f.* The department may grant an extension to the period of approval for the following reasons:

(1) A delay in the department's approval decision which is beyond the control of the provider or department.

(2) A request for an extension from a provider to permit the provider to prepare and obtain department approval of corrective actions. The department shall establish the length of extensions on a case-by-case basis.

*g.* The department may revoke the provider's approval at any time for any of the following reasons:

(1) Findings of a site visit indicate that the provider has failed to implement the corrective actions submitted pursuant to paragraph 77.37(13) "e."

(2) The provider has failed to provide information requested pursuant to paragraph 77.37(13) "f."

(3) The provider refuses to allow the department to conduct a site visit pursuant to paragraph 77.37(13) "h."

(4) There are instances of noncompliance with the standards which were not identified from information submitted on the application.

*h.* An approved provider shall immediately notify the department, applicable county, or region, the applicable mental health and developmental disabilities planning council, and other interested parties of a decision to withdraw from a home- and community-based services intellectual disability waiver service.

*i.* Following certification, any provider may request technical assistance from the department to bring into conformity those areas found in noncompliance with HCBS requirements. If multiple deficiencies are noted during a review, the department may require that technical assistance be provided to a provider to assist in the implementation of the provider's corrective actions. Providers may be given technical assistance as needed.

*j.* Appeals. Any adverse action can be appealed by the provider under 441—Chapter 7.

**77.37(13) Review of providers.** Reviews of compliance with standards as indicated in this chapter shall be conducted by designated members of the HCBS staff.

*a.* This review may include on-site case record audits; review of administrative procedures, clinical practices, personnel records, performance improvement systems and documentation; and interviews with staff, consumers, the board of directors, or others deemed appropriate, consistent with the confidentiality safeguards of state and federal laws.

*b.* A review visit shall be scheduled with the provider with additional reviews conducted at the discretion of the department.

*c.* The on-site review team will consist of designated members of the HCBS staff.

*d.* Following a certification review, the certification review team leader shall submit a copy of the department's written report of findings to the provider within 30 working days after completion of the certification review.

*e.* The provider shall develop a plan of corrective action, if applicable, identifying completion time frames for each review recommendation.

*f.* Providers required to make corrective actions and improvements shall submit the corrective action and improvement plan to the Bureau of Long-Term Care, 1305 East Walnut Street, Des Moines, Iowa 50319-0114, within 30 working days after the receipt of a report issued as a result of the review team's visit. The corrective actions may include: specific problem areas cited, corrective actions to be implemented by the provider, dates by which each corrective measure will be completed, and quality assurance and improvement activities to measure and ensure continued compliance.

*g.* The department may request the provider to supply subsequent reports on implementation of a corrective action plan submitted pursuant to 77.37(13) "e" and 77.37(13) "f."

*h.* The department may conduct a site visit to verify all or part of the information submitted.

**77.37(14) *Supported community living providers.***

*a.* The department will contract only with public or private agencies to provide the supported community living service. The department does not recognize individuals as service providers under the supported community living program.

*b.* Providers of services meeting the definition of foster care shall also be licensed according to applicable 441—Chapters 108, 112, 114, 115, and 116.

*c.* Providers of service may employ or contract with individuals meeting the definition of foster family homes to provide supported community living services. These individuals shall be licensed according to applicable 441—Chapters 112 and 113.

*d.* All supported community living providers shall meet the following requirements:

(1) The provider shall demonstrate how the provider will meet the outcomes and processes in rule 441—77.37(249A) for each of the consumers being served. The provider shall supply timelines showing how the provider will come into compliance with rules 441—77.37(249A), 441—78.41(249A), and 441—83.60(249A) to 441—83.70(249A) and 441—subrule 79.1(15) within one year of certification.

These timelines shall include:

1. Implementation of necessary staff training and consumer input.

2. Implementation of provider system changes to allow for flexibility in staff duties, services based on what each individual needs, and removal of housing as part of the service.

(2) The provider shall demonstrate that systems are in place to measure outcomes and processes for individual consumers before certification can be given.

*e.* The department shall approve living units designed to serve up to four persons except as necessary to prevent an overconcentration of supported community living units in a geographic area.

*f.* The department shall approve a living unit designed to serve five persons if both of the following conditions are met:

(1) Approval will not result in an overconcentration of supported community living units in a geographic area.

(2) The county in which the living unit is located provides to the bureau of long-term care verification in writing that the approval is needed to address one or more of the following issues:

1. The quantity of services currently available in the county is insufficient to meet the need;

2. The quantity of affordable rental housing in the county is insufficient to meet the need; or

3. Approval will result in a reduction in the size or quantity of larger congregate settings.

**77.37(15) *Respite care providers.***

*a.* The following agencies may provide respite services:

(1) Group living foster care facilities for children licensed by the department according to 441—Chapters 112 and 114 to 116 and child care centers licensed according to 441—Chapter 109.

(2) Nursing facilities, intermediate care facilities for the mentally retarded, and hospitals enrolled as providers in the Iowa Medicaid program.

(3) Residential care facilities for persons with mental retardation licensed by the department of inspections and appeals.

(4) Home health agencies that are certified to participate in the Medicare program.

(5) Camps certified by the American Camping Association.

(6) Adult day care providers that meet the conditions of participation set forth in subrule 77.37(25).  
(7) Agencies authorized to provide similar services through a contract with the department of public health (IDPH) for local public health services. The agency must provide a current IDPH local public health services contract number.

(8) Agencies certified by the department to provide respite services in the consumer's home that meet the requirements of 77.37(1) and 77.37(3) through 77.37(9).

(9) Child care facilities, which are defined as child care centers, preschools, or child development homes registered pursuant to 441—Chapter 110.

(10) Assisted living programs certified by the department of inspections and appeals.

b. Respite providers shall meet the following conditions:

(1) Providers shall maintain the following information that shall be updated at least annually:

1. The consumer's name, birth date, age, and address and the telephone number of each parent, guardian or primary caregiver.

2. An emergency medical care release.

3. Emergency contact telephone numbers such as the number of the consumer's physician and the parents, guardian, or primary caregiver.

4. The consumer's medical issues, including allergies.

5. The consumer's daily schedule which includes the consumer's preferences in activities or foods or any other special concerns.

(2) Procedures shall be developed for the dispensing, storage, authorization, and recording of all prescription and nonprescription medications administered. Home health agencies must follow Medicare regulations for medication dispensing.

All medications shall be stored in their original containers, with the accompanying physician's or pharmacist's directions and label intact. Medications shall be stored so they are inaccessible to consumers and the public. Nonprescription medications shall be labeled with the consumer's name.

In the case of medications that are administered on an ongoing, long-term basis, authorization shall be obtained for a period not to exceed the duration of the prescription.

(3) Policies shall be developed for:

1. Notifying the parent, guardian or primary caregiver of any injuries or illnesses that occur during respite provision. A parent's, guardian's or primary caregiver's signature is required to verify receipt of notification.

2. Requiring the parent, guardian or primary caregiver to notify the respite provider of any injuries or illnesses that occurred prior to respite provision.

3. Documenting activities and times of respite. This documentation shall be made available to the parent, guardian or primary caregiver upon request.

4. Ensuring the safety and privacy of the individual. Policies shall at a minimum address threat of fire, tornado, or flood and bomb threats.

c. A facility providing respite under this subrule shall not exceed the facility's licensed capacity, and services shall be provided in locations consistent with licensure.

d. Respite provided outside the consumer's home or the facility covered by the licensure, certification, accreditation, or contract must be approved by the parent, guardian or primary caregiver and the interdisciplinary team and must be consistent with the way the location is used by the general public. Respite in these locations shall not exceed 72 continuous hours.

**77.37(16) Supported employment providers.**

a. The following agencies may provide supported employment services:

(1) An agency that is accredited by the Commission on Accreditation of Rehabilitation Facilities as an organizational employment service provider, a community employment service provider, or a provider of a similar service.

(2) An agency that is accredited by the Council on Accreditation of Services for Families and Children for similar services.

(3) An agency that is accredited by the Joint Commission on Accreditation of Healthcare Organizations for similar services.

(4) An agency that is accredited by the Council on Quality and Leadership in Supports for People with Disabilities for similar services.

(5) An agency that is accredited by the International Center for Clubhouse Development.

*b.* Providers responsible for the payroll of members shall have policies that ensure compliance with state and federal labor laws and regulations, which include, but are not limited to:

(1) Member vacation, sick leave and holiday compensation.

(2) Procedures for payment schedules and pay scale.

(3) Procedures for provision of workers' compensation insurance.

(4) Procedures for the determination and review of commensurate wages.

*c.* The department will contract only with public or private agencies to provide supported employment services. The department does not recognize individuals as service providers under the supported employment program.

**77.37(17)** *Home and vehicle modification providers.* The following providers may provide home and vehicle modification:

*a.* Providers certified to participate as supported community living service providers under the home- and community-based services intellectual disability or brain injury waiver.

*b.* Providers eligible to participate as home and vehicle modification providers under the elderly or health and disability waiver, enrolled as home and vehicle modification providers under the physical disability waiver, or certified as home and vehicle modification providers under the brain injury waiver.

*c.* Community businesses that have all necessary licenses and permits to operate in conformity with federal, state, and local laws and regulations and that submit verification of current liability and workers' compensation insurance.

**77.37(18)** *Personal emergency response system providers.* Personal emergency response system providers shall be agencies which meet the conditions of participation set forth in subrule 77.33(2) to maintain certification.

**77.37(19)** *Nursing providers.* Nursing providers shall be agencies that are certified to participate in the Medicare program as home health agencies.

**77.37(20)** *Home health aide providers.* Home health aide providers shall be agencies which are certified to participate in the Medicare program as home health agencies and which have an HCBS agreement with the department.

**77.37(21)** *Consumer-directed attendant care providers.* The following providers may provide consumer-directed attendant care service:

*a.* An individual who contracts with the member to provide attendant care service and who is:

(1) At least 18 years of age.

(2) Qualified by training or experience to carry out the member's plan of care pursuant to the department-approved case plan or individual comprehensive plan.

(3) Not the spouse of the member or a parent or stepparent of a member aged 17 or under.

(4) Not the recipient of respite services paid through home- and community-based services on behalf of a member who receives home- and community-based services.

*b.* Agencies authorized to provide similar services through a contract with the department of public health (IDPH) for local public health services. The agency must provide a current IDPH local public health services contract number.

*c.* Home health agencies which are certified to participate in the Medicare program.

*d.* Chore providers subcontracting with area agencies on aging or with letters of approval from the area agencies on aging stating that the organization is qualified to provide chore services.

*e.* Community action agencies as designated in Iowa Code section 216A.93.

*f.* Providers certified under an HCBS waiver for supported community living.

*g.* Assisted living programs that are certified by the department of inspections and appeals under 481—Chapter 69.

*h.* Adult day service providers that are certified by the department of inspections and appeals under 481—Chapter 70.

**77.37(22) Interim medical monitoring and treatment providers.**

- a. The following providers may provide interim medical monitoring and treatment services:
- (1) Child care facilities, which are defined as child care centers licensed pursuant to 441—Chapter 109, preschools, or child development homes registered pursuant to 441—Chapter 110.
  - (2) Rescinded IAB 9/1/04, effective 11/1/04.
  - (3) Rescinded IAB 9/1/04, effective 11/1/04.
  - (4) Home health agencies certified to participate in the Medicare program.
  - (5) Supported community living providers certified according to subrule 77.37(14) or 77.39(13).
- b. Staff requirements. Staff members providing interim medical monitoring and treatment services to members shall meet all of the following requirements:

- (1) Be at least 18 years of age.
- (2) Not be the spouse of the member or a parent or stepparent of the member if the member is aged 17 or under.
- (3) Not be a usual caregiver of the member.
- (4) Be qualified by training or experience to provide medical intervention or intervention in a medical emergency necessary to carry out the member's plan of care. The training or experience required must be determined by the member's usual caregivers and a licensed medical professional on the member's interdisciplinary team and must be documented in the member's service plan.

c. Service documentation. Providers shall maintain clinical and fiscal records necessary to fully disclose the extent of services furnished to members. Records shall specify by service date the procedures performed, together with information concerning progress of treatment.

**77.37(23) Residential-based supported community living service providers.**

- a. The department shall contract only with public or private agencies to provide residential-based supported community living services.
- b. Subject to the requirements of this rule, the following agencies may provide residential-based supported community living services:
- (1) Agencies licensed as group living foster care facilities under 441—Chapter 114.
  - (2) Agencies licensed as residential facilities for mentally retarded children under 441—Chapter 116.
  - (3) Other agencies providing residential-based supported community living services that meet the following conditions:

1. The agency must provide orientation training on the agency's purpose, policies, and procedures within one month of hire or contracting for all employed and contracted treatment staff and must provide 24 hours of training during the first year of employment or contracting. The agency must also provide at least 12 hours of training per year after the first year of employment for all employed and contracted treatment staff. Annual training shall include, at a minimum, training on children's mental retardation and developmental disabilities services and children's mental health issues. Identification and reporting of child abuse shall be covered in training at least every five years, in accordance with Iowa Code section 232.69.

2. The agency must have standards for the rights and dignity of children that are age-appropriate. These standards shall include the following:

- Children, their families, and their legal representatives decide what personal information is shared and with whom.
- Children are a part of family and community life and perform varied social roles.
- Children have family connections, a social network, and varied relationships.
- Children develop and accomplish personal goals.
- Children are valued.
- Children live in positive environments.
- Children exercise their rights and responsibilities.
- Children make informed choices about how they spend their free time.
- Children choose their daily routine.

3. The agency must use methods of self-evaluation by which:

- Past performance is reviewed.
  - Current functioning is evaluated.
  - Plans are made for the future based on the review and evaluation.
4. The agency must have a governing body that receives and uses input from a wide range of local community interests and consumer representatives and provides oversight that ensures the provision of high-quality supports and services to children.
  5. Children, their parents, and their legal representatives must have the right to appeal the service provider's application of policies or procedures or any staff person's action that affects the consumer. The service provider shall distribute the policies for consumer appeals and procedures to children, their parents, and their legal representatives.
    - c. As a condition of participation, all providers of residential-based supported community living services must have the following on file:
      - (1) Current accreditations, evaluations, inspections, and reviews by applicable regulatory and licensing agencies and associations.
      - (2) Documentation of the fiscal capacity of the provider to initiate and operate the specified programs on an ongoing basis.
      - (3) The provider's written agreement to work cooperatively with the department.
    - d. As a condition of participation, all providers of residential-based supported community living services must develop, review, and revise service plans for each child, as follows:
      - (1) The service plan shall be developed in collaboration with the social worker or case manager, child, family, and, if applicable, the foster parents, unless a treatment rationale for the lack of involvement of one of these parties is documented in the plan. The service provider shall document the dates and content of the collaboration on the service plan. The service provider shall provide a copy of the service plan to the family and the case manager, unless otherwise ordered by a court of competent jurisdiction.
      - (2) Initial service plans shall be developed after services have been authorized and within 30 calendar days of initiating services.
      - (3) The service plan shall identify the following:
        1. Strengths and needs of the child.
        2. Goals to be achieved to meet the needs of the child.
        3. Objectives for each goal that are specific, measurable, and time-limited and include indicators of progress toward each goal.
        4. Specific service activities to be provided to achieve the objectives.
        5. The persons responsible for providing the services. When daily living and social skills development is provided in a group care setting, designation may be by job title.
        6. Date of service initiation and date of individual service plan development.
        7. Service goals describing how the child will be reunited with the child's family and community.
      - (4) Individuals qualified to provide all services identified in the service plan shall review the services identified in the service plan to ensure that the services are necessary, appropriate, and consistent with the identified needs of the child, as listed on Form 470-3273, Mental Retardation Functional Assessment Tool.
      - (5) The service worker or case manager shall review all service plans to determine progress toward goals and objectives 90 calendar days from the initiation of services and every 90 calendar days thereafter for the duration of the services.

At a minimum, the provider shall submit written reports to the service worker or case manager at six-month intervals and when changes to the service plan are needed.
      - (6) The individual service plan shall be revised when any of the following occur:
        1. Service goals or objectives have been achieved.
        2. Progress toward goals and objectives is not being made.
        3. Changes have occurred in the identified service needs of the child, as listed on Form 470-3273, Mental Retardation Functional Assessment Tool.
        4. The service plan is not consistent with the identified service needs of the child, as listed in the service plan.

(7) The service plan shall be signed and dated by qualified staff of each reviewing provider after each review and revision.

(8) Any revisions of the service plan shall be made in collaboration with the child, family, case manager, and, if applicable, the foster parents and shall reflect the needs of the child. The service provider shall provide a copy of the revised service plan to the family and case manager, unless otherwise ordered by a court of competent jurisdiction.

*e.* The residential-based supportive community living service provider shall also furnish residential-based living units for all recipients of the residential-based supported community living services. Except as provided herein, living units provided may be of no more than four beds. Service providers who receive approval from the bureau of long-term care may provide living units of up to eight beds. The bureau shall approve five- to eight-bed living units only if all of the following conditions are met:

(1) Rescinded IAB 8/7/02, effective 10/1/02.

(2) There is a need for the service to be provided in a five- to eight-person living unit instead of a smaller living unit, considering the location of the programs in an area.

(3) The provider supplies the bureau of long-term care with a written plan acceptable to the department that addresses how the provider will reduce its living units to four-bed units within a two-year period of time. This written plan shall include the following:

1. How the transition will occur.

2. What physical change will need to take place in the living units.

3. How children and their families will be involved in the transitioning process.

4. How this transition will affect children's social and educational environment.

*f.* Certification process and review of service providers.

(1) The certification process for providers of residential-based supported community living services shall be pursuant to subrule 77.37(10).

(2) The initial certification of residential-based supported community living services shall be pursuant to subrule 77.37(11).

(3) Period and conditions of certification.

1. Initial certification. Providers eligible for initial certification by the department shall be issued an initial certification for 270 calendar days, effective on the date identified on the certificate of approval, based on documentation provided.

2. Recertification. After the initial certification, recertification shall be based on an on-site review and shall be contingent upon demonstration of compliance with certification requirements.

An exit conference shall be held with the provider to share preliminary findings of the recertification review. A review report shall be written and sent to the provider within 30 calendar days unless the parties mutually agree to extend that time frame.

Recertification shall become effective on the date identified on the Certificate of Approval, Form 470-3410, and shall terminate one year from the month of issuance.

Corrective actions may be required in connection with recertification and may be monitored through the assignment of follow-up monitoring either by written report, a plan of corrective actions and improvements, an on-site review, or the provision of technical assistance.

3. Probational certification. Probational certification for 270 calendar days may be issued to a provider who cannot demonstrate compliance with all certification requirements on recertification review to give the provider time to establish and implement corrective actions and improvement activities.

During the probational certification period, the department may require monitoring of the implementation of the corrective actions through on-site visits, written reports, or technical assistance.

Probational certification shall not be renewed or extended and shall require a full on-site follow-up review to be completed. The provider must demonstrate compliance with all certification requirements at the time of the follow-up review in order to maintain certification.

4. Immediate jeopardy. If, during the course of any review, a review team member encounters a situation that places a member in immediate jeopardy, the team member shall immediately notify the provider, the department, and other team members. "Immediate jeopardy" refers to circumstances

where the life, health, or safety of a member will be severely jeopardized if the circumstances are not immediately corrected.

The provider shall correct the situation within 24 to 48 hours. If the situation is not corrected within the prescribed time frame, the provider shall not be certified. The department shall immediately discontinue funding for that provider's service. If this action is appealed and the member or legal guardian wants to maintain the provider's services, funding can be reinstated. At that time the provider shall take appropriate action to ensure the life, health, and safety of the members deemed to be at risk. The case manager or department service worker shall notify the county or region in the event the county or region is funding a service that may assist the member in the situation.

5. Abuse reporting. As a mandatory reporter, each review team member shall follow appropriate procedure in all cases where a condition reportable to child and adult protective services is observed.

6. Extensions. The department shall establish the length of extensions on a case-by-case basis. The department may grant an extension to the period of certification for the following reasons:

- A delay in the department's approval decision exists which is beyond the control of the provider or department.

- A request for an extension is received from a provider to permit the provider to prepare and obtain department approval of corrective actions.

7. Revocation. The department may revoke the provider's approval at any time for any of the following reasons:

- The findings of a site visit indicate that the provider has failed to implement the corrective actions submitted pursuant to paragraph 77.37(13) "e" and numbered paragraph 77.37(23) "f"(3) "4."

- The provider has failed to provide information requested pursuant to paragraph 77.37(13) "f" and numbered paragraph 77.37(23) "f"(3) "4."

- The provider refuses to allow the department to conduct a site visit pursuant to paragraph 77.37(13) "h" and subparagraph 77.37(23) "f"(3).

- There are instances of noncompliance with the standards that were not identified from information submitted on the application.

8. Notice of intent to withdraw. An approved provider shall immediately notify the department, applicable county, the applicable mental health and developmental disabilities planning council, and other interested parties of a decision to withdraw as a provider of residential-based supported community living services.

9. Technical assistance. Following certification, any provider may request technical assistance from the department regarding compliance with program requirements. The department may require that technical assistance be provided to a provider to assist in the implementation of any corrective action plan.

10. Appeals. The provider can appeal any adverse action under 441—Chapter 7.

(4) Providers of residential-based supported community living services shall be subject to reviews of compliance with program requirements pursuant to subrule 77.37(13).

**77.37(24) Transportation service providers.** The following providers may provide transportation:

a. Accredited providers of home- and community-based services.

b. Regional transit agencies as recognized by the Iowa department of transportation.

c. Transportation providers that contract with county governments.

d. Community action agencies as designated in Iowa Code section 216A.93.

e. Nursing facilities licensed under Iowa Code chapter 135C.

f. Area agencies on aging as designated in rule 17—4.4(231), subcontractors of area agencies on aging, or organizations with letters of approval from the area agencies on aging stating that the organization is qualified to provide transportation services.

g. Transportation providers contracting with the nonemergency medical transportation contractor.

**77.37(25) Adult day care providers.** Adult day care providers shall be agencies that are certified by the department of inspections and appeals as being in compliance with the standards for adult day services programs at 481—Chapter 70.

**77.37(26) Prevocational services providers.** Providers of prevocational services must be accredited by one of the following:

*a.* The Commission on Accreditation of Rehabilitation Facilities as a work adjustment service provider or an organizational employment service provider.

*b.* The Council on Quality and Leadership.

**77.37(27) Day habilitation providers.** Day habilitation services may be provided by:

*a.* Agencies accredited by the Commission on Accreditation of Rehabilitation Facilities to provide services that qualify as day habilitation under 441—subrule 78.41(14).

*b.* Agencies accredited by the Commission on Accreditation of Rehabilitation Facilities to provide other services that began providing services that qualify as day habilitation under 441—subrule 78.41(14) since their last accreditation survey. The agency may provide day habilitation services until the current accreditation expires. When the current accreditation expires, the agency must qualify under paragraph “a” or “d.”

*c.* Agencies not accredited by the Commission on Accreditation of Rehabilitation Facilities that have applied to the Commission within the last 12 months for accreditation to provide services that qualify as day habilitation under 441—subrule 78.41(14). An agency that has not received accreditation within 12 months after application to the Commission is no longer a qualified provider.

*d.* Agencies accredited by the Council on Quality and Leadership.

*e.* Agencies that have applied to the Council on Quality and Leadership for accreditation within the last 12 months. An agency that has not received accreditation within 12 months after application to the Council is no longer a qualified provider.

**77.37(28) Financial management service.** Consumers who elect the consumer choices option shall work with a financial institution that meets the qualifications in subrule 77.30(13).

**77.37(29) Independent support brokerage.** Consumers who elect the consumer choices option shall work with an independent support broker who meets the qualifications in subrule 77.30(14).

**77.37(30) Self-directed personal care.** Consumers who elect the consumer choices option may choose to purchase self-directed personal care services from an individual or business that meets the requirements in subrule 77.30(15).

**77.37(31) Individual-directed goods and services.** Consumers who elect the consumer choices option may choose to purchase individual-directed goods and services from an individual or business that meets the requirements in subrule 77.30(16).

**77.37(32) Self-directed community supports and employment.** Consumers who elect the consumer choices option may choose to purchase self-directed community supports and employment from an individual or business that meets the requirements in subrule 77.30(17).

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

[**ARC 7936B**, IAB 7/1/09, effective 9/1/09; **ARC 9314B**, IAB 12/29/10, effective 3/1/11; **ARC 0191C**, IAB 7/11/12, effective 7/1/12; **ARC 0359C**, IAB 10/3/12, effective 12/1/12; **ARC 0757C**, IAB 5/29/13, effective 8/1/13; **ARC 1071C**, IAB 10/2/13, effective 10/1/13]

**441—77.38(249A) Assertive community treatment.** Services in the assertive community treatment (ACT) program shall be rendered by a multidisciplinary team composed of practitioners from the disciplines described in this rule. The team shall be under the clinical supervision of a psychiatrist. The program shall designate an individual team member who shall be responsible for administration of the program, including authority to sign documents and receive payment on behalf of the program.

**77.38(1) Minimum composition.** At a minimum, the team shall consist of a nurse, a mental health service provider, and a substance abuse treatment professional.

**77.38(2) Psychiatrists.** A psychiatrist on the team shall be a physician (MD or DO) who:

*a.* Is licensed under 653—Chapter 9,

*b.* Is certified as a psychiatrist by the American Board of Medical Specialties’ Board of Psychiatry and Neurology or by the American Osteopathic Board of Neurology and Psychiatry, and

*c.* Has experience treating serious and persistent mental illness.

**77.38(3) Registered nurses.** A nurse on the team shall:

*a.* Be licensed as a registered nurse under 655—Chapter 3, and

b. Have experience treating persons with serious and persistent mental illness.

**77.38(4) Mental health service providers.** A mental health service provider on the team shall be:

a. A mental health counselor or marital and family therapist who:

- (1) Is licensed under 645—Chapter 31, and
- (2) Has experience treating persons with serious and persistent mental illness; or

b. A social worker who:

- (1) Is licensed as a master or independent social worker under 645—Chapter 280, and
- (2) Has experience treating persons with serious and persistent mental illness.

**77.38(5) Psychologists.** A psychologist on the team shall:

a. Be licensed under 645—Chapter 240, and

b. Have experience treating persons with serious and persistent mental illness.

**77.38(6) Substance abuse treatment professionals.** A substance abuse treatment professional on the team shall:

a. Be an appropriately credentialed counselor pursuant to 641—paragraph 155.21(8) “i,” and

b. Have at least three years of experience treating substance abuse.

**77.38(7) Peer specialists.** A peer specialist on the team shall be a person with serious and persistent mental illness who has met all requirements of a nationally standardized peer support training program, including at least 30 hours of training and satisfactory completion of an examination.

**77.38(8) Community support specialists.** A community support specialist on the team shall be a person who:

a. Has a bachelor’s degree (BA or BS) in a human services field (sociology, social work, counseling, psychology, or human services), and

b. Has experience supporting persons with serious and persistent mental illness.

**77.38(9) Case managers.** A case manager on the team shall be a person who:

a. Has a bachelor’s degree (BA or BS) in a human services field (sociology, social work, counseling, psychology, or human services),

b. Has experience managing care for persons with serious and persistent mental illness, and

c. Meets the qualifications of “qualified case managers and supervisors” in rule 441—24.1(225C).

**77.38(10) Advanced registered nurse practitioners.** An advanced registered nurse practitioner on the team shall:

a. Be licensed under 655—Chapter 7,

b. Have a mental health certification, and

c. Have experience treating serious and persistent mental illness.

**77.38(11) Physician assistants.** A physician assistant on the team shall:

a. Be licensed under 645—Chapter 326,

b. Have experience treating persons with serious and persistent mental illness, and

c. Practice under the supervision of a psychiatrist.

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

[ARC 9440B, IAB 4/6/11, effective 4/1/11]

**441—77.39(249A) HCBS brain injury waiver service providers.** Providers shall be eligible to participate in the Medicaid brain injury waiver program if they meet the requirements in this rule and the subrules applicable to the individual service. Providers and each of their staff members involved in direct consumer service must have training regarding or experience with consumers who have a brain injury, with the exception of providers of home and vehicle modification, specialized medical equipment, transportation, personal emergency response, financial management, independent support brokerage, self-directed personal care, individual-directed goods and services, and self-directed community supports and employment.

Services shall be rendered by a person who is at least 16 years old (except as otherwise provided in this rule) and is not the spouse of the consumer served or the parent or stepparent of a consumer aged 17 or under. People who are 16 or 17 years old must be employed and supervised by an enrolled HCBS provider unless they are employed to provide self-directed personal care services through the

consumer choices option. A person hired for self-directed personal care services need not be supervised by an enrolled HCBS provider. A person hired through the consumer choices option for independent support brokerage, self-directed personal care, individual-directed goods and services, or self-directed community support and employment is not required to enroll as a Medicaid provider and is not subject to review under subrule 77.39(11). Consumer-directed attendant care and interim medical monitoring and treatment providers must be at least 18 years of age.

In addition, behavioral programming, supported community living, and supported employment providers shall meet the outcome-based standards set forth below in subrules 77.39(1) and 77.39(2) evaluated according to subrules 77.39(8) to 77.39(10), and the requirements of subrules 77.39(3) to 77.39(7). Respite providers shall also meet the standards in subrule 77.39(1).

**77.39(1) Organizational standards (Outcome 1).** Organizational outcome-based standards for HCBS BI providers are as follows:

*a.* The organization demonstrates the provision and oversight of high-quality supports and services to consumers.

*b.* The organization demonstrates a defined mission commensurate with consumers' needs, desires, and abilities.

*c.* The organization establishes and maintains fiscal accountability.

*d.* The organization has qualified staff commensurate with the needs of the consumers they serve. These staff demonstrate competency in performing duties and in all interactions with clients.

*e.* The organization provides needed training and supports to its staff. This training includes at a minimum:

(1) Consumer rights.

(2) Confidentiality.

(3) Provision of consumer medication.

(4) Identification and reporting of child and dependent adult abuse.

(5) Individual consumer support needs.

*f.* The organization has a systematic, organizationwide, planned approach to designing, measuring, evaluating, and improving the level of its performance. The organization:

(1) Measures and assesses organizational activities and services annually.

(2) Gathers information from consumers, family members, and staff.

(3) Conducts an internal review of consumer service records, including all major and minor incident reports according to subrule 77.37(8).

(4) Tracks incident data and analyzes trends annually to assess the health and safety of consumers served by the organization.

(5) Identifies areas in need of improvement.

(6) Develops a plan to address the areas in need of improvement.

(7) Implements the plan and documents the results.

*g.* Consumers and their legal representatives have the right to appeal the provider's implementation of the 20 outcomes, or staff or contractual person's action which affects the consumer. The provider shall distribute the policies for consumer appeals and procedures to consumers.

*h.* The provider shall have written policies and procedures and a staff training program for the identification and reporting of child and dependent adult abuse to the department pursuant to 441—Chapters 175 and 176.

*i.* The governing body has an active role in the administration of the agency.

*j.* The governing body receives and uses input from a wide range of local community interests and consumer representation and provides oversight that ensures the provision of high-quality supports and services to consumers.

**77.39(2) Rights and dignity.** Outcome-based standards for rights and dignity are as follows:

*a.* (Outcome 2) Consumers are valued.

*b.* (Outcome 3) Consumers live in positive environments.

*c.* (Outcome 4) Consumers work in positive environments.

*d.* (Outcome 5) Consumers exercise their rights and responsibilities.

- e. (Outcome 6) Consumers have privacy.
- f. (Outcome 7) When there is a need, consumers have support to exercise and safeguard their rights.
- g. (Outcome 8) Consumers decide which personal information is shared and with whom.
- h. (Outcome 9) Consumers make informed choices about where they work.
- i. (Outcome 10) Consumers make informed choices on how they spend their free time.
- j. (Outcome 11) Consumers make informed choices about where and with whom they live.
- k. (Outcome 12) Consumers choose their daily routine.
- l. (Outcome 13) Consumers are a part of community life and perform varied social roles.
- m. (Outcome 14) Consumers have a social network and varied relationships.
- n. (Outcome 15) Consumers develop and accomplish personal goals.
- o. (Outcome 16) Management of consumers' money is addressed on an individualized basis.
- p. (Outcome 17) Consumers maintain good health.
- q. (Outcome 18) The consumer's living environment is reasonably safe in the consumer's home and community.
- r. (Outcome 19) The consumer's desire for intimacy is respected and supported.
- s. (Outcome 20) Consumers have an impact on the services they receive.

**77.39(3) *The right to appeal.*** Consumers and their legal representatives have the right to appeal the provider's application of policies or procedures, or any staff or contractual person's action which affects the consumer. The provider shall distribute the policies for consumer appeals and procedures to consumers.

**77.39(4) *Storage and provision of medication.*** If the provider stores, handles, prescribes, dispenses or administers prescription or over-the-counter medications, the provider shall develop procedures for the storage, handling, prescribing, dispensing or administration of medication. For controlled substances, procedures shall be in accordance with department of inspections and appeals rule 481—63.18(135).

**77.39(5) *Research.*** If the provider conducts research involving consumers, the provider shall have written policies and procedures addressing the research. These policies and procedures shall ensure that consumers' rights are protected.

**77.39(6) *Incident management and reporting.*** As a condition of participation in the medical assistance program, HCBS brain injury waiver service providers must comply with the requirements of Iowa Code sections 232.69 and 235B.3 regarding the reporting of child abuse and dependent adult abuse and with the incident management and reporting requirements in this subrule. **EXCEPTION:** The conditions in this subrule do not apply to providers of goods and services purchased under the consumer choices option or providers of home and vehicle modification, personal emergency response, and transportation.

*a. Definitions.*

*"Major incident"* means an occurrence involving a consumer during service provision that:

1. Results in a physical injury to or by the consumer that requires a physician's treatment or admission to a hospital;
2. Results in the death of any person;
3. Requires emergency mental health treatment for the consumer;
4. Requires the intervention of law enforcement;
5. Requires a report of child abuse pursuant to Iowa Code section 232.69 or a report of dependent adult abuse pursuant to Iowa Code section 235B.3;
6. Constitutes a prescription medication error or a pattern of medication errors that leads to the outcome in paragraph "1," "2," or "3"; or
7. Involves a consumer's location being unknown by provider staff who are assigned protective oversight.

*"Minor incident"* means an occurrence involving a consumer during service provision that is not a major incident and that:

1. Results in the application of basic first aid;
2. Results in bruising;

3. Results in seizure activity;
4. Results in injury to self, to others, or to property; or
5. Constitutes a prescription medication error.

*b. Reporting procedure for minor incidents.* Minor incidents may be reported in any format designated by the provider. When a minor incident occurs or a staff member becomes aware of a minor incident, the staff member involved shall submit the completed incident report to the staff member's supervisor within 72 hours of the incident. The completed report shall be maintained in a centralized file with a notation in the consumer's file.

*c. Reporting procedure for major incidents.* When a major incident occurs or a staff member becomes aware of a major incident:

(1) The staff member involved shall notify the following persons of the incident by the end of the next calendar day after the incident:

1. The staff member's supervisor.
2. The consumer or the consumer's legal guardian. EXCEPTION: Notification to the consumer is required only if the incident took place outside of the provider's service provision. Notification to the guardian, if any, is always required.
3. The consumer's case manager.

(2) By the end of the next calendar day after the incident, the staff member who observed or first became aware of the incident shall also report as much information as is known about the incident to the department's bureau of long-term care either:

1. By direct data entry into the Iowa Medicaid Provider Access System, or
2. By faxing or mailing Form 470-4698, Critical Incident Report, according to the directions on the form.

(3) The following information shall be reported:

1. The name of the consumer involved.
2. The date and time the incident occurred.
3. A description of the incident.
4. The names of all provider staff and others who were present at the time of the incident or who responded after becoming aware of the incident. The confidentiality of other waiver-eligible or non-waiver-eligible consumers who were present must be maintained by the use of initials or other means.
5. The action that the provider staff took to manage the incident.
6. The resolution of or follow-up to the incident.
7. The date the report is made and the handwritten or electronic signature of the person making the report.

(4) Submission of the initial report will generate a workflow in the Individualized Services Information System (ISIS) for follow-up by the case manager. When complete information about the incident is not available at the time of the initial report, the provider must submit follow-up reports until the case manager is satisfied with the incident resolution and follow-up. The completed report shall be maintained in a centralized file with a notation in the consumer's file.

*d. Tracking and analysis.* The provider shall track incident data and analyze trends to assess the health and safety of consumers served and determine if changes need to be made for service implementation or if staff training is needed to reduce the number or severity of incidents.

**77.39(7) Intake, admission, service coordination, discharge, and referral.**

*a.* The provider shall have written policies and procedures according to state and federal laws for intake, admission, service coordination, discharge and referral.

*b.* The provider shall ensure the rights of persons applying for services.

**77.39(8) Certification process.** Reviews of compliance with standards for initial certification and recertification shall be conducted by the department of human services' bureau of long-term care quality assurance staff. Certification carries no assurance that the approved provider will receive funding.

- a.* Rescinded IAB 9/1/04, effective 11/1/04.
- b.* Rescinded IAB 9/1/04, effective 11/1/04.

c. Rescinded IAB 9/1/04, effective 11/1/04.  
d. The department may request any information from the prospective service provider which is considered pertinent to arriving at a certification decision. This may include, but is not limited to:

(1) Current accreditations, evaluations, inspections and reviews by regulatory and licensing agencies and associations.

(2) Fiscal capacity of the prospective provider to initiate and operate the specified programs on an ongoing basis.

**77.39(9) Initial certification.** The department shall review the application and accompanying information to see if the provider has the necessary framework to provide services in accordance with all applicable requirements and standards.

a. The department shall make a determination regarding initial certification within 60 days of receipt of the application and notify the provider in writing of the decision unless extended by mutual consent of the parties involved.

b. The decision of the department on initial certification of the providers shall be based on all relevant information, including:

(1) The application for status as an approved provider according to requirements of rules.

(2) A determination of the financial position of the prospective provider in relation to its ability to meet the stated need.

c. Providers applying for initial certification shall be offered technical assistance.

**77.39(10) Period of certification.** Provider certification shall become effective on the date identified on the certificate of approval and shall terminate in 270 calendar days, one year, or three calendar years from the month of issue. The renewal of certification shall be contingent upon demonstration of continued compliance with certification requirements.

a. Initial certification. Providers eligible for initial certification by the department shall be issued an initial certification for 270 calendar days based on documentation provided.

b. Recertification. After the initial certification, the level of certification shall be based on an on-site review unless the provider has been accredited for similar services by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), the Commission on Accreditation of Rehabilitation Facilities (CARF), the Council on Quality and Leadership in Supports for People with Disabilities (The Council), or the Council on Accreditation of Services for Families and Children (COA). The on-site reviews for supported community living and supported employment use interviews with consumers and significant people in the consumer's life to determine whether or not the 20 individual value-based outcomes set forth in subrules 77.39(1) and 77.39(2) and corresponding processes are present for the consumer. Respite services are required to meet Outcome 1 and participate in satisfaction surveys.

Once the outcomes and processes have been determined for all the consumers in the sample, a review team then determines which of the 20 outcomes and processes are present for the provider. A specific outcome is present for the provider when the specific outcome is determined to be present for 75 percent or more of the consumers interviewed. A specific process is present for the provider when the process is determined to be present for 75 percent or more of the consumers interviewed. Since the processes are in the control of the provider and the outcomes are more in the control of the consumer, length of certification will be based more heavily on whether or not the processes are in place to help consumers obtain desired outcomes.

An exit conference shall be held with the organization to share preliminary findings of the certification review. A review report shall be written and sent to the provider within 30 calendar days unless the parties mutually agree to extend that time frame.

Provider certification shall become effective on the date identified on the Certificate of Approval, Form 470-3410, and shall terminate in 270 calendar days, one year, or three calendar years from the month of issue. The renewal of certification shall be contingent upon demonstration of continued compliance with certification requirements.

c. The department may issue four categories of recertification:

(1) *Three-year certification with excellence.* An organization is eligible for certification with excellence if the number of processes present is 18 or higher and the number of outcomes and

corresponding processes present together is 12 or higher. Both criteria need to be met to receive three-year certification with excellence. Corrective actions may be required which may be monitored through the assignment of follow-up monitoring either by written report, a plan of corrective actions and improvements, an on-site review, or the provision of technical assistance.

(2) *Three-year certification with follow-up monitoring.* An organization is eligible for this type of certification if the number of processes present is 17 or higher and the number of outcomes and corresponding processes present together is 11 or higher. Both criteria need to be met to receive three-year certification. Corrective actions are required which may be monitored through the assignment of follow-up monitoring either by written report, a plan of corrective actions and improvements, an on-site review, or the provision of technical assistance.

(3) *One-year certification.* An organization is eligible for this type of certification when the number of processes present is 14 or higher and the number of outcomes and processes present together is 9 or higher. Both criteria need to be met to receive one-year certification. One-year certification may also be given in lieu of longer certification when previously required corrective actions have not been implemented or completed. Corrective actions are required which may be monitored through the assignment of follow-up monitoring either by written report, a plan of corrective actions and improvements, an on-site review, or the provision of technical assistance.

(4) *Probational certification.* A probational certification may be issued to those providers who cannot meet requirements for a one-year certification. This time period shall be granted to the provider to establish and implement corrective actions and improvement activities. During this time period the department may require monitoring of the implementation of the corrective actions through on-site visits, written reports or technical assistance. Probational certification issued for 270 calendar days shall not be renewed or extended and shall require a full on-site follow-up review to be completed. The provider shall be required to achieve at least a one-year certification status at the time of the follow-up review in order to maintain certification.

*d.* During the course of the review, if a team member encounters a situation that places a consumer in immediate jeopardy, the team member shall immediately notify the provider, the department, and other team members. "Immediate jeopardy" refers to circumstances where the life, health, or safety of a member will be severely jeopardized if the circumstances are not immediately corrected.

(1) The provider shall correct the situation within 24 to 48 hours. If the situation is not corrected within the prescribed time frame, that portion of the provider's services that was the subject of the notification shall not be certified. The department shall immediately discontinue funding for that provider's service.

(2) If this action is appealed and the member, legal guardian, or attorney in fact under a durable power of attorney for health care wants to maintain the provider's services, funding can be reinstated. At that time the provider shall take appropriate action to ensure the life, health, and safety of the members deemed to be at risk as a result of the provider's inaction.

*e.* As a mandatory reporter, each team member shall be required to follow appropriate procedure in all cases where a condition reportable to child and adult protective services is observed.

*f.* The department may grant an extension to the period of approval for the following reasons:

(1) A delay in the department's approval decision which is beyond the control of the provider or department.

(2) A request for an extension from a provider to permit the provider to prepare and obtain department approval of corrective actions. The department shall establish the length of extensions on a case-by-case basis.

*g.* The department may revoke the provider's approval at any time for any of the following reasons:

(1) Findings of a site visit indicate that the provider has failed to implement the corrective actions submitted pursuant to paragraph 77.39(11) "d."

(2) The provider has failed to provide information requested pursuant to paragraph 77.39(11) "e."

(3) The provider refuses to allow the department to conduct a site visit pursuant to paragraph 77.39(11) "f."

(4) There are instances of noncompliance with the standards which were not identified from information submitted on the application.

*h.* An approved provider shall immediately notify the department, applicable county, or region, the applicable mental health and developmental disabilities planning council, and other interested parties of a decision to withdraw from an HCBS BI waiver service.

*i.* Following certification, any provider may request technical assistance from the department to bring into conformity those areas found in noncompliance with HCBS requirements. If multiple deficiencies are noted during a review, the department may require that technical assistance be provided to a provider to assist in the implementation of the provider's corrective actions. Providers may be given technical assistance as needed.

*j.* Appeals. Any adverse action can be appealed by the provider under 441—Chapter 7.

**77.39(11) Departmental reviews.** Reviews of compliance with standards as indicated in this chapter shall be conducted by the division of mental health and developmental disabilities quality assurance review staff. This review may include on-site case record audits, administrative procedures, clinical practices, and interviews with staff, consumers, and board of directors consistent with the confidentiality safeguards of state and federal laws.

*a.* Reviews shall be conducted annually with additional reviews conducted at the discretion of the department.

*b.* Following a departmental review, the department shall submit a copy of the department's determined survey report to the service provider, noting service deficiencies and strengths.

*c.* The service provider shall develop a plan of corrective action identifying completion time frames for each survey deficiency.

*d.* The corrective action plan shall be submitted to the Division of Mental Health and Developmental Disabilities, 5th Floor, Hoover State Office Building, Des Moines, Iowa 50319-0114, and include a statement dated and signed, if applicable, by the chief administrative officer and president or chairperson of the governing body that all information submitted to the department is accurate and complete.

*e.* The department may request the provider to supply subsequent reports on implementation of a corrective action plan submitted pursuant to paragraphs 77.39(11) "c" and "d."

*f.* The department may conduct a site visit to verify all or part of the information submitted.

**77.39(12) Case management service providers.** Case management provider organizations are eligible to participate in the Medicaid HCBS brain injury waiver program provided that they meet the standards in 441—Chapter 24 and they are the department of human services, a county or consortium of counties, or a provider under subcontract to the department or a county or consortium of counties.

**77.39(13) Supported community living providers.**

*a.* The department shall certify only public or private agencies to provide the supported community living service. The department does not recognize individuals as service providers under the supported community living program.

*b.* Providers of services meeting the definition of foster care shall also be licensed according to applicable 441—Chapters 108, 112, 114, 115, and 116, which deal with foster care licensing.

*c.* Providers of service may employ or contract with individuals meeting the definition of foster family homes to provide supported community living services. These individuals shall be licensed according to applicable 441—Chapters 112 and 113, which deal with foster care licensing.

*d.* The department shall approve living units designed to serve four consumers if the geographic location of the program does not result in an overconcentration of programs in an area.

(1) and (2) Rescinded IAB 8/7/02, effective 10/1/02.

*e.* The department shall approve living units designed to serve up to four persons except as necessary to prevent an overconcentration of supported community living units in a geographic area.

*f.* The department shall approve a living unit designed to serve five persons if both of the following conditions are met:

(1) Approval will not result in an overconcentration of supported community living units in a geographic area.

(2) The county in which the living unit is located provides to the bureau of long-term care verification in writing that the approval is needed to address one or more of the following issues:

1. The quantity of services currently available in the county is insufficient to meet the need;
2. The quantity of affordable rental housing in the county is insufficient to meet the need; or
3. Approval will result in a reduction in the size or quantity of larger congregate settings.

**77.39(14) Respite service providers.** Respite providers are eligible to be providers of respite service in the HCBS brain injury waiver if they have documented training or experience with persons with a brain injury.

*a.* The following agencies may provide respite services:

- (1) Respite providers certified under the HCBS intellectual disability waiver.
- (2) Adult day care providers that meet the conditions of participation set forth in subrule 77.39(20).
- (3) Group living foster care facilities for children licensed by the department according to 441—Chapters 112 and 114 to 116 and child care centers licensed according to 441—Chapter 109.
- (4) Camps certified by the American Camping Association.
- (5) Home care agencies that meet the conditions of participation set forth in subrule 77.30(1).
- (6) Nursing facilities, intermediate care facilities for the mentally retarded, and hospitals enrolled as providers in the Iowa Medicaid program.
- (7) Residential care facilities for persons with mental retardation licensed by the department of inspections and appeals.
- (8) Home health agencies that are certified to participate in the Medicare program.
- (9) Agencies certified by the department to provide respite services in the consumer's home that meet the requirements of subrules 77.39(1) and 77.39(3) through 77.39(7).
- (10) Child care facilities, which are defined as child care centers, preschools, or child development homes registered pursuant to 441—Chapter 110.
- (11) Assisted living programs certified by the department of inspections and appeals.

*b.* Respite providers shall meet the following conditions:

- (1) Providers shall maintain the following information that shall be updated at least annually:
  1. The consumer's name, birth date, age, and address and the telephone number of each parent, guardian or primary caregiver.
  2. An emergency medical care release.
  3. Emergency contact telephone numbers such as the number of the consumer's physician and the parents, guardian, or primary caregiver.
  4. The consumer's medical issues, including allergies.
  5. The consumer's daily schedule which includes the consumer's preferences in activities or foods or any other special concerns.
- (2) Procedures shall be developed for the dispensing, storage, authorization, and recording of all prescription and nonprescription medications administered. Home health agencies must follow Medicare regulations for medication dispensing.

All medications shall be stored in their original containers, with the accompanying physician's or pharmacist's directions and label intact. Medications shall be stored so they are inaccessible to consumers and the public. Nonprescription medications shall be labeled with the consumer's name.

In the case of medications that are administered on an ongoing, long-term basis, authorization shall be obtained for a period not to exceed the duration of the prescription.

(3) Policies shall be developed for:

1. Notifying the parent, guardian or primary caregiver of any injuries or illnesses that occur during respite provision. A parent's, guardian's or primary caregiver's signature is required to verify receipt of notification.
2. Requiring the parent, guardian or primary caregiver to notify the respite provider of any injuries or illnesses that occurred prior to respite provision.
3. Documenting activities and times of respite. This documentation shall be made available to the parent, guardian or primary caregiver upon request.

4. Ensuring the safety and privacy of the individual. Policies shall at a minimum address threat of fire, tornado, or flood and bomb threats.

c. A facility providing respite under this subrule shall not exceed the facility's licensed capacity, and services shall be provided in locations consistent with licensure.

d. Respite provided outside the consumer's home or the facility covered by the licensure, certification, accreditation, or contract must be approved by the parent, guardian or primary caregiver and the interdisciplinary team and must be consistent with the way the location is used by the general public. Respite in these locations shall not exceed 72 continuous hours.

**77.39(15) Supported employment providers.**

a. The following agencies may provide supported employment services:

(1) An agency that is accredited by the Commission on Accreditation of Rehabilitation Facilities as an organizational employment service provider, a community employment service provider or a provider of a similar service.

(2) An agency that is accredited by the Council on Accreditation of Services for Families and Children for similar services.

(3) An agency that is accredited by the Joint Commission on Accreditation of Healthcare Organizations for similar services.

(4) An agency that is accredited by the Council on Quality and Leadership in Supports for People with Disabilities for similar services.

(5) An agency that is accredited by the International Center for Clubhouse Development.

b. Providers responsible for the payroll of members shall have policies that ensure compliance with state and federal labor laws and regulations, which include, but are not limited to:

(1) Member vacation, sick leave and holiday compensation.

(2) Procedures for payment schedules and pay scale.

(3) Procedures for provision of workers' compensation insurance.

(4) Procedures for the determination and review of commensurate wages.

c. The department will contract only with public or private agencies to provide supported employment services. The department does not recognize individuals as service providers under the supported employment program.

**77.39(16) Home and vehicle modification providers.** The following providers may provide home and vehicle modification:

a. Providers eligible to participate as home and vehicle modification providers under the elderly or health and disability waiver, enrolled as home and vehicle modification providers under the physical disability waiver, or certified as home and vehicle modification providers under the physical disability waiver.

b. Community businesses that have all necessary licenses and permits to operate in conformity with federal, state, and local laws and regulations and that submit verification of current liability and workers' compensation insurance.

**77.39(17) Personal emergency response system providers.** Personal emergency response system providers shall be agencies which meet the conditions of participation set forth in subrule 77.33(2).

a. Providers shall be certified annually.

b. The service provider shall submit documentation to the department supporting continued compliance with the requirements set forth in subrule 77.33(2) 90 days before the expiration of the current certification.

**77.39(18) Transportation service providers.** This service is not to be provided at the same time as supported community service, which includes transportation. The following providers may provide transportation:

a. Area agencies on aging as designated in rule 17—4.4(231) or with letters of approval from the area agencies on aging stating the organization is qualified to provide transportation services.

b. Community action agencies as designated in Iowa Code section 216A.93.

c. Regional transit agencies as recognized by the Iowa department of transportation.

d. Providers with purchase of service contracts to provide transportation pursuant to 441—Chapter 150.

e. Nursing facilities licensed pursuant to Iowa Code chapter 135C.

f. Transportation providers contracting with the nonemergency medical transportation contractor.

**77.39(19) Specialized medical equipment providers.** The following providers may provide specialized medical equipment:

a. Medical equipment and supply dealers participating as providers in the Medicaid program.

b. Retail and wholesale businesses participating as providers in the Medicaid program which provide specialized medical equipment as defined in 441—subrule 78.43(8).

**77.39(20) Adult day care providers.** Adult day care providers shall be agencies that are certified by the department of inspections and appeals as being in compliance with the standards for adult day services programs at 481—Chapter 70.

**77.39(21) Family counseling and training providers.** Family counseling and training providers shall be one of the following:

a. Providers certified under the community mental health center standards established by the mental health and developmental disabilities commission, set forth in 441—Chapter 24, Divisions I and III, and that employ staff to provide family counseling and training who meet the definition of qualified brain injury professional as set forth in rule 441—83.81(249A).

b. Providers licensed as meeting the hospice standards and requirements set forth in department of inspections and appeals rules in 481—Chapter 53 or certified to meet the standards under the Medicare program for hospice programs, and that employ staff who meet the definition of qualified brain injury professional as set forth in rule 441—83.81(249A).

c. Providers accredited under the mental health service provider standards established by the mental health and developmental and disabilities commission, set forth in 441—Chapter 24, Divisions I and IV, and that employ staff to provide family counseling and training who meet the definition of qualified brain injury professional as set forth in rule 441—83.81(249A).

d. Individuals who meet the definition of qualified brain injury professional as set forth in rule 441—83.81(249A).

e. Agencies certified as brain injury waiver providers pursuant to rule 441—77.39(249A) that employ staff to provide family counseling who meet the definition of a qualified brain injury professional as set forth in rule 441—83.81(249A).

**77.39(22) Prevocational services providers.** Providers of prevocational services must meet the Commission on Accreditation of Rehabilitation Facilities standards for work adjustment service providers.

**77.39(23) Behavioral programming providers.** Behavioral programming providers shall be required to have experience with or training regarding the special needs of persons with a brain injury. In addition, they must meet the following requirements.

a. Behavior assessment, and development of an appropriate intervention plan, and periodic reassessment of the plan, and training of staff who shall implement the plan must be done by a qualified brain injury professional as defined in rule 441—83.81(249A). Formal assessment of the consumers' intellectual and behavioral functioning must be done by a licensed psychologist or a psychiatrist who is certified by the American Board of Psychiatry.

b. Implementation of the plan and training and supervision of caregivers, including family members, must be done by behavioral aides who have been trained by a qualified brain injury professional as defined in rule 441—83.81(249A) and who are employees of one of the following:

(1) Agencies which are certified under the community mental health center standards established by the mental health and developmental disabilities commission, set forth in 441—Chapter 24, Divisions I and III.

(2) Agencies which are licensed as meeting the hospice standards and requirements set forth in department of inspections and appeals rules 481—Chapter 53 or which are certified to meet the standards under the Medicare program for hospice programs.

(3) Agencies which are accredited under the mental health service provider standards established by the mental health and disabilities commission, set forth in 441—Chapter 24, Divisions I and IV.

(4) Home health aide providers meeting the standards set forth in subrule 77.33(3). Home health aide providers certified by Medicare shall be considered to have met these standards.

(5) Brain injury waiver providers certified pursuant to rule 441—77.39(249A).

**77.39(24) Consumer-directed attendant care providers.** The following providers may provide consumer-directed attendant care service:

a. An individual who contracts with the member to provide attendant care service and who is:

(1) At least 18 years of age.

(2) Qualified by training or experience to carry out the member's plan of care pursuant to the department-approved case plan or individual comprehensive plan.

(3) Not the spouse of the member or a parent or stepparent of a member aged 17 or under.

(4) Not the recipient of respite services paid through home- and community-based services on behalf of a member who receives home- and community-based services.

b. Agencies authorized to provide similar services through a contract with the department of public health (IDPH) for local public health services. The agency must provide a current IDPH local public health services contract number.

c. Home health agencies which are certified to participate in the Medicare program.

d. Chore providers subcontracting with area agencies on aging or with letters of approval from the area agencies on aging stating that the organization is qualified to provide chore services.

e. Community action agencies as designated in Iowa Code section 216A.93.

f. Providers certified under an HCBS waiver for supported community living.

g. Assisted living programs that are certified by the department of inspections and appeals under 481—Chapter 69.

h. Adult day service providers that are certified by the department of inspections and appeals under 481—Chapter 70.

**77.39(25) Interim medical monitoring and treatment providers.**

a. The following providers may provide interim medical monitoring and treatment services:

(1) Child care facilities, which are defined as child care centers licensed pursuant to 441—Chapter 109, preschools, or child development homes registered pursuant to 441—Chapter 110.

(2) Rescinded IAB 9/1/04, effective 11/1/04.

(3) Rescinded IAB 9/1/04, effective 11/1/04.

(4) Home health agencies certified to participate in the Medicare program.

(5) Supported community living providers certified according to subrule 77.37(14) or 77.39(13).

b. Staff requirements. Staff members providing interim medical monitoring and treatment services to members shall meet all of the following requirements:

(1) Be at least 18 years of age.

(2) Not be the spouse of the member or a parent or stepparent of the member if the member is aged 17 or under.

(3) Not be a usual caregiver of the member.

(4) Be qualified by training or experience to provide medical intervention or intervention in a medical emergency necessary to carry out the member's plan of care. The training or experience required must be determined by the member's usual caregivers and a licensed medical professional on the member's interdisciplinary team and must be documented in the member's service plan.

c. Service documentation. Providers shall maintain clinical and fiscal records necessary to fully disclose the extent of services furnished to members. Records shall specify by service date the procedures performed, together with information concerning progress of treatment.

**77.39(26) Financial management service.** Consumers who elect the consumer choices option shall work with a financial institution that meets the qualifications in subrule 77.30(13).

**77.39(27) Independent support brokerage.** Consumers who elect the consumer choices option shall work with an independent support broker who meets the qualifications in subrule 77.30(14).

**77.39(28) *Self-directed personal care.*** Consumers who elect the consumer choices option may choose to purchase self-directed personal care services from an individual or business that meets the requirements in subrule 77.30(15).

**77.39(29) *Individual-directed goods and services.*** Consumers who elect the consumer choices option may choose to purchase individual-directed goods and services from an individual or business that meets the requirements in subrule 77.30(16).

**77.39(30) *Self-directed community supports and employment.*** Consumers who elect the consumer choices option may choose to purchase self-directed community supports and employment from an individual or business that meets the requirements in subrule 77.30(17).

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

[ARC 7936B, IAB 7/1/09, effective 9/1/09; ARC 9314B, IAB 12/29/10, effective 3/1/11; ARC 0191C, IAB 7/11/12, effective 7/1/12; ARC 0359C, IAB 10/3/12, effective 12/1/12; ARC 0757C, IAB 5/29/13, effective 8/1/13; ARC 1071C, IAB 10/2/13, effective 10/1/13]

**441—77.40(249A) *Lead inspection agencies.*** The Iowa department of public health and agencies certified by the Iowa department of public health pursuant to 641—subrule 70.5(5) are eligible to participate in the Medicaid program as providers of lead inspection services.

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

**441—77.41(249A) *HCBS physical disability waiver service providers.*** Providers shall be eligible to participate in the Medicaid physical disability waiver program if they meet the requirements in this rule and the subrules applicable to the individual service. Enrolled providers shall maintain the certification listed in the applicable subrules in order to remain eligible providers.

Services shall be rendered by a person who is at least 16 years old (except as otherwise provided in this rule) and is not the spouse of the consumer served or the parent or stepparent of a consumer aged 17 or under. People who are 16 or 17 years old must be employed and supervised by an enrolled HCBS provider unless they are employed to provide self-directed personal care services through the consumer choices option. A person hired for self-directed personal care services need not be supervised by an enrolled HCBS provider. A person hired through the consumer choices option for independent support brokerage, self-directed personal care, individual-directed goods and services, or self-directed community support and employment is not required to enroll as a Medicaid provider and is not subject to the requirements of subrule 77.41(1).

**77.41(1) *Enrollment process.*** Reviews of compliance with standards for initial enrollment shall be conducted by the department's quality assurance staff. Enrollment carries no assurance that the approved provider will receive funding.

Review of a provider may occur at any time.

The department may request any information from the prospective service provider that is pertinent to arriving at an enrollment decision. This may include, but is not limited to:

*a.* Current accreditations, evaluations, inspection reports, and reviews by regulatory and licensing agencies and associations.

*b.* Fiscal capacity of the prospective provider to initiate and operate the specified programs on an ongoing basis.

**77.41(2) *Consumer-directed attendant care providers.*** The following providers may provide consumer-directed attendant care service:

*a.* An individual who contracts with the member to provide consumer-directed attendant care and who is:

(1) At least 18 years of age.

(2) Qualified by training or experience to carry out the member's plan of care pursuant to the department-approved case plan or individual comprehensive plan.

(3) Not the spouse or guardian of the member or a parent or stepparent of a member aged 17 or under.

(4) Not the recipient of respite services paid through home- and community-based services on behalf of a member who receives home- and community-based services.

*b.* Agencies authorized to provide similar services through a contract with the department of public health (IDPH) for local public health services. The agency must provide a current IDPH local public health services contract number.

*c.* Home health agencies that are certified to participate in the Medicare program.

*d.* Chore providers subcontracting with area agencies on aging or with letters of approval from the area agencies on aging stating that the organization is qualified to provide chore services.

*e.* Community action agencies as designated in Iowa Code section 216A.103.

*f.* Providers certified under an HCBS waiver for supported community living.

*g.* Assisted living programs that are certified by the department of inspections and appeals under 481—Chapter 69.

*h.* Adult day service providers that are certified by the department of inspections and appeals under 481—Chapter 70.

**77.41(3)** *Home and vehicle modification providers.* The following providers may provide home and vehicle modifications:

*a.* Providers eligible to participate as home and vehicle modification providers under the elderly or health and disability waiver or certified as home and vehicle modification providers under the home- and community-based services intellectual disability or brain injury waiver.

*b.* Community businesses that have all necessary licenses and permits to operate in conformity with federal, state, and local laws and regulations and that submit verification of current liability and workers' compensation insurance.

**77.41(4)** *Personal emergency response system providers.* Personal emergency response system providers shall be agencies which meet the conditions of participation set forth in subrule 77.33(2).

**77.41(5)** *Specialized medical equipment providers.* The following providers may provide specialized medical equipment:

*a.* Medical equipment and supply dealers participating as providers in the Medicaid program.

*b.* Retail and wholesale businesses participating as providers in the Medicaid program which provide specialized medical equipment as defined in 441—subrule 78.46(4).

**77.41(6)** *Transportation service providers.* The following providers may provide transportation:

*a.* Area agencies on aging as designated in 17—4.4(231) or with letters of approval from the area agencies on aging stating the organization is qualified to provide transportation services.

*b.* Community action agencies as designated in Iowa Code section 216A.93.

*c.* Regional transit agencies as recognized by the Iowa department of transportation.

*d.* Nursing facilities licensed pursuant to Iowa Code chapter 135C.

*e.* Transportation providers contracting with the nonemergency medical transportation contractor.

**77.41(7)** *Financial management service.* Consumers who elect the consumer choices option shall work with a financial institution that meets the qualifications in subrule 77.30(13).

**77.41(8)** *Independent support brokerage.* Consumers who elect the consumer choices option shall work with an independent support broker who meets the qualifications in subrule 77.30(14).

**77.41(9)** *Self-directed personal care.* Consumers who elect the consumer choices option may choose to purchase self-directed personal care services from an individual or business that meets the requirements in subrule 77.30(15).

**77.41(10)** *Individual-directed goods and services.* Consumers who elect the consumer choices option may choose to purchase individual-directed goods and services from an individual or business that meets the requirements in subrule 77.30(16).

**77.41(11)** *Self-directed community supports and employment.* Consumers who elect the consumer choices option may choose to purchase self-directed community supports and employment from an individual or business that meets the subrule requirements in 77.30(17).

**77.41(12)** *Incident management and reporting.* As a condition of participation in the medical assistance program, HCBS physical disability waiver service providers must comply with the requirements of Iowa Code sections 232.69 and 235B.3 regarding the reporting of child abuse and dependent adult abuse and with the incident management and reporting requirements in this subrule. EXCEPTION: The conditions in this subrule do not apply to providers of goods and services purchased

under the consumer choices option or providers of home and vehicle modification, specialized medical equipment, personal emergency response, and transportation.

*a. Definitions.*

“*Major incident*” means an occurrence involving a consumer during service provision that:

1. Results in a physical injury to or by the consumer that requires a physician’s treatment or admission to a hospital;
2. Results in the death of any person;
3. Requires emergency mental health treatment for the consumer;
4. Requires the intervention of law enforcement;
5. Requires a report of child abuse pursuant to Iowa Code section 232.69 or a report of dependent adult abuse pursuant to Iowa Code section 235B.3;
6. Constitutes a prescription medication error or a pattern of medication errors that leads to the outcome in paragraph “1,” “2,” or “3”; or
7. Involves a consumer’s location being unknown by provider staff who are assigned protective oversight.

“*Minor incident*” means an occurrence involving a consumer during service provision that is not a major incident and that:

1. Results in the application of basic first aid;
2. Results in bruising;
3. Results in seizure activity;
4. Results in injury to self, to others, or to property; or
5. Constitutes a prescription medication error.

*b. Reporting procedure for minor incidents.* Minor incidents may be reported in any format designated by the provider. When a minor incident occurs or a staff member becomes aware of a minor incident, the staff member involved shall submit the completed incident report to the staff member’s supervisor within 72 hours of the incident. The completed report shall be maintained in a centralized file with a notation in the consumer’s file.

*c. Reporting procedure for major incidents.* When a major incident occurs or a staff member becomes aware of a major incident:

(1) The staff member involved shall notify the following persons of the incident by the end of the next calendar day after the incident:

1. The staff member’s supervisor.
2. The consumer or the consumer’s legal guardian. EXCEPTION: Notification to the consumer is required only if the incident took place outside of the provider’s service provision. Notification to the guardian, if any, is always required.
3. The consumer’s case manager.

(2) By the end of the next calendar day after the incident, the staff member who observed or first became aware of the incident shall also report as much information as is known about the incident to the department’s bureau of long-term care either:

1. By direct data entry into the Iowa Medicaid Provider Access System, or
2. By faxing or mailing Form 470-4698, Critical Incident Report, according to the directions on the form.

(3) The following information shall be reported:

1. The name of the consumer involved.
2. The date and time the incident occurred.
3. A description of the incident.
4. The names of all provider staff and others who were present at the time of the incident or who responded after becoming aware of the incident. The confidentiality of other waiver-eligible or non-waiver-eligible consumers who were present must be maintained by the use of initials or other means.
5. The action that the provider staff took to manage the incident.
6. The resolution of or follow-up to the incident.

7. The date the report is made and the handwritten or electronic signature of the person making the report.

(4) Submission of the initial report will generate a workflow in the Individualized Services Information System (ISIS) for follow-up by the case manager. When complete information about the incident is not available at the time of the initial report, the provider must submit follow-up reports until the case manager is satisfied with the incident resolution and follow-up. The completed report shall be maintained in a centralized file with a notation in the consumer's file.

*d. Tracking and analysis.* The provider shall track incident data and analyze trends to assess the health and safety of consumers served and determine if changes need to be made for service implementation or if staff training is needed to reduce the number or severity of incidents.

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

[ARC 7936B, IAB 7/1/09, effective 9/1/09; ARC 9314B, IAB 12/29/10, effective 3/1/11; ARC 0191C, IAB 7/11/12, effective 7/1/12; ARC 0359C, IAB 10/3/12, effective 12/1/12; ARC 0757C, IAB 5/29/13, effective 8/1/13; ARC 1071C, IAB 10/2/13, effective 10/1/13]

**441—77.42(249A) Public health agencies.** Public health agencies are eligible to participate in the medical assistance program when they serve as a public health entity within the local board of health jurisdiction pursuant to 641—subrule 77.3(3).

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

[ARC 0358C, IAB 10/3/12, effective 11/7/12]

**441—77.43(249A) Infant and toddler program providers.** An agency is eligible to participate in the medical assistance program as a provider of infant and toddler program services under rule 441—78.49(249A) if the agency:

1. Is in good standing under the infants and toddlers with disabilities program administered by the department of education, the department of public health, the department of human services, and the Iowa Child Health Specialty Clinics pursuant to the interagency agreement between these agencies under Subchapter III of the federal Individuals with Disabilities Education Act (IDEA); and

2. Meets the following additional requirements.

**77.43(1) Licensure.** Covered services shall be provided by personnel who are licensed, endorsed, registered, recognized, or qualified as provided in this subrule and shall be within the scope of the applicable license, endorsement, registration, recognition, or qualification.

*a.* Personnel providing audiological or speech-language services shall be licensed by the Iowa board of speech pathology and audiology as a speech pathologist or audiologist pursuant to 645—Chapters 299, 300 and 303 through 305.

*b.* Personnel providing physical therapy shall be licensed by the Iowa board of physical and occupational therapy as a physical therapist pursuant to 645—Chapters 199 through 204.

*c.* Personnel providing occupational therapy shall be licensed by the Iowa board of physical and occupational therapy as an occupational therapist pursuant to 645—Chapters 205 through 210.

*d.* Personnel providing psychological evaluations and counseling or psychotherapy services shall be:

(1) Endorsed by the Iowa board of educational examiners as a school psychologist pursuant to rule 282—15.11(272);

(2) Licensed by the Iowa board of psychology as a psychologist pursuant to 645—Chapters 239 through 243;

(3) Licensed by the Iowa board of social work as a social worker pursuant to 645—Chapters 279 through 284;

(4) Licensed by the Iowa board of medicine as a physician pursuant to 653—Chapters 9 through 11; or

(5) Registered by the Iowa nursing board as an advanced registered nurse practitioner pursuant to 655—Chapter 7.

*e.* Personnel providing nursing services shall be licensed by the Iowa nursing board as a registered or licensed practical nurse pursuant to 655—Chapters 3 through 6.

*f.* Personnel providing vision services shall be:

- (1) Licensed by the Iowa nursing board as a registered or licensed practical nurse pursuant to 655—Chapters 3 through 6;
- (2) Licensed by the Iowa board of medicine as a physician pursuant to 653—Chapters 9 through 11; or
- (3) Licensed by the Iowa board of optometry as an optometrist pursuant to 645—Chapter 180.
  - g. Developmental services shall be provided by personnel who meet standards established pursuant to department of education rule 281—120.19(34CFR303).
  - h. Medical transportation shall be provided by licensed drivers.
  - i. Other services shall be provided by staff who are:
    - (1) Recognized as a special education paraprofessional pursuant to department of education rule 281—41.403(256B);
    - (2) Endorsed by the Iowa board of educational examiners as a school psychologist pursuant to rule 282—15.11(272);
    - (3) Endorsed by the Iowa board of educational examiners as a speech-language pathologist pursuant to rule 282—15.12(272);
    - (4) Endorsed by the Iowa board of educational examiners as an orientation and mobility specialist pursuant to rule 282—15.15(272);
    - (5) Endorsed by the Iowa board of educational examiners as a school occupational therapist pursuant to rule 282—15.16(272);
    - (6) Endorsed by the Iowa board of educational examiners as a school physical therapist pursuant to rule 282—15.17(272);
    - (7) Endorsed by the Iowa board of educational examiners as a special education nurse pursuant to rule 282—15.18(272);
    - (8) Endorsed by the Iowa board of educational examiners as a school social worker pursuant to rule 282—15.19(272);
    - (9) Licensed by the Iowa nursing board as a registered or licensed practical nurse pursuant to 655—Chapters 3 through 6; or
    - (10) Licensed by the Iowa board of medicine as a physician pursuant to 653—Chapters 9 through 11.

**77.43(2) Documentation requirements.** As a condition of participation, the provider shall be responsible for maintaining accurate and current documentation of services provided in the child's record. Documentation of all services performed is required and must include:

- a. Date, time, location, and description of each service provided and identification of the individual rendering the service by name and professional or paraprofessional designation.
- b. An assessment and response to interventions and services.
- c. An individual family service plan (IFSP) including all changes and revisions, as developed by the service coordinator pursuant to rule 281—41.5(256B,34CFR300).
- d. Documentation of progress toward achieving the child's or family's action steps and outcomes as identified in the individual family service plan (IFSP).

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

**441—77.44(249A) Local education agency services providers.** School districts accredited by the department of education pursuant to 281—Chapter 12, the Iowa Braille and Sight Saving School governed by the state board of regents pursuant to Iowa Code section 262.7(4), and the State School for the Deaf governed by the state board of regents pursuant to Iowa Code section 262.7(5) are eligible to participate in the medical assistance program as providers of local education agency (LEA) services under rule 441—78.50(249A) if the following conditions are met.

**77.44(1) Licensure.** Covered services shall be provided by personnel who are licensed, endorsed, registered, recognized, or qualified as provided in this subrule and shall be within the scope of the applicable license, endorsement, registration, recognition, or qualification.

*a.* Personnel providing audiological or speech-language services shall be licensed by the Iowa board of speech pathology and audiology as a speech pathologist or audiologist pursuant to 645—Chapters 299, 300 and 303 through 305.

*b.* Personnel providing physical therapy shall be licensed by the Iowa board of physical and occupational therapy as a physical therapist pursuant to 645—Chapters 199 through 204.

*c.* Personnel providing occupational therapy shall be licensed by the Iowa board of physical and occupational therapy as an occupational therapist pursuant to 645—Chapters 205 through 210.

*d.* Personnel providing psychological evaluations and counseling or psychotherapy services shall be:

(1) Endorsed by the Iowa board of educational examiners as a school psychologist pursuant to rule 282—15.11(272);

(2) Licensed by the Iowa board of psychology as a psychologist pursuant to 645—Chapters 239 through 243;

(3) Licensed by the Iowa board of social work as a social worker pursuant to 645—Chapters 279 through 284;

(4) Licensed by the Iowa board of medicine as a physician pursuant to 653—Chapters 9 through 11; or

(5) Registered by the Iowa nursing board as an advanced registered nurse practitioner pursuant to 655—Chapter 7.

*e.* Personnel providing nursing services shall be licensed by the Iowa nursing board as a registered or licensed practical nurse pursuant to 655—Chapters 3 through 6.

*f.* Personnel providing vision services shall be:

(1) Licensed by the Iowa nursing board as a registered or licensed practical nurse pursuant to 655—Chapters 3 through 6;

(2) Licensed by the Iowa board of medicine as a physician pursuant to 653—Chapters 9 through 11; or

(3) Licensed by the Iowa board of optometry as an optometrist pursuant to 645—Chapter 180.

*g.* Developmental services shall be provided by personnel who meet standards established pursuant to department of education rule 281—120.19(34CFR303).

*h.* Medical transportation shall be provided by licensed drivers.

*i.* Other services shall be provided by staff who are:

(1) Recognized as a special education paraprofessional pursuant to department of education rule 281—41.403(256B);

(2) Endorsed by the Iowa board of educational examiners as a school psychologist pursuant to rule 282—15.11(272);

(3) Endorsed by the Iowa board of educational examiners as a speech-language pathologist pursuant to rule 282—15.12(272);

(4) Endorsed by the Iowa board of educational examiners as an orientation and mobility specialist pursuant to rule 282—15.15(272);

(5) Endorsed by the Iowa board of educational examiners as a school occupational therapist pursuant to rule 282—15.16(272);

(6) Endorsed by the Iowa board of educational examiners as a school physical therapist pursuant to rule 282—15.17(272);

(7) Endorsed by the Iowa board of educational examiners as a special education nurse pursuant to rule 282—15.18(272);

(8) Endorsed by the Iowa board of educational examiners as a school social worker pursuant to rule 282—15.19(272);

(9) Licensed by the Iowa nursing board as a registered or licensed practical nurse pursuant to 655—Chapters 3 through 6; or

(10) Licensed by the Iowa board of medicine as a physician pursuant to 653—Chapters 9 through 11.

**77.44(2) Documentation requirements.** As a condition of participation, the provider shall be responsible for maintaining accurate and current documentation in the child's record. Documentation of all services performed is required and must include:

- a. Date, time, duration, location, and description of each service delivered and identification of the individual rendering the service by name and professional or paraprofessional designation.
- b. An assessment and response to interventions and services.
- c. Progress toward goals in the individual education plan (IEP) or individual health plan (IHP) pursuant to 281—Chapter 41, Division VIII, or 281—subrule 41.96(1).

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

**441—77.45(249A) Indian health service 638 facilities.** A health care facility owned and operated by American Indian or Alaskan native tribes or tribal organizations with funding authorized by Title I or Title III of the Indian Self-Determination and Education Assistance Act (P.L. 93-638) is eligible to participate in the medical assistance program if the following conditions are met:

**77.45(1) Licensure.** Services must be rendered by practitioners who meet applicable professional licensure requirements.

**77.45(2) Documentation.** Medical records must be maintained at the same standards as are required for the applicable licensed medical practitioner.

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

**441—77.46(249A) HCBS children's mental health waiver service providers.** HCBS children's mental health waiver services shall be rendered by provider agencies that meet the general provider standards in subrule 77.46(1) and also meet the standards in subrules 77.46(2) to 77.46(5) that are specific to the waiver services provided. A provider that is approved for the same service under another HCBS Medicaid waiver shall be eligible to enroll for that service under the children's mental health waiver.

**77.46(1) General provider standards.** All providers of HCBS children's mental health waiver services shall meet the following standards:

a. *Fiscal capacity.* Providers must demonstrate the fiscal capacity to provide services on an ongoing basis.

b. *Direct care staff.*

- (1) Direct care staff must be at least 18 years of age.
- (2) Providers must complete child abuse, dependent adult abuse, and criminal background screenings pursuant to Iowa Code section 249A.29 before employment of a staff member who will provide direct care.

(3) Direct care staff may not be the spouse of the consumer or the parent or stepparent of the consumer.

c. *Outcome-based standards and quality assurance.*

(1) Providers shall implement the following outcome-based standards for the rights and dignity of children with serious emotional disturbance:

1. Consumers are valued.
2. Consumers are a part of community life.
3. Consumers develop meaningful goals.
4. Consumers maintain physical and mental health.
5. Consumers are safe.
6. Consumers and their families have an impact on the services received.

(2) The department's quality assurance staff shall conduct random quality assurance reviews to assess the degree to which the outcome-based standards have been implemented in service provision. Results of outcome-based quality assurance reviews shall be forwarded to the certifying or accrediting entity.

(3) A quality assurance review shall include interviews with the consumer and the consumer's parents or legal guardian, with informed consent, and interviews with designated targeted case managers.

(4) A quality assurance review may include interviews with provider staff, review of case files, review of staff training records, review of compliance with the general provider standards in this subrule, and review of other organizational policies and procedures and documentation.

(5) Corrective action shall be required if the quality assurance review demonstrates that service provision or provider policies and procedures do not reflect the outcome-based standards. Technical assistance for corrective action shall be available from the department's quality assurance staff.

*d. Incident management and reporting.* As a condition of participation in the medical assistance program, HCBS children's mental health waiver service providers must comply with the requirements of Iowa Code sections 232.69 and 235B.3 regarding the reporting of child abuse and dependent adult abuse and must comply with the following incident management and reporting requirements. **EXCEPTION:** The conditions in this paragraph do not apply to providers of environmental modifications and adaptive devices.

(1) Definitions.

*"Major incident"* means an occurrence involving a consumer during service provision that:

1. Results in a physical injury to or by the consumer that requires a physician's treatment or admission to a hospital;
2. Results in the death of any person;
3. Requires emergency mental health treatment for the consumer;
4. Requires the intervention of law enforcement;
5. Requires a report of child abuse pursuant to Iowa Code section 232.69 or a report of dependent adult abuse pursuant to Iowa Code section 235B.3;
6. Constitutes a prescription medication error or a pattern of medication errors that leads to the outcome in paragraph "1," "2," or "3"; or
7. Involves a consumer's location being unknown by provider staff who are assigned protective oversight.

*"Minor incident"* means an occurrence involving a consumer during service provision that is not a major incident and that:

1. Results in the application of basic first aid;
2. Results in bruising;
3. Results in seizure activity;
4. Results in injury to self, to others, or to property; or
5. Constitutes a prescription medication error.

(2) Reporting procedure for minor incidents. Minor incidents may be reported in any format designated by the provider. When a minor incident occurs or a staff member becomes aware of a minor incident, the staff member involved shall submit the completed incident report to the staff member's supervisor within 72 hours of the incident. The completed report shall be maintained in a centralized file with a notation in the consumer's file.

(3) Notification procedure for major incidents. When a major incident occurs or a staff member becomes aware of a major incident, the staff member involved shall notify the following persons of the incident by the end of the next calendar day after the incident:

1. The staff member's supervisor.
2. The consumer or the consumer's legal guardian. **EXEPTION:** Notification to the consumer is required only if the incident took place outside of the provider's service provision. Notification to the guardian, if any, is always required.
3. The consumer's case manager.

(4) Reporting procedure for major incidents. By the end of the next calendar day after a major incident, the staff member who observed or first became aware of the incident shall also report as much information as is known about the incident to the department's bureau of long-term care either:

1. By direct data entry into the Iowa Medicaid Provider Access System, or
2. By faxing or mailing Form 470-4698, Critical Incident Report, according to the directions on the form.

(5) Information to be reported. The following information shall be reported about a major incident:

1. The name of the consumer involved.
2. The date and time the incident occurred.
3. A description of the incident.
4. The names of all provider staff and others who were present at the time of the incident or who responded after becoming aware of the incident. The confidentiality of other waiver-eligible or non-waiver-eligible consumers who were present must be maintained by the use of initials or other means.
5. The action that the provider staff took to manage the incident.
6. The resolution of or follow-up to the incident.
7. The date the report is made and the handwritten or electronic signature of the person making the report.

(6) Response to report. Submission of the initial report will generate a workflow in the Individualized Services Information System (ISIS) for follow-up by the case manager. When complete information about a major incident is not available at the time of the initial report, the provider must submit follow-up reports until the case manager is satisfied with the incident resolution and follow-up. The completed report shall be maintained in a centralized file with a notation in the consumer's file.

(7) Tracking and analysis. The provider shall track incident data and analyze trends to assess the health and safety of consumers served and determine if changes need to be made for service implementation or if staff training is needed to reduce the number or severity of incidents.

**77.46(2) Environmental modifications, adaptive devices, and therapeutic resources providers.** The following agencies may provide environmental modifications, adaptive devices, and therapeutic resources under the children's mental health waiver:

- a. A community business that:
  - (1) Possesses all necessary licenses and permits to operate in conformity with federal, state, and local statutes and regulations, including Iowa Code chapter 490; and
  - (2) Submits verification of current liability and workers' compensation insurance.
- b. A retail or wholesale business that otherwise participates as a provider in the Medicaid program.
- c. A home and vehicle modification provider enrolled under another HCBS Medicaid waiver.
- d. A provider enrolled under the HCBS home- and community-based services intellectual disability or brain injury waiver as a supported community living provider.
- e. A provider enrolled under the HCBS children's mental health waiver as a family and community support services provider.

**77.46(3) Family and community support services providers.**

a. *Qualified providers.* The following agencies may provide family and community support services under the children's mental health waiver:

- (1) Behavioral health intervention providers qualified under 441—77.12(249A).
- (2) Community mental health centers accredited in good standing as providers of outpatient psychotherapy and counseling under 441—Chapter 24.

b. *Staff training.* The agency shall meet the following training requirements as a condition of providing family and community support services under the children's mental health waiver:

- (1) Within one month of employment, staff members must receive the following training:
  1. Orientation regarding the agency's mission, policies, and procedures; and
  2. Orientation regarding HCBS philosophy and outcomes for rights and dignity found in 77.36(1)“c” for the children's mental health waiver.
- (2) Within four months of employment, staff members must receive training regarding the following:
  1. Serious emotional disturbance in children and provision of services to children with serious emotional disturbance;
  2. Confidentiality;
  3. Provision of medication according to agency policy and procedure;
  4. Identification and reporting of child abuse;
  5. Incident reporting;

6. Documentation of service provision;
7. Appropriate behavioral interventions; and
8. Professional ethics.

(3) Until a staff member receives the training identified in subparagraphs (1) and (2), the staff member shall not provide any direct service without the presence of experienced staff.

(4) Within the first year of employment, staff members must complete 24 hours of training in children's mental health issues.

(5) During each consecutive year of employment, staff members must complete 12 hours of training in children's mental health issues.

*c. Support of crisis intervention plan.* As a condition of providing services under the children's mental health waiver, a family and community support provider shall develop and implement policies and procedures for maintaining the integrity of the individualized crisis intervention plan as defined in 441—24.1(225C) that is developed by each consumer's interdisciplinary team. The policies and procedures shall address:

(1) Sharing with the case manager and the interdisciplinary team information pertinent to the development of the consumer's crisis intervention plan.

(2) Training staff before service provision, in cooperation with the consumer's parents or legal guardian, regarding the consumer's individual mental health needs and individualized supports as identified in the crisis intervention plan.

(3) Ensuring that all staff have access to a written copy of the most current crisis intervention plan during service provision.

(4) Ensuring that the plan contains current and accurate information by updating the case manager within 24 hours regarding any circumstance or issue that would have an impact on the consumer's mental health or change the consumer's crisis intervention plan.

*d. Intake, admission, and discharge.* As a condition of providing services under the children's mental health waiver, a family and community support provider shall have written policies and procedures for intake, admission, and discharge.

**77.46(4) In-home family therapy providers.**

*a. Qualified providers.* The following agencies may provide in-home family therapy under the children's mental health waiver:

(1) Community mental health centers accredited in good standing as providers of outpatient psychotherapy and counseling under 441—Chapter 24.

(2) Mental health professionals licensed pursuant to 645—Chapter 31, 240, or 280 or possessing an equivalent license in another state.

*b. Staff training.* The agency shall meet the following training requirements as a condition of providing in-home family therapy under the children's mental health waiver:

(1) Within one month of employment, staff members must receive the following training:

1. Orientation regarding the agency's mission, policies, and procedures; and
2. Orientation regarding HCBS philosophy and outcomes for rights and dignity found in 77.46(1) "c" for the children's mental health waiver.

(2) Within four months of employment, staff members must receive training regarding the following:

1. Serious emotional disturbance in children and service provision to children with serious emotional disturbance;

2. Confidentiality;

3. Provision of medication according to agency policy and procedure;

4. Identification and reporting of child abuse;

5. Incident reporting;

6. Documentation of service provision;

7. Appropriate behavioral interventions; and

8. Professional ethics.

(3) Until a staff member receives the training identified in subparagraphs (1) and (2), the staff member shall not provide any direct service without the presence of experienced staff.

(4) Within the first year of employment, staff members must complete 24 hours of training in children's mental health issues.

(5) During each consecutive year of employment, staff members must complete 12 hours of training in children's mental health issues.

*c. Support of crisis intervention plan.* As a condition of providing services under the children's mental health waiver, an in-home family therapy provider shall develop and implement policies and procedures for maintaining the integrity of the individualized crisis intervention plan as defined in 441—24.1(225C) that is developed by each consumer's interdisciplinary team. The policies and procedures shall address:

(1) Sharing with the case manager and the interdisciplinary team information pertinent to the development of the consumer's crisis intervention plan.

(2) Training staff before service provision, in cooperation with the consumer's parents or legal guardian, regarding the consumer's individual mental health needs and individualized supports as identified in the crisis intervention plan.

(3) Ensuring that all staff have access to a written copy of the most current crisis intervention plan during service provision.

(4) Ensuring that the plan contains current and accurate information by updating the case manager within 24 hours regarding any circumstance or issue that would have an impact on the consumer's mental health or change the consumer's crisis intervention plan.

*d. Intake, admission, and discharge.* As a condition of providing services under the children's mental health waiver, an in-home family therapy provider shall have written policies and procedures for intake, admission, and discharge.

**77.46(5) Respite care providers.**

*a. Qualified providers.* The following agencies may provide respite services under the children's mental health waiver:

(1) Providers certified or enrolled as respite providers under another Medicaid HCBS waiver.

(2) Group living foster care facilities for children licensed in good standing by the department according to 441—Chapters 112 and 114 to 116.

(3) Child care centers licensed in good standing by the department according to 441—Chapter 109 and child development homes registered according to 441—Chapter 110.

(4) Camps certified in good standing by the American Camping Association.

(5) Home health agencies that are certified in good standing to participate in the Medicare program.

(6) Agencies authorized to provide similar services through a contract with the department of public health (IDPH) for local public health services. The agency must provide a current IDPH local public health services contract number.

(7) Adult day care providers that are certified in good standing by the department of inspections and appeals as being in compliance with the standards for adult day services programs at 481—Chapter 70.

(8) Assisted living programs certified in good standing by the department of inspections and appeals.

(9) Residential care facilities for persons with mental retardation licensed in good standing by the department of inspections and appeals.

(10) Nursing facilities, intermediate care facilities for the mentally retarded, and hospitals enrolled as providers in the Iowa Medicaid program.

*b. Staff training.* The agency shall meet the following training requirements as a condition of providing respite care under the children's mental health waiver:

(1) Within one month of employment, staff members must receive the following training:

1. Orientation regarding the agency's mission, policies, and procedures; and

2. Orientation regarding HCBS philosophy and outcomes for rights and dignity for the children's mental health waiver in 77.46(1) "c."

(2) Within four months of employment, staff members must receive training regarding the following:

1. Serious emotional disturbance in children and provision of services to children with serious emotional disturbance;
2. Confidentiality;
3. Provision of medication according to agency policy and procedure;
4. Identification and reporting of child abuse;
5. Incident reporting;
6. Documentation of service provision;
7. Appropriate behavioral interventions; and
8. Professional ethics.

(3) Until a staff member receives the training identified in subparagraphs (1) and (2), the staff member shall not provide any direct service without the oversight of supervisory staff and shall obtain feedback from the family within 24 hours of service provision.

(4) Within the first year of employment, staff members must complete 24 hours of training in children's mental health issues.

(5) During each consecutive year of employment, staff members must complete 12 hours of training in children's mental health issues.

*c. Consumer-specific information.* The following information must be written, current, and accessible to the respite provider during service provision:

- (1) The consumer's legal and preferred name, birth date, and age, and the address and telephone number of the consumer's usual residence.
- (2) The consumer's typical schedule.
- (3) The consumer's preferences in activities and foods or any other special concerns.
- (4) The consumer's crisis intervention plan.

*d. Written notification of injury.* The respite provider shall inform the parent, guardian or usual caregiver that written notification must be given to the respite provider of any recent injuries or illnesses that have occurred before respite provision.

*e. Medication dispensing.* Respite providers shall develop policies and procedures for the dispensing, storage, and recording of all prescription and nonprescription medications administered during respite provision. Home health agencies must follow Medicare regulations regarding medication dispensing.

*f. Support of crisis intervention plan.* As a condition of providing services under the children's mental health waiver, a respite provider shall develop and implement policies and procedures for maintaining the integrity of the individualized crisis intervention plan as defined in 441—24.1(225C) that is developed by each consumer's interdisciplinary team. The policies and procedures shall address:

- (1) Sharing with the case manager and the interdisciplinary team information pertinent to the development of the consumer's crisis intervention plan.
- (2) Training staff before service provision, in cooperation with the consumer's parents or legal guardian, regarding the consumer's individual mental health needs and individualized supports as identified in the crisis intervention plan.
- (3) Ensuring that all staff have access to a written copy of the most current crisis intervention plan during service provision.

(4) Ensuring that the plan contains current and accurate information by updating the case manager within 24 hours regarding any circumstance or issue that would have an impact on the consumer's mental health or change the consumer's crisis intervention plan.

*g. Service documentation.* Documentation of respite care shall be made available to the consumer, parents, guardian, or usual caregiver upon request.

*h. Capacity.* A facility providing respite care under this subrule shall not exceed the facility's licensed capacity, and services shall be provided in a location and for a duration consistent with the facility's licensure.

*i. Service provided outside home or facility.* For respite care to be provided in a location other than the consumer's home or the provider's facility:

- (1) The care must be approved by the parent, guardian or usual caregiver;
- (2) The care must be approved by the interdisciplinary team in the consumer's service plan;
- (3) The care must be consistent with the way the location is used by the general public; and
- (4) Respite care in these locations shall not exceed 72 continuous hours.

This rule is intended to implement Iowa Code section 249A.4 and 2005 Iowa Acts, chapter 167, section 13, and chapter 117, section 3.

[ARC 7741B, IAB 5/6/09, effective 7/1/09; ARC 7936B, IAB 7/1/09, effective 9/1/09; ARC 9314B, IAB 12/29/10, effective 3/1/11; ARC 9487B, IAB 5/4/11, effective 7/1/11]

**441—77.47(249A) Health home services providers.** Subject to the requirements of this rule, a designated provider may participate in the medical assistance program as a provider of health home services.

**77.47(1) Qualifications.** A designated provider of health home services must be a Medicaid-enrolled entity or provider that is determined through the provider enrollment process to have the systems and infrastructure in place to provide health home services.

*a. Staffing.* At a minimum, a qualifying provider must fill the following roles:

- (1) Designated practitioner.
- (2) Dedicated care coordinator.
- (3) Health coach.
- (4) Clinic support staff.

*b. Data management.* A qualifying provider shall ensure that all clinical data related to the member are maintained with the member's medical records through the use of health information technology.

*c. Collaboration with case managers.* Health homes providing services to members eligible pursuant to 441—subparagraph 78.53(2)“a”(1) or (2) must collaborate, at least quarterly, with targeted case managers, other case managers, or DHS service workers for each member receiving case management services. Strategies to prevent duplication of coordination efforts by the health home and case managers or service workers must be developed by the health home and documented upon request. Documentation may include but is not limited to records of joint staffing meetings where a member's medical needs, current activities, and waiver services needs are reviewed and appropriately updated.

*d. Provision of integrated health home services.* Health homes providing services to members eligible pursuant to 441—subparagraph 78.53(2)“a”(3) or (4) must be integrated health homes that:

- (1) Consist of a team of health care professionals trained in providing health home services to members with a serious mental illness (SMI) and to members with a serious emotional disturbance (SED);
- (2) Have a direct agreement with the Iowa Medicaid managed behavioral health organization to provide health home services for members with SMI or SED;
- (3) Coordinate all community and social support services needs for members enrolled in the health home; and
- (4) Follow a system of care model in providing health home services to members with SED, including collaboration with the child welfare, public health, juvenile justice, and education systems.

**77.47(2) Report on quality measures.** As a condition of participation in the medical assistance program as a provider of health home services and of receiving payment for health home services provided, a designated provider must report to the Iowa Medicaid enterprise on measures for determining the quality of such services. When appropriate and feasible, a designated provider shall use health information technology in providing the Iowa Medicaid enterprise with such information.

**77.47(3) Selection.** As a condition of payment for health home services provided to a Medicaid member eligible to receive such services pursuant to 441—subrule 78.53(2), a designated provider must be selected by the member as the member’s health home, as reported by provider attestation.

This rule is intended to implement Iowa Code section 249A.4 and 2011 Iowa Acts, chapter 129, section 10.

[ARC 0198C, IAB 7/11/12, effective 7/1/12; ARC 0838C, IAB 7/24/13, effective 7/1/13]

**441—77.48(249A) Speech-language pathologists.** Speech-language pathologists who are enrolled in the Medicare program are eligible to participate in Medicaid. Speech-language pathologists who are not enrolled in the Medicare program are eligible to participate in Medicaid if they are licensed and in independent practice, as an individual or as a group.

**77.48(1)** Speech-language pathologists in another state are eligible to participate if they are licensed in that state and meet the Medicare criteria for enrollment.

**77.48(2)** Speech-language pathologists who provide services to Medicaid members who are also Medicare beneficiaries must be enrolled in the Medicare program.

This rule is intended to implement Iowa Code section 249A.4 and 2012 Iowa Acts, Senate File 2158.

[ARC 0360C, IAB 10/3/12, effective 12/1/12]

**441—77.49(249A) Physician assistants.** All physician assistants licensed to practice in the state of Iowa are eligible for participation in the program. Physician assistants duly licensed to practice in other states are also eligible for participation. Enrollment is for the purpose of providing professional services for Medicaid members including orders and referrals, as required under Public Law 111-148, Section 6401, otherwise known as the Patient Protection and Affordable Care Act (PPACA). Enrollment will not affect the provider’s payment arrangements with facilities or supervising providers.

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

[ARC 0580C, IAB 2/6/13, effective 4/1/13]

**441—77.50(249A) Ordering and referring providers.** A provider who provides services, including orders and referrals, to a Medicaid member shall be enrolled as a Medicaid provider as a condition of payment eligibility for services rendered to that Medicaid member. A provider who does not individually bill for services rendered due to, for example, payment arrangements with a facility or supervising provider, shall also be required to enroll. Enrollment will be for the purpose of ordering or referring items and providing professional services to Medicaid members and will not affect the provider’s payment arrangements with such facilities or supervising providers.

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

[ARC 0580C, IAB 2/6/13, effective 4/1/13]

[Filed 3/11/70, amended 6/21/73, 2/13/75, 3/21/75]

[Filed 6/25/76, Notice 5/17/76—published 7/12/76, effective 8/16/76]

[Filed 12/6/77, Notice 10/19/77—published 12/28/77, effective 2/1/78]

[Filed 2/8/78, Notice 12/28/78—published 3/8/78, effective 4/12/78]

[Filed without Notice 3/31/78—published 4/19/78, effective 7/1/78]

[Filed 2/26/82, Notice 10/14/81—published 3/17/82, effective 5/1/82]

[Filed 5/20/83, Notice 3/30/83—published 6/8/83, effective 8/1/83]

[Filed emergency 10/7/83—published 10/26/83, effective 11/1/83]

[Filed without Notice 10/7/83—published 10/26/83, effective 12/1/83]

[Filed 11/18/83, Notice 10/12/83—published 12/7/83, effective 2/1/84]

[Filed 4/29/85, Notice 2/27/85—published 5/22/85, effective 7/1/85]

[Filed 1/22/86, Notice 12/4/85—published 2/12/86, effective 4/1/86]

[Filed emergency 1/15/87—published 2/11/87, effective 1/15/87]

[Filed 3/3/87, Notice 12/31/86—published 3/25/87, effective 5/1/87]

[Filed emergency 8/28/87—published 9/23/87, effective 9/1/87]

[Filed emergency 6/9/88—published 6/29/88, effective 7/1/88]

[Filed 9/2/88, Notice 6/29/88—published 9/21/88, effective 11/1/88]

- [Filed emergency 11/23/88 after Notices 7/13/88, 9/21/88—published 12/14/88, effective 1/1/89]
  - [Filed 12/8/88, Notice 10/19/88—published 12/28/88, effective 2/1/89]
  - [Filed 7/14/89, Notice 4/19/89—published 8/9/89, effective 10/1/89]
  - [Filed 9/15/89, Notice 8/9/89—published 10/4/89, effective 12/1/89]
- [Filed emergency 12/15/89 after Notice 10/4/89—published 1/10/90, effective 1/1/90]
  - [Filed 4/13/90, Notice 11/29/90—published 5/2/90, effective 8/1/90]
  - [Filed 7/13/90, Notice 5/16/90—published 8/8/90, effective 10/1/90]
  - [Filed 10/12/90, Notice 8/8/90—published 10/31/90, effective 2/1/91]
    - [Filed emergency 1/17/91—published 2/6/91, effective 2/1/91]
    - [Filed 1/17/91, Notice 11/14/90—published 2/6/91, effective 4/1/91]
    - [Filed 3/14/91, Notice 2/6/91—published 4/3/91, effective 6/1/91]
    - [Filed 6/14/91, Notice 5/1/91—published 7/10/91, effective 9/1/91]
    - [Filed 7/10/91, Notice 5/29/91—published 8/7/91, effective 10/1/91]
    - [Filed 9/18/91, Notice 7/10/91—published 10/16/91, effective 12/1/91]
- [Filed emergency 1/16/92 after Notice 11/27/91—published 2/5/92, effective 3/1/92]
- [Filed emergency 5/13/92 after Notice 4/1/92—published 6/10/92, effective 5/14/92]
  - [Filed emergency 6/12/92—published 7/8/92, effective 7/1/92]
  - [Filed 8/14/92, Notice 7/8/92—published 9/2/92, effective 11/1/92]
  - [Filed 9/11/92, Notice 7/8/92—published 9/30/92, effective 12/1/92]
- [Filed emergency 7/13/93 after Notice 5/12/93—published 8/4/93, effective 8/1/93]
  - [Filed without Notice 8/12/93—published 9/1/93, effective 11/1/93]
  - [Filed 8/12/93, Notices 4/28/93, 7/7/93—published 9/1/93, effective 11/1/93]
- [Filed emergency 12/16/93 after Notice 10/27/93—published 1/5/94, effective 1/1/94]
  - [Filed 12/16/93, Notice 9/1/93—published 1/5/94, effective 3/1/94]
  - [Filed emergency 2/10/94 after Notice 1/5/94—published 3/2/94, effective 3/1/94]
    - [Filed 3/10/94, Notice 2/2/94—published 3/30/94, effective 6/1/94]
    - [Filed 11/9/94, Notice 9/14/94—published 12/7/94, effective 2/1/95]
    - [Filed 12/15/94, Notice 11/9/94—published 1/4/95, effective 3/5/95]
    - [Filed 5/11/95, Notice 3/29/95—published 6/7/95, effective 8/1/95]
- [Filed 11/16/95, Notices 8/2/95, 9/13/95, 9/27/95—published 12/6/95, effective 2/1/96]
  - [Filed 7/10/96, Notice 4/24/96—published 7/31/96, effective 10/1/96]
  - [Filed 10/9/96, Notice 8/14/96—published 11/6/96, effective 1/1/97]
  - [Filed 2/12/97, Notice 12/18/96—published 3/12/97, effective 5/1/97]
  - [Filed 3/12/97, Notices 1/1/97, 1/29/97—published 4/9/97, effective 6/1/97]
- [Filed emergency 5/14/97 after Notice 3/12/97—published 6/4/97, effective 7/1/97]
  - [Filed 6/12/97, Notice 4/23/97—published 7/2/97, effective 9/1/97]
  - [Filed 11/12/97, Notice 9/10/97—published 12/3/97, effective 2/1/98]
  - [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 6/10/98]
  - [Filed 10/14/98, Notice 7/1/98—published 11/4/98, effective 12/9/98]
  - [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 emergency 9/13/99—published 10/6/99, effective 10/1/99]
    - [Filed 11/10/99, Notice 10/6/99—published 12/1/99, effective 2/1/00]
      - [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 9/12/00, Notice 6/14/00—published 10/4/00, effective 12/1/00]
- [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 emergency 6/13/01 after Notice 4/18/01—published 7/11/01, effective 7/1/01]
  - [Filed emergency 6/13/01—published 7/11/01, effective 7/1/01]

- [Filed 6/13/01, Notice 4/18/01—published 7/11/01, effective 9/1/01]
- [Filed 11/14/01, Notice 10/3/01—published 12/12/01, effective 2/1/02]◊
- [Filed 12/12/01, Notice 7/11/01—published 1/9/02, effective 3/1/02]
- [Filed 12/12/01, Notice 10/17/01—published 1/9/02, effective 3/1/02]◊
- [Filed emergency 1/9/02 after Notice 11/14/01—published 2/6/02, effective 2/1/02]
- [Filed 1/9/02, Notice 11/14/01—published 2/6/02, effective 4/1/02]
- [Filed 3/13/02, Notice 1/23/02—published 4/3/02, effective 6/1/02]
- [Filed 7/15/02, Notice 5/1/02—published 8/7/02, effective 10/1/02]
- [Filed emergency 11/18/02—published 12/11/02, effective 12/15/02]
- [Filed emergency 6/12/03—published 7/9/03, effective 7/1/03]
- [Filed 9/22/03, Notice 7/9/03—published 10/15/03, effective 12/1/03]◊
- [Filed emergency 6/14/04 after Notice 4/28/04—published 7/7/04, effective 7/1/04]
- [Filed 8/12/04, Notice 6/23/04—published 9/1/04, effective 11/1/04]
- [Filed without Notice 5/4/05—published 5/25/05, effective 7/1/05]
- [Filed emergency 9/21/05—published 10/12/05, effective 10/1/05]
- [Filed 3/10/06, Notice 10/12/05—published 3/29/06, effective 5/3/06]
- [Filed 4/17/06, Notice 2/15/06—published 5/10/06, effective 7/1/06]
- [Filed emergency 8/10/06 after Notice 3/15/06—published 8/30/06, effective 10/1/06]
- [Filed emergency 9/14/06—published 10/11/06, effective 10/1/06]
- [Filed emergency 10/12/06 after Notice 8/30/06—published 11/8/06, effective 11/1/06]
- [Filed emergency 12/13/06—published 1/3/07, effective 1/1/07]
- [Filed emergency 3/14/07 after Notice 1/3/07—published 4/11/07, effective 4/1/07]
- [Filed 3/14/07, Notice 10/11/06—published 4/11/07, effective 5/16/07]
- [Filed 7/12/07, Notice 5/23/07—published 8/1/07, effective 9/5/07]
- [Filed 8/9/07, Notice 6/20/07—published 8/29/07, effective 11/1/07]
- [Filed 6/11/08, Notice 4/23/08—published 7/2/08, effective 9/1/08]
- [Filed emergency 10/14/08 after Notice 7/16/08—published 11/5/08, effective 12/1/08]
- [Filed 11/12/08, Notice 9/24/08—published 12/3/08, effective 2/1/09]
- [Filed 12/11/08, Notice 10/22/08—published 1/14/09, effective 3/1/09]
- [Filed ARC 7741B (Notice ARC 7526B, IAB 1/28/09), IAB 5/6/09, effective 7/1/09]
- [Filed ARC 7936B (Notice ARC 7653B, IAB 3/25/09), IAB 7/1/09, effective 9/1/09]
- [Filed ARC 9314B (Notice ARC 9112B, IAB 10/6/10), IAB 12/29/10, effective 3/1/11]
- [Filed Emergency After Notice ARC 9440B (Notice ARC 9276B, IAB 12/15/10), IAB 4/6/11,  
effective 4/1/11]
- [Filed ARC 9487B (Notice ARC 9399B, IAB 2/23/11), IAB 5/4/11, effective 7/1/11]
- [Filed Emergency After Notice ARC 9649B (Notice ARC 9538B, IAB 6/1/11), IAB 8/10/11, effective  
8/1/11]
- [Filed Emergency ARC 0191C, IAB 7/11/12, effective 7/1/12]
- [Filed Emergency After Notice ARC 0198C (Notice ARC 0117C, IAB 5/2/12), IAB 7/11/12, effective  
7/1/12]
- [Filed ARC 0358C (Notice ARC 0231C, IAB 7/25/12), IAB 10/3/12, effective 11/7/12]
- [Filed ARC 0360C (Notice ARC 0203C, IAB 7/11/12), IAB 10/3/12, effective 12/1/12]
- [Filed ARC 0359C (Notice ARC 0193C, IAB 7/11/12), IAB 10/3/12, effective 12/1/12]
- [Filed ARC 0485C (Notice ARC 0259C, IAB 8/8/12), IAB 12/12/12, effective 2/1/13]
- [Filed ARC 0545C (Notice ARC 0366C, IAB 10/3/12), IAB 1/9/13, effective 3/1/13]
- [Filed ARC 0580C (Notice ARC 0434C, IAB 10/31/12), IAB 2/6/13, effective 4/1/13]
- [Filed ARC 0757C (Notice ARC 0615C, IAB 2/20/13), IAB 5/29/13, effective 8/1/13]
- [Filed Emergency After Notice ARC 0838C (Notice ARC 0667C, IAB 4/3/13; Amended Notice ARC  
0748C, IAB 5/15/13), IAB 7/24/13, effective 7/1/13]
- [Filed Emergency ARC 0848C, IAB 7/24/13, effective 7/1/13]
- [Filed Emergency After Notice ARC 1071C (Notice ARC 0887C, IAB 7/24/13), IAB 10/2/13,  
effective 10/1/13]

[Filed ARC 1051C (Notice ARC 0847C, IAB 7/24/13), IAB 10/2/13, effective 11/6/13]

◊ Two or more ARCs

<sup>1</sup> December 15, 2002, effective date of 77.37(14)“e”(2) and 77.39(13)“e” delayed 70 days by the Administrative Rules Review Committee at its meeting held December 10, 2002; at its meeting held February 21, 2003, the Committee delayed the effective date until adjournment of the 2003 Session of the General Assembly.



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

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

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

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

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

**78.1(1)** Payment will not be made for:

*a.* Drugs dispensed by a physician or other legally qualified practitioner (dentist, podiatrist, optometrist, physician assistant, or advanced registered nurse practitioner) unless it is established that there is no licensed retail pharmacy in the community in which the legally qualified practitioner's office is maintained. Rate of payment shall be established as in subrule 78.2(2), but no professional fee shall be paid. Payment will not be made for biological 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 Iowa Foundation for Medical Care 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 Iowa Foundation for Medical Care, 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 Iowa Foundation for Medical Care 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 Iowa Foundation for Medical Care (IFMC) 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 IFMC will be granted only if the procedures are determined to be necessary based on the condition of the patient and the published criteria established by the IFMC and the department. If not so approved by the IFMC, 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 IFMC, 6000 Westown Parkway, Suite 350E, West Des Moines, Iowa 50265-7771, or in local hospital utilization review offices.

The “Preprocedure Surgical Review List” shall be published by the department in the provider manuals for physicians, hospitals, and ambulatory surgical centers. The “Preprocedure Surgical Review List” shall be developed by the department with advice and consultation from the IFMC and appropriate professional organizations and will list the procedures for which prior review is required and the steps that must be followed in requesting such review. The department shall update the “Preprocedure Surgical Review List” annually. (Cross-reference 78.28(1) “e.”)

**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 bone marrow transplants for the treatment of aplastic anemia, severe combined immunodeficiency disease, Wiskott-Aldrich syndrome, or the following types of leukemia: acute myelocytic leukemia in relapse or remission, chronic myelogenous leukemia, and acute lymphocytic leukemia in remission.

(3) Autologous bone marrow transplants for treatment of the following conditions: acute leukemia in remission with a high probability of relapse when there is no matched donor; resistant non-Hodgkin’s lymphomas; lymphomas presenting poor prognostic features; recurrent or refractory neuroblastoma; or advanced Hodgkin’s disease when conventional therapy has failed and there is no matched donor.

(4) Liver transplants for persons with extrahepatic biliary arsesia 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 Iowa Foundation for Medical Care. (Cross-reference 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. Artificial hearts and ventricular assist devices, either as a permanent replacement for a human heart or as a temporary life-support system until a human heart becomes available for transplants, 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 and heart-lung transplants described above require preprocedure review by the Iowa Foundation for Medical Care. (Cross-reference 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 Iowa Foundation for Medical Care. (Cross-reference 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 Iowa Foundation for Medical Care. (Cross-reference 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 Dental Terminology, Third Edition (CDT-3), for the purpose of preventing the worsening of early childhood caries in children aged 0 to 36 months of age, when rendered by physicians 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]

**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).

**78.2(5) *Nonprescription drugs.*** 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  
Guaifenesin 100 mg/5 ml with dextromethorphan 10 mg/5 ml liquid  
Ibuprofen suspension 100 mg/5 ml  
Ibuprofen tablets 200 mg  
Insulin  
Lactic acid (ammonium lactate) lotion 12%  
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.

**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]

**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 IFMC 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 IFMC that the lower level of care is required or (b) for the days IFMC 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 IFMC 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 IFMC that the lower level of care is required or (b) for the days IFMC 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 on the “Outpatient/Same Day Surgery List” produced by the Iowa Foundation for Medical Care shall be made only when attending physician has secured approval from the hospital's utilization review department prior to admittance to the hospital. Approval shall be granted 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 Iowa Foundation for Medical Care, 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 Iowa Foundation for Medical Care may add, delete or modify entries on the “Outpatient/Same Day Surgery List.”

**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 IFMC is required if hospitals are to be reimbursed for certain frequently performed surgical procedures as set forth under subrule 78.1(19). Criteria are available from IFMC, 6000 Westown Parkway, Suite 350E, West Des Moines, Iowa 50265-7771, or in local hospital utilization review offices. (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]

**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. Salzman, D.D.S., American Journal of Orthodontics, October 1968.

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

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

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

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

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

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

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

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

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

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

[ARC 9702B, IAB 9/7/11, effective 9/1/11; ARC 9883B, IAB 11/30/11, effective 1/4/12; ARC 0631C, IAB 3/6/13, effective 5/1/13]

**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-9	CATEGORY I	ICD-9	CATEGORY II	ICD-9	CATEGORY III
307.81	Tension headache	353.0	Brachial plexus lesions	721.7	Traumatic spondylopathy
721.0	Cervical spondylosis without myelopathy	353.1	Lumbosacral plexus lesions	722.0	Displacement of cervical intervertebral disc without myelopathy
721.2	Thoracic spondylosis without myelopathy	353.2	Cervical root lesions, NEC	722.10	Displacement of lumbar intervertebral disc without myelopathy
721.3	Lumbosacral spondylosis without myelopathy	353.3	Thoracic root lesions, NEC	722.11	Displacement of thoracic intervertebral disc without myelopathy
723.1	Cervicalgia	353.4	Lumbosacral root lesions, NEC	722.4	Degeneration of cervical intervertebral disc
724.1	Pain in thoracic spine	353.8	Other nerve root and plexus disorders	722.51	Degeneration of thoracic or thoracolumbar intervertebral disc
724.2	Lumbago	719.48	Pain in joint (other specified sites, must specify site)	722.52	Degeneration of lumbar or lumbosacral intervertebral disc
724.5	Backache, unspecified	720.1	Spinal enthesopathy	722.81	Post laminectomy syndrome, cervical region
784.0	Headache	722.91	Calcification of intervertebral cartilage or disc, cervical region	722.82	Post laminectomy syndrome, thoracic region
		722.92	Calcification of intervertebral cartilage or disc, thoracic region	722.83	Post laminectomy syndrome, lumbar region
		722.93	Calcification of intervertebral cartilage or disc, lumbar region	724.3	Sciatica
		723.0	Spinal stenosis in cervical region		
		723.2	Cervicocranial syndrome		
		723.3	Cervicobrachial syndrome		
		723.4	Brachial neuritis or radiculitis, NOC		
		723.5	Torticollis, unspecified		
		724.01	Spinal stenosis, thoracic region		
		724.02	Spinal stenosis, lumbar region		
		724.4	Thoracic or lumbosacral neuritis or radiculitis		
		724.6	Disorders of sacrum, ankylosis		
		724.79	Disorders of coccyx, coccygodynia		

ICD-9 CATEGORY I	ICD-9 CATEGORY II	ICD-9 CATEGORY III
	724.8 Other symptoms referable to back, facet syndrome	
	729.1 Myalgia and myositis, unspecified	
	729.4 Fascitis, unspecified	
	738.40 Acquired spondylolisthesis	
	756.12 Spondylolisthesis	
	846.0 Sprains and strains of sacroiliac region, lumbosacral (joint; ligament)	
	846.1 Sprains and strains of sacroiliac region, sacroiliac ligament	
	846.2 Sprains and strains of sacroiliac region, sacrospinatus (ligament)	
	846.3 Sprains and strains of sacroiliac region, sacrotuberous (ligament)	
	846.8 Sprains and strains of sacroiliac region, other specified sites of sacroiliac region	
	847.0 Sprains and strains, neck	
	847.1 Sprains and strains, thoracic	
	847.2 Sprains and strains, lumbar	
	847.3 Sprains and strains, sacrum	
	847.4 Sprains and strains, coccyx	

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.

**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 62 days thereafter. 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 62 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.**

a. Payment shall be made for medical social work services when all of the following conditions are met and the problems are not responding to medical treatment and there does not appear to be a medical reason for the lack of response. The services:

- (1) Are reasonable and necessary to the treatment of a member's illness or injury.
- (2) Contribute meaningfully to the treatment of the member's condition.
- (3) Are under the direction of a physician.
- (4) Are provided by or under the supervision of a qualified medical or psychiatric social worker.
- (5) Address social problems that are impeding the member's recovery.

b. Medical social services directed toward minimizing the problems an illness may create for the member and family, e.g., encouraging them to air their concerns and providing them with reassurance, are not considered reasonable and necessary to the treatment of the patient's illness or injury.

**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, hemaplegic, activity-limiting disease, sickle cell anemia, uncontrolled hypertension, uncontrolled diabetes, mental illness, or mental retardation.
- (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 mental retardation.

(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) Mental retardation 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]

**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.

**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.

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]

**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 an Axis I psychological disorder, subject to the limitations in this rule.

**78.12(1) Definitions.**

“*Axis I disorder*” means a diagnosed mental disorder, except for personality disorders and mental retardation, as set forth in the “Diagnostic and Statistical Manual IV-TR,” Fourth Edition.

“*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 Axis I 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.), 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:

1. Is licensed by the applicable state authority for that profession;
2. Is enrolled in the Iowa Plan for Behavioral Health (Iowa Plan) pursuant to 441—Chapter 88, Division IV; and
3. Is qualified to provide clinical assessment services (Current Procedural Terminology code 90801) under the Iowa Plan pursuant to 441—Chapter 88, Division IV.

**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 provided in connection with this rule for members enrolled in the Iowa Plan are covered services under the Iowa Plan pursuant to 441—Chapter 88, Division IV.

*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 an Axis I 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]

**441—78.13(249A) Nonemergency medical transportation.** Nonemergency transportation to receive medical care, including any reimbursement of transportation expenses incurred by a Medicaid member, shall be provided through the broker designated by the department pursuant to a contract between the department and the broker, as specified in this rule.

**78.13(1) Member request.** When a member needs nonemergency transportation, one way or round trip, to receive medical care provided by the Medicaid program, including any reimbursement of transportation expenses incurred by the member, the member must contact the broker in advance. The broker shall establish and publicize the procedures for members to request transportation services. The broker is required to provide transportation within 72 hours of a request only if receipt of medical care within 72 hours is medically necessary.

**78.13(2) Necessary services.** Transportation shall be provided only when the member needs transportation to receive necessary services covered by the Iowa Medicaid program from an enrolled provider, including transportation needed to obtain prescribed drugs.

**78.13(3) Access to free transportation.** Transportation shall be provided only if the member does not have access to transportation that is available at no cost to the member, such as transportation provided by volunteers, relatives, friends, social service agencies, nursing facilities, residential care centers, or any

other source. EXCEPTION: If a prescribed drug is needed immediately, transportation will be provided to obtain the drug even if free delivery is available.

**78.13(4) *Closest medical provider.*** Transportation beyond 20 miles (one way) shall be provided only to the closest qualified provider unless:

*a.* The difference between the closest qualified provider and the provider requested by the member is less than 10 miles (one way); or

*b.* The additional cost of transportation to the provider requested by the member is medically justified based on:

- (1) A previous relationship between the member and the requested provider,
- (2) Prior experience of the member with closer providers, or
- (3) Special expertise or experience of the requested provider.

**78.13(5) *Coverage.*** Based on the information provided by the member and the provisions of this rule, the broker shall arrange and reimburse for the most economical form of transportation appropriate to the needs of the member.

*a.* The broker may require that public transportation be used when reasonably available and the member's condition does not preclude its use.

*b.* The broker may arrange and reimburse for transportation by arranging to reimburse the member for transportation expenses. In that case, the member shall submit transportation expenses to the broker on Form 470-0386, Medical Transportation Claim, or an equivalent electronic form.

*c.* When a member is unable to travel alone due to age or due to physical or mental incapacity, the broker shall provide for the expenses of an attendant.

*d.* The broker shall provide for meals, lodging, and other incidental transportation expenses required for the member and for any attendant required due to the age or incapacity of the member in connection with transportation provided under this rule.

**78.13(6) *Exceptions for nursing facility residents.***

*a.* Nonemergency medical transportation for residents of nursing facilities within 30 miles of the nursing facility (one way) shall not be provided through the broker but shall be the responsibility of the nursing facility.

*b.* Nonemergency medical transportation for residents of nursing facilities beyond 30 miles from the nursing facility (one way) shall be provided through the broker, but the nursing facility shall contact the broker on behalf of the resident.

**78.13(7) *Grievances.*** Pursuant to its contract with the department, the broker shall establish an internal grievance procedure for members and transportation providers. Members who have exhausted the grievance process may appeal to the department pursuant to 441—Chapter 7 as an “aggrieved person.” For transportation providers, the grievance process shall end with binding arbitration, with a designee of the Iowa Medicaid enterprise as arbitrator.

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

[ARC 8344B, IAB 12/2/09, effective 12/1/09; ARC 8643B, IAB 4/7/10, effective 3/11/10; ARC 8994B, IAB 8/11/10, effective 10/1/10]

**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 Web site.

**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 Iowa Foundation for Medical Care (IFMC) 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 IFMC, 1776 West Lakes Parkway, West Des Moines, Iowa 50266-8239, or in local hospital utilization review offices. (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]

**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 Plan for Behavioral Health.

**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.

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

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

*"Comprehensive service plan"* means an individualized, 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.

*"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.

*"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.

“*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.

**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 member’s case manager or integrated health home care coordinator has completed an assessment of the member’s need for service, and, based on that assessment, the Iowa Medicaid enterprise medical services unit or the Iowa Plan for Behavioral Health contractor has determined that the member is in need of home- and community-based habilitation services. A member who is not eligible for integrated health home services shall receive Medicaid case management under 441—Chapter 90 as a home- and community-based habilitation service. The designated case manager or integrated health home care coordinator shall:

(1) Complete a needs-based evaluation that meets the standards for assessment established in 441—subrule 90.5(1) before services begin and annually thereafter.

(2) Use the evaluation results to develop a comprehensive service plan as specified in subrule 78.27(4).

*e. Plan for service.* The department or the Iowa Plan for Behavioral Health contractor has approved the member’s 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 or in a treatment plan that has been authorized by the Iowa Plan for Behavioral Health contractor 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).

*f. Iowa Plan for Behavioral Health eligibility.* Members eligible to enroll in the Iowa Plan for Behavioral Health shall be eligible to receive home- and community-based habilitation services only through the Iowa Plan for Behavioral Health.

**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 Iowa Plan for Behavioral Health contractor or by entering a program request for habilitation services in ISIS for members who are not eligible to enroll in the Iowa Plan for Behavioral Health for any reason. The department or the Iowa Plan for Behavioral Health contractor shall issue a notice of decision to the applicant when financial eligibility, determination of needs-based eligibility, and approval of the comprehensive service plan or treatment plan 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 for the member. 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.

(2) With 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 Iowa Plan for Behavioral Health contractor, or by the Iowa Medicaid enterprise for members who are not eligible to enroll in the Iowa Plan for Behavioral Health, in the individualized services information system 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, integrated health home care coordinator, or service worker within 30 calendar days after plan approval.

(10) Any changes to the comprehensive service plan or treatment plan must be approved by the Iowa Plan for Behavioral Health contractor, or by the Iowa Medicaid enterprise for members not eligible to enroll in the Iowa Plan for Behavioral Health, in the individualized services information system 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.*

- (1) A treatment plan that has been validated and authorized by the Iowa Plan for Behavioral Health contractor shall be considered approved.
- (2) For members who are not Iowa Plan-eligible, 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 a nonresidential setting separate from the member's residence. Services shall not be provided in the member's home. When the member lives in a residential care facility of more than 16 beds, day habilitation services provided in the facility are not considered to be provided in the member's home if the services are provided in an area apart from the member's sleeping accommodations.

*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 habilitation.** "Prevocational habilitation" means services that prepare a member for paid or unpaid employment.

*a. Scope.* Prevocational habilitation services include teaching concepts such as compliance, attendance, task completion, problem solving, and safety. Services are not oriented to a specific job task, but instead are aimed at a generalized result. Services shall be reflected in the member's comprehensive service plan and shall be directed to habilitative objectives rather than to explicit employment objectives.

*b. Setting.* Prevocational habilitation services may be provided in a variety of community-based settings based on the individual need of the member. Meals provided as part of these services shall not constitute a full nutritional regimen (three meals per day).

*c. Exclusions.* Prevocational habilitation payment shall not be made for the following:

- (1) Services that are available 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 for the service under these programs shall be maintained in the file of each member receiving prevocational habilitation 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 prevocational services.

**78.27(10) Supported employment habilitation.** "Supported employment habilitation" means services associated with maintaining competitive paid employment.

*a. Scope.* Supported employment habilitation services are intensive, ongoing supports that enable members to perform in a regular work setting. Services are provided to members who need support because of their disabilities and who are unlikely to obtain competitive employment at or above the minimum wage absent the provision of supports. Covered services include:

(1) Activities to obtain a job. Covered services directed to obtaining a job must be provided to or on behalf of a member for whom competitive employment is reasonably expected within less than one year. Services must be focused on job placement, not on teaching generalized employment skills or habilitative goals. Three conditions must be met before services are provided. First, the member and the interdisciplinary team described in subrule 78.27(4) must complete the form that Iowa vocational rehabilitation services uses to identify the supported employment services appropriate to meet a person's employment needs. Second, the member's interdisciplinary team must determine that the identified services are necessary. Third, the Iowa Medicaid enterprise medical services unit must approve the services. Available components of activities to obtain a job are as follows:

1. Job development services. Job development services are directed toward obtaining competitive employment. A unit of service is a job placement that the member holds for 30 consecutive calendar days

or more. Payment is available once the service is authorized in the member's service plan. A member may receive two units of job development services during a 12-month period. The activities provided to the member may include job procurement training, including grooming and hygiene, application, résumé development, interviewing skills, follow-up letters, and job search activities; job retention training, including promptness, coworker relations, transportation skills, disability-related supports, job benefits, and an understanding of employee rights and self-advocacy; and customized job development services specific to the member.

2. Employer development services. The focus of employer development services is to support employers in hiring and retaining members in their workforce and to communicate expectations of the employers to the interdisciplinary team described in subrule 78.27(4). Employer development services may be provided only to members who are reasonably expected to work for no more than 10 hours per week. A unit of service is one job placement that the member holds for 30 consecutive calendar days or more. Payment for this service may be made only after the member holds the job for 30 days. A member may receive two units of employer development services during a 12-month period if the member is competitively employed for 30 or more consecutive calendar days and the other conditions for service approval are met. The services provided may include: developing relationships with employers and providing leads for individual members when appropriate; job analysis for a specific job; development of a customized training plan identifying job-specific skill requirements, employer expectations, teaching strategies, time frames, and responsibilities; identifying and arranging reasonable accommodations with the employer; providing disability awareness and training to the employer when it is deemed necessary; and providing technical assistance to the employer regarding the training progress as identified on the member's customized training plan.

3. Enhanced job search activities. Enhanced job search activities are associated with obtaining initial employment after job development services have been provided to the member for a minimum of 30 days or with assisting the member in changing jobs due to layoff, termination, or personal choice. The interdisciplinary team must review and update the Iowa vocational rehabilitation services supported employment readiness analysis form to determine if this service remains appropriate for the member's employment goals. A unit of service is 15 minutes. A maximum of 104 units may be provided in a 12-month period. The services provided may include: job opening identification with the member; assistance with applying for a job, including completion of applications or interviews; and work site assessment and job accommodation evaluation.

(2) Supports to maintain employment, including the following services provided to or on behalf of the member:

1. Individual work-related behavioral management.
2. Job coaching.
3. On-the-job or work-related crisis intervention.
4. Assistance in the use of skills related to sustaining competitive paid employment, including assistance with communication skills, problem solving, and safety.
5. Assistance with time management.
6. Assistance with appropriate grooming.
7. Employment-related supportive contacts.
8. On-site vocational assessment after employment.
9. Employer consultation.

b. *Setting.* Supported employment may be conducted in a variety of settings, particularly work sites where persons without disabilities are employed.

(1) The majority of coworkers at any employment site with more than two employees where members seek, obtain, or maintain employment must be persons without disabilities.

(2) In the performance of job duties at any site where members seek, obtain, or maintain employment, the member must have daily contact with other employees or members of the general public who do not have disabilities, unless the absence of daily contact with other employees or the general public is typical for the job as performed by persons without disabilities.

(3) When services for maintaining employment are provided to members in a teamwork or “enclave” setting, the team shall include no more than eight people with disabilities.

*c. Service requirements.* The following requirements shall apply to all supported employment services:

(1) All supported employment services shall provide individualized and ongoing support contacts at intervals necessary to promote successful job retention.

(2) The provider shall provide employment-related adaptations required to assist the member in the performance of the member’s job functions as part of the service.

(3) Community transportation options (such as carpools, coworkers, self or public transportation, families, volunteers) shall be attempted before the service provider provides transportation. When no other resources are available, employment-related transportation between work and home and to or from activities related to employment may be provided as part of the service.

(4) Members may access both services to maintain employment and services to obtain a job for the purpose of job advancement or job change. A member may receive a maximum of three job placements in a 12-month period and a maximum of 40 units per week of services to maintain employment.

*d. Exclusions.* Supported employment habilitation payment shall not be made for the following:

(1) Services that are available 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 under these programs shall be maintained in the file of each member receiving supported employment services.

(2) Incentive payments 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 or maintaining members in day activity programs, work activity programs, or sheltered workshop programs.

(6) Supports for volunteer work or unpaid internships.

(7) Tuition for education or vocational training.

(8) Individual advocacy that is not member-specific.

**78.27(11)** *Adverse service actions.*

*a. Denial.* Services shall be denied when the department or the Iowa Plan for Behavioral Health contractor 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 or the Iowa Plan for Behavioral Health contractor 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 or the Iowa Plan for Behavioral Health contractor 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

or the Iowa Plan for Behavioral Health contractor 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.*

(1) The Iowa Plan for Behavioral Health contractor shall give notice of any adverse action and the right to appeal in accordance with 441—Chapter 7.

(2) 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]

**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 Iowa Foundation for Medical Care (IFMC) 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 IFMC will be granted only if the procedures are determined to be necessary based on the condition of the patient and on the published criteria established by the department and the IFMC. If not so approved by the IFMC, 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 IFMC, 3737 Woodland Avenue, Suite 500, West Des Moines, Iowa 50265, or in local hospital utilization review offices.

The “Preprocedure Surgical Review List” shall be published by the department in the provider manuals for physicians, hospitals, and ambulatory surgical centers. (Cross-reference 78.1(19))

*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.

**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 preadmission review. Payment for inpatient hospital admissions is approved when it meets the criteria for inpatient hospital care as determined by the

IFMC or its delegated hospitals. Criteria are available from IFMC, 6000 Westown Parkway, Suite 350E, West Des Moines, Iowa 50265-7771, or in local hospital utilization review offices. (Cross-reference 441—78.3(249A))

c. Preprocedure review by the IFMC 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 IFMC will be granted only if the procedures are determined to be necessary based on the condition of the patient and the criteria established by the department and IFMC. 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(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)** Rescinded IAB 1/3/96, effective 3/1/96.

**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")

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]

**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 Iowa Foundation for Medical Care. 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, bulimia, or bulimarexia. Compulsive overeaters are not acceptable 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 as established by the DSM III R (Diagnostic and Statistical Manual, Third Edition, Revised).

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

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

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

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

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

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

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

Hematologic considerations including anemia, leukopenia, or thrombocytopenia.

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

Skin considerations including lanugo or dry skin.

Aspiration pneumonia, a pulmonary factor.

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

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

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

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

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

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

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

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

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

*c.* Cardiac rehabilitation.

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

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

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

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

A cardiac rehabilitation nurse shall carry out the exercise prescription after assessment of the patient. The nurse shall be able to interpret cardiac 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]

**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.**

**78.33(1)** Payment will be approved for targeted case management services that are provided pursuant to 441—Chapter 90 to:

- a.* Members who are 18 years of age or over and have a primary diagnosis of mental retardation, developmental disabilities, or chronic mental illness as defined in rule 441—90.1(249A).
- b.* Members who are under 18 years of age and are receiving services under the HCBS intellectual disability waiver or children's mental health waiver.

**78.33(2)** Notwithstanding subrule 78.33(1), payment shall not be made for targeted case management services for members who are enrolled in the Iowa Plan for Behavioral Health to receive habilitation pursuant to rule 441—78.27(249A) and are enrolled in an integrated health home as described in rule 441—78.53(249A). Members enrolled in the Iowa Plan for Behavioral Health for habilitation and an integrated health home shall receive care coordination in lieu of case management.

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]

**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.

**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.* 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.

*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 only in the member's home; in a registered child development home; in 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.

(1) Payment of up to \$6,366.64 per year may be made to certified providers upon satisfactory completion of the service.

(2) The case manager or service worker shall encumber a portion of the cost of a modification every month within the monthly dollar cap allowed for the member until the entire cost of the modification is encumbered within a consecutive 12-month period.

*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 maximum of two meals is allowed per day. A unit of service is a meal.

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

**78.34(13) Consumer choices option.** The consumer choices option provides a member with a flexible monthly individual budget that is based on the member's service needs. With the individual budget, the member shall have the authority to purchase goods and services to meet the member's assessed needs and may choose to employ providers of services and supports. The services, supports, and items that are purchased with an individual budget must be directly related to a member's assessed need or goal established in the member's service plan. Components of this service are set forth below.

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

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

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

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

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

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

(4) The department shall compute the utilization adjustment factor for each service by dividing the net costs of all claims paid for the service by the total of the authorized costs for that service, using at least 12 consecutive months of aggregate service data. The utilization adjustment factor shall be no lower than 60 percent. The department shall analyze and adjust the utilization adjustment factor at least annually in order to maintain cost neutrality.

(5) Individual budgets for respite services shall be computed based on the average cost for services identified in subparagraph 78.34(13)“b”(2). Respite services are not subject to the utilization adjustment factor in subparagraph 78.34(13)“b”(3).

(6) Anticipated costs for home and vehicle modification are not subject to the average cost in subparagraph 78.34(13)“b”(2) or the utilization adjustment factor in subparagraph 78.34(13)“b”(3). Anticipated costs for home and vehicle modification shall not include the costs of the financial management services or the independent support broker. Before becoming part of the individual budget, all home and vehicle modifications shall be identified in the member’s service plan and approved by the case manager or service worker. Costs for home and vehicle modification may be paid to the financial management services provider in a one-time payment.

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

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

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

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

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

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

1. Promote opportunities for community living and inclusion.
2. Increase independence or substitute for human assistance, to the extent the expenditures would otherwise be made for that human assistance.

3. Be accommodated within the member's budget without compromising the member's health and safety.

4. Be provided to the member or directed exclusively toward the benefit of the member.

5. Be the least costly to meet the member's needs.

6. Not be available through another source.

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

(1) The costs of the financial management service.

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

(3) The costs of any optional service component chosen by the member as described in paragraph 78.34(13) "d." Costs of the following items and services shall not be covered by the individual budget:

1. Child care services.

2. Clothing not related to an assessed medical need.

3. Conference, meeting or similar venue expenses other than the costs of approved services the member needs while attending the conference, meeting or similar venue.

4. Costs associated with shipping items to the member.

5. Experimental and non-FDA-approved medications, therapies, or treatments.

6. Goods or services covered by other Medicaid programs.

7. Home furnishings.

8. Home repairs or home maintenance.

9. Homeopathic treatments.

10. Insurance premiums or copayments.

11. Items purchased on installment payments.

12. Motorized vehicles.

13. Nutritional supplements.

14. Personal entertainment items.

15. Repairs and maintenance of motor vehicles.

16. Room and board, including rent or mortgage payments.

17. School tuition.

18. Service animals.

19. Services covered by third parties or services that are the responsibility of a non-Medicaid program.

20. Sheltered workshop services.

21. Social or recreational purchases not related to an assessed need or goal identified in the member's service plan.

22. Vacation expenses, other than the costs of approved services the member needs while on vacation.

(4) The costs of any approved home or vehicle modification. When authorized, the budget may include an amount allocated for a home or vehicle modification. Before becoming part of the individual budget, all home and vehicle modifications shall be identified in the member's service plan and approved by the case manager or service worker. The authorized amount shall not be used for anything other than the specific modification.

(5) Any amount set aside in a savings plan to reserve funds for the future purchase of self-directed personal care, individual-directed goods and services, or self-directed community supports and services as defined in paragraph 78.34(13) "d." The savings plan shall meet the requirements in paragraph 78.34(13) "f."

*f. Savings plan.* A member savings plan must be in writing and be approved by the department before the start of the savings plan. Amounts allocated to the savings plan must result from efficiencies in meeting identified needs of the member.

- (1) The savings plan shall identify:
  1. The specific goods, services, supports or supplies to be purchased through the savings plan.
  2. The amount of the individual budget allocated each month to the savings plan.
  3. The amount of the individual budget allocated each month to meet the member's identified service needs.
  4. How the member's assessed needs will continue to be met through the individual budget when funds are placed in savings.

(2) With the exception of funds allocated for respite care, the savings plan shall not include funds budgeted for direct services that were not received. The budgeted amount associated with unused direct services other than respite care shall revert to the Medicaid program at the end of each month. Funds from unused respite services may be allocated to the savings plan but shall not be used for anything other than future respite care.

(3) Funds accumulated under a savings plan shall be used only to purchase items that increase independence or substitute for human assistance to the extent that expenditures would otherwise be made for human assistance, including additional goods, supports, services or supplies. The self-directed personal care, individual-directed goods and services, or self-directed community supports and services purchased with funds from a savings plan must:

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

(4) All funds allocated to a savings plan that are not expended by December 31 of each year shall revert to the Medicaid program.

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

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

- (1) Contract with entities to provide services and supports as described in this subrule.
- (2) Determine the amount to be paid for services. Reimbursement rates shall be consistent with rates paid by others in the community for the same or substantially similar services. Reimbursement rates for the independent support broker and the financial management service are subject to the limits in 441—subrule 79.1(2).

(3) Schedule the provision of services.

(4) Authorize payment for optional service components identified in the individual budget.

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

*h. Delegation of budget authority.* The member may delegate responsibility for the individual budget to a representative in addition to the independent support broker.

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

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

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

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

*i. Employer authority.* The member shall have the authority to be the common-law employer of employees providing services and support under the consumer choices option. A common-law employer has the right to direct and control the performance of the services. The member may perform the following functions:

(1) Recruit employees.

(2) Select employees from a worker registry.

(3) Verify employee qualifications.

(4) Specify additional employee qualifications.

(5) Determine employee duties.

- (6) Determine employee wages and benefits.
- (7) Schedule employees.
- (8) Train and supervise employees.

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

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

- (1) Assist the member with developing the member's initial and subsequent individual budgets and with making any changes to the individual budget.
- (2) Have monthly contact with the member for the first four months of implementation of the initial individual budget and have quarterly contact thereafter.
- (3) Complete the required employment packet with the financial management service.
- (4) Assist with interviewing potential employees and entities providing services and supports if requested by the member.
- (5) Assist the member with determining whether a potential employee meets the qualifications necessary to perform the job.
- (6) Assist the member with obtaining a signed consent from a potential employee to conduct background checks if requested by the member.
- (7) Assist the member with negotiating with entities providing services and supports if requested by the member.
- (8) Assist the member with contracts and payment methods for services and supports if requested by the member.
- (9) Assist the member with developing an emergency backup plan. The emergency backup plan shall address any health and safety concerns.
- (10) Review expenditure reports from the financial management service to ensure that services and supports in the individual budget are being provided.
- (11) Document in writing on the independent support broker timecard every contact the broker has with the member. Contact documentation shall include information on the extent to which the member's individual budget has addressed the member's needs and the satisfaction of the member.

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

- (1) Receive Medicaid funds in an electronic transfer.
- (2) Process and pay invoices for approved goods and services included in the individual budget.
- (3) Enter the individual budget into the Web-based tracking system chosen by the department and enter expenditures as they are paid.
- (4) Provide real-time individual budget account balances for the member, the independent support broker, and the department, available at a minimum during normal business hours (9 a.m. to 5 p.m., Monday through Friday).
- (5) Conduct criminal background checks on potential employees pursuant to 441—Chapter 119.
- (6) Verify for the member an employee's citizenship or alien status.
- (7) Assist the member with fiscal and payroll-related responsibilities including, but not limited to:
  1. Verifying that hourly wages comply with federal and state labor rules.
  2. Collecting and processing timecards.
  3. Withholding, filing, and paying federal, state and local income taxes, Medicare and Social Security (FICA) taxes, and federal (FUTA) and state (SUTA) unemployment and disability insurance taxes, as applicable.
  4. Computing and processing other withholdings, as applicable.
  5. Processing all judgments, garnishments, tax levies, or other withholding on an employee's pay as may be required by federal, state, or local laws.
  6. Preparing and issuing employee payroll checks.
  7. Preparing and disbursing IRS Forms W-2 and W-3 annually.

8. Processing federal advance earned income tax credit for eligible employees.
9. Refunding over-collected FICA, when appropriate.
10. Refunding over-collected FUTA, when appropriate.
- (8) Assist the member in completing required federal, state, and local tax and insurance forms.
- (9) Establish and manage documents and files for the member and the member's employees.
- (10) Monitor timecards, receipts, and invoices to ensure that they are consistent with the individual budget. Keep records of all timecards and invoices for each member for a total of five years.
- (11) Provide to the department, the independent support broker, and the member monthly and quarterly status reports that include a summary of expenditures paid and amount of budget unused.
- (12) Establish an accessible customer service system and a method of communication for the member and the independent support broker that includes alternative communication formats.
- (13) Establish a customer services complaint reporting system.
- (14) Develop a policy and procedures manual that is current with state and federal regulations and update as necessary.
- (15) Develop a business continuity plan in the case of emergencies and natural disasters.
- (16) Provide to the department an annual independent audit of the financial management service.
- (17) Assist in implementing the state's quality management strategy related to the financial management service.

**78.34(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. Services must be billed in whole units.
- d. 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]

**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, 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.

**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.

**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 maximum of two meals is allowed per day. A unit of service is a meal.

**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, to receive medical services when not reimbursed through nonemergency medical transportation, 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.* 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.

(5) 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.

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

- (1) Retain accountability for actions that are delegated.
- (2) Ensure appropriate assessment, planning, implementation, and evaluation.
- (3) Make on-site supervisory visits every two weeks with the service provider present.

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

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

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

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

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

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

- (1) Dressing.
- (2) Bathing, shampooing, hygiene, and grooming.
- (3) Access to and from bed or a wheelchair, transferring, ambulation, and mobility in general.
- (4) Toileting, including bowel, bladder, and catheter assistance (emptying the catheter bag, collecting a specimen, and cleaning the external area around the catheter).
- (5) Meal preparation, cooking, and assistance with feeding, not including the cost of meals themselves. Meal preparation and cooking shall be provided only in the member's home.
- (6) Housekeeping, laundry, and shopping essential to the member's health care at home.
- (7) Taking medications ordinarily self-administered, including those ordered by a physician or other qualified health care provider.
- (8) Minor wound care.

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

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

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

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

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

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

(2) Intravenous therapy administered by a registered nurse.

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

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

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

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

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

(8) Colostomy care.

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

(10) Postsurgical nursing care.

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

(12) Preparing and monitoring response to therapeutic diets.

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

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

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

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

(3) Costs of food.

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

(5) Exercise that does not require skilled services.

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

(7) Reminders and cueing.

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

(9) Transportation costs.

(10) Wait times for any activity.

**78.37(16) Consumer choices option.** The consumer choices option provides a member with a flexible monthly individual budget that is based on the member's service needs. With the individual budget, the member shall have the authority to purchase goods and services to meet the member's assessed needs and may choose to employ providers of services and supports. The services, supports,

and items that are purchased with an individual budget must be directly related to a member's assessed need or goal established in the member's service plan. Components of this service are set forth below.

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

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

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

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

(2) The department shall determine an average unit cost for each service listed in subparagraph 78.37(16) "b"(1) based on actual unit costs from the previous fiscal year plus a cost-of-living adjustment.

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

(4) The department shall compute the utilization adjustment factor for each service by dividing the net costs of all claims paid for the service by the total of the authorized costs for that service, using at least 12 consecutive months of aggregate service data. The utilization adjustment factor shall be no lower than 60 percent. The department shall analyze and adjust the utilization adjustment factor at least annually in order to maintain cost neutrality.

(5) Individual budgets for respite services shall be computed based on the average cost for services identified in subparagraph 78.37(16) "b"(2). Respite services are not subject to the utilization adjustment factor in subparagraph 78.37(16) "b"(3).

(6) Anticipated costs for home and vehicle modification and assistive devices are not subject to the average cost in subparagraph 78.37(16) "b"(2) or the utilization adjustment factor in subparagraph 78.37(16) "b"(3). Anticipated costs for home and vehicle modification and assistive devices shall not include the costs of the financial management services or the independent support broker. Before becoming part of the individual budget, all home and vehicle modifications and assistive devices shall be identified in the member's service plan and approved by the case manager or service worker. Costs for home and vehicle modification and assistive devices may be paid to the financial management services provider in a one-time payment.

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

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

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

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

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

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

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

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

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

(3) The costs of any optional service component chosen by the member as described in paragraph 78.37(16) "d." Costs of the following items and services shall not be covered by the individual budget:

1. Child care services.
2. Clothing not related to an assessed medical need.
3. Conference, meeting or similar venue expenses other than the costs of approved services the member needs while attending the conference, meeting or similar venue.
4. Costs associated with shipping items to the member.
5. Experimental and non-FDA-approved medications, therapies, or treatments.
6. Goods or services covered by other Medicaid programs.
7. Home furnishings.
8. Home repairs or home maintenance.
9. Homeopathic treatments.
10. Insurance premiums or copayments.
11. Items purchased on installment payments.
12. Motorized vehicles.
13. Nutritional supplements.
14. Personal entertainment items.
15. Repairs and maintenance of motor vehicles.
16. Room and board, including rent or mortgage payments.
17. School tuition.
18. Service animals.
19. Services covered by third parties or services that are the responsibility of a non-Medicaid program.
20. Sheltered workshop services.

21. Social or recreational purchases not related to an assessed need or goal identified in the member's service plan.

22. Vacation expenses, other than the costs of approved services the member needs while on vacation.

(4) The costs of any approved home or vehicle modification or assistive device. When authorized, the budget may include an amount allocated for a home or vehicle modification or an assistive device. Before becoming part of the individual budget, all home and vehicle modifications and assistive devices shall be identified in the member's service plan and approved by the case manager or service worker. The authorized amount shall not be used for anything other than the specific modification or device.

(5) Any amount set aside in a savings plan to reserve funds for the future purchase of self-directed personal care, individual-directed goods and services, or self-directed community supports and services as defined in paragraph 78.37(16) "d." The savings plan shall meet the requirements in paragraph 78.37(16) "f."

*f. Savings plan.* A member savings plan must be in writing and be approved by the department before the start of the savings plan. Amounts allocated to the savings plan must result from efficiencies in meeting identified needs of the member.

(1) The savings plan shall identify:

1. The specific goods, services, supports or supplies to be purchased through the savings plan.

2. The amount of the individual budget allocated each month to the savings plan.

3. The amount of the individual budget allocated each month to meet the member's identified service needs.

4. How the member's assessed needs will continue to be met through the individual budget when funds are placed in savings.

(2) With the exception of funds allocated for respite care, the savings plan shall not include funds budgeted for direct services that were not received. The budgeted amount associated with unused direct services other than respite care shall revert to the Medicaid program at the end of each month. Funds from unused respite services may be allocated to the savings plan but shall not be used for anything other than future respite care.

(3) Funds accumulated under a savings plan shall be used only to purchase items that increase independence or substitute for human assistance to the extent that expenditures would otherwise be made for human assistance, including additional goods, supports, services or supplies. The self-directed personal care, individual-directed goods and services, or self-directed community supports and services purchased with funds from a savings plan must:

1. Be used to meet a member's identified need,

2. Be medically necessary, and

3. Be approved by the member's case manager or service worker.

(4) All funds allocated to a savings plan that are not expended by December 31 of each year shall revert to the Medicaid program.

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

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

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

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

(3) Schedule the provision of services.

(4) Authorize payment for optional service components identified in the individual budget.

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

*h. Delegation of budget authority.* The member may delegate responsibility for the individual budget to a representative in addition to the independent support broker.

- (1) The representative must be at least 18 years old.
- (2) The representative shall not be a current provider of service to the member.
- (3) The member shall sign a consent form that designates who the member has chosen as a representative and what responsibilities the representative shall have.
- (4) The representative shall not be paid for this service.

*i. Employer authority.* The member shall have the authority to be the common-law employer of employees providing services and support under the consumer choices option. A common-law employer has the right to direct and control the performance of the services. The member may perform the following functions:

- (1) Recruit employees.
- (2) Select employees from a worker registry.
- (3) Verify employee qualifications.
- (4) Specify additional employee qualifications.
- (5) Determine employee duties.
- (6) Determine employee wages and benefits.
- (7) Schedule employees.
- (8) Train and supervise employees.

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

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

- (1) Assist the member with developing the member's initial and subsequent individual budgets and with making any changes to the individual budget.
- (2) Have monthly contact with the member for the first four months of implementation of the initial individual budget and have quarterly contact thereafter.
- (3) Complete the required employment packet with the financial management service.
- (4) Assist with interviewing potential employees and entities providing services and supports if requested by the member.
- (5) Assist the member with determining whether a potential employee meets the qualifications necessary to perform the job.
- (6) Assist the member with obtaining a signed consent from a potential employee to conduct background checks if requested by the member.
- (7) Assist the member with negotiating with entities providing services and supports if requested by the member.
- (8) Assist the member with contracts and payment methods for services and supports if requested by the member.
- (9) Assist the member with developing an emergency backup plan. The emergency backup plan shall address any health and safety concerns.
- (10) Review expenditure reports from the financial management service to ensure that services and supports in the individual budget are being provided.
- (11) Document in writing on the independent support broker timecard every contact the broker has with the member. Contact documentation shall include information on the extent to which the member's individual budget has addressed the member's needs and the satisfaction of the member.

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

- (1) Receive Medicaid funds in an electronic transfer.
- (2) Process and pay invoices for approved goods and services included in the individual budget.
- (3) Enter the individual budget into the Web-based tracking system chosen by the department and enter expenditures as they are paid.

- (4) Provide real-time individual budget account balances for the member, the independent support broker, and the department, available at a minimum during normal business hours (9 a.m. to 5 p.m., Monday through Friday).
- (5) Conduct criminal background checks on potential employees pursuant to 441—Chapter 119.
- (6) Verify for the member an employee's citizenship or alien status.
- (7) Assist the member with fiscal and payroll-related responsibilities including, but not limited to:
  1. Verifying that hourly wages comply with federal and state labor rules.
  2. Collecting and processing timecards.
  3. Withholding, filing, and paying federal, state and local income taxes, Medicare and Social Security (FICA) taxes, and federal (FUTA) and state (SUTA) unemployment and disability insurance taxes, as applicable.
  4. Computing and processing other withholdings, as applicable.
  5. Processing all judgments, garnishments, tax levies, or other withholding on an employee's pay as may be required by federal, state, or local laws.
  6. Preparing and issuing employee payroll checks.
  7. Preparing and disbursing IRS Forms W-2 and W-3 annually.
  8. Processing federal advance earned income tax credit for eligible employees.
  9. Refunding over-collected FICA, when appropriate.
  10. Refunding over-collected FUTA, when appropriate.
- (8) Assist the member in completing required federal, state, and local tax and insurance forms.
- (9) Establish and manage documents and files for the member and the member's employees.
- (10) Monitor timecards, receipts, and invoices to ensure that they are consistent with the individual budget. Keep records of all timecards and invoices for each member for a total of five years.
- (11) Provide to the department, the independent support broker, and the member monthly and quarterly status reports that include a summary of expenditures paid and amount of budget unused.
- (12) Establish an accessible customer service system and a method of communication for the member and the independent support broker that includes alternative communication formats.
- (13) Establish a customer services complaint reporting system.
- (14) Develop a policy and procedures manual that is current with state and federal regulations and update as necessary.
- (15) Develop a business continuity plan in the case of emergencies and natural disasters.
- (16) Provide to the department an annual independent audit of the financial management service.
- (17) Assist in implementing the state's quality management strategy related to the financial management service.

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

*a.* Case management services shall be provided as set forth in rules 441—90.5(249A) and 441—90.8(249A).

*b.* Case management shall not include the provision of direct services by the case managers.

*c.* Payment for case management shall not be made until the consumer is enrolled in the waiver. Payment shall be made only for case management services performed on behalf of the consumer during a month when the consumer is enrolled.

**78.37(18) Assisted living on-call service.** The assisted living on-call service provides staff on call 24 hours per day to meet a member's scheduled, unscheduled, and unpredictable needs in a manner that promotes maximum dignity and independence and provides safety and security. A unit of service is one day. To determine units of service provided, the provider will use census information based on member bed status each day.

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

**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.

**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 maximum of two meals is allowed per day. A unit of service is a meal.

**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.* 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.

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

- (1) Retain accountability for actions that are delegated.
- (2) Ensure appropriate assessment, planning, implementation, and evaluation.
- (3) Make on-site supervisory visits every two weeks with the service provider present.

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

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

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

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

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

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

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

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

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

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

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

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

(2) Intravenous therapy administered by a registered nurse.

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

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

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

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

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

(8) Colostomy care.

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

(10) Postsurgical nursing care.

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

(12) Preparing and monitoring response to therapeutic diets.

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

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

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

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

(3) Costs of food.

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

(5) Exercise that does not require skilled services.

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

(7) Reminders and cueing.

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

(9) Transportation costs.

(10) Wait times for any activity.

**78.38(9) Consumer choices option.** The consumer choices option provides a member with a flexible monthly individual budget that is based on the member's service needs. With the individual budget, the member shall have the authority to purchase goods and services to meet the member's assessed needs and may choose to employ providers of services and supports. The services, supports, and items that are purchased with an individual budget must be directly related to a member's assessed need or goal established in the member's service plan. Components of this service are set forth below.

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

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

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

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

(2) The department shall determine an average unit cost for each service listed in subparagraph 78.38(9) "b"(1) based on actual unit costs from the previous fiscal year plus a cost-of-living adjustment.

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

(4) The department shall compute the utilization adjustment factor for each service by dividing the net costs of all claims paid for the service by the total of the authorized costs for that service, using at least 12 consecutive months of aggregate service data. The utilization adjustment factor shall be no lower than 60 percent. The department shall analyze and adjust the utilization adjustment factor at least annually in order to maintain cost neutrality.

(5) Individual budgets for respite services shall be computed based on the average cost for services identified in subparagraph 78.38(9) "b"(2). Respite services are not subject to the utilization adjustment factor in subparagraph 78.38(9) "b"(3).

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

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

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

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

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

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

1. Promote opportunities for community living and inclusion.
2. Increase independence or substitute for human assistance, to the extent the expenditures would otherwise be made for that human assistance.

3. Be accommodated within the member's budget without compromising the member's health and safety.

4. Be provided to the member or directed exclusively toward the benefit of the member.

5. Be the least costly to meet the member's needs.

6. Not be available through another source.

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

(1) The costs of the financial management service.

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

(3) The costs of any optional service component chosen by the member as described in paragraph 78.38(9) "d." Costs of the following items and services shall not be covered by the individual budget:

1. Child care services.

2. Clothing not related to an assessed medical need.

3. Conference, meeting or similar venue expenses other than the costs of approved services the member needs while attending the conference, meeting or similar venue.

4. Costs associated with shipping items to the member.

5. Experimental and non-FDA-approved medications, therapies, or treatments.

6. Goods or services covered by other Medicaid programs.

7. Home furnishings.

8. Home repairs or home maintenance.

9. Homeopathic treatments.

10. Insurance premiums or copayments.

11. Items purchased on installment payments.

12. Motorized vehicles.

13. Nutritional supplements.

14. Personal entertainment items.

15. Repairs and maintenance of motor vehicles.

16. Room and board, including rent or mortgage payments.

17. School tuition.

18. Service animals.

19. Services covered by third parties or services that are the responsibility of a non-Medicaid program.

20. Sheltered workshop services.

21. Social or recreational purchases not related to an assessed need or goal identified in the member's service plan.

22. Vacation expenses, other than the costs of approved services the member needs while on vacation.

(4) The costs of any approved home or vehicle modification. When authorized, the budget may include an amount allocated for a home or vehicle modification. Before becoming part of the individual budget, all home and vehicle modifications shall be identified in the member's service plan and approved by the case manager or service worker. The authorized amount shall not be used for anything other than the specific modification.

(5) Any amount set aside in a savings plan to reserve funds for the future purchase of self-directed personal care, individual-directed goods and services, or self-directed community supports and services as defined in paragraph 78.38(9) "d." The savings plan shall meet the requirements in paragraph 78.38(9) "f."

*f. Savings plan.* A member savings plan must be in writing and be approved by the department before the start of the savings plan. Amounts allocated to the savings plan must result from efficiencies in meeting identified needs of the member.

- (1) The savings plan shall identify:
  1. The specific goods, services, supports or supplies to be purchased through the savings plan.
  2. The amount of the individual budget allocated each month to the savings plan.
  3. The amount of the individual budget allocated each month to meet the member's identified service needs.
  4. How the member's assessed needs will continue to be met through the individual budget when funds are placed in savings.
- (2) With the exception of funds allocated for respite care, the savings plan shall not include funds budgeted for direct services that were not received. The budgeted amount associated with unused direct services other than respite care shall revert to the Medicaid program at the end of each month. Funds from unused respite services may be allocated to the savings plan but shall not be used for anything other than future respite care.
- (3) Funds accumulated under a savings plan shall be used only to purchase items that increase independence or substitute for human assistance to the extent that expenditures would otherwise be made for human assistance, including additional goods, supports, services or supplies. The self-directed personal care, individual-directed goods and services, or self-directed community supports and services purchased with funds from a savings plan must:
  1. Be used to meet a member's identified need,
  2. Be medically necessary, and
  3. Be approved by the member's case manager or service worker.
- (4) All funds allocated to a savings plan that are not expended by December 31 of each year shall revert to the Medicaid program.
- (5) The annual reassessment of a member's needs must take into account the purchases of goods and services that substitute for human assistance. Adjustments shall be made to the services used to determine the individual budget based on the reassessment.
- g. Budget authority.* The member shall have authority over the individual budget authorized by the department to perform the following tasks:
  - (1) Contract with entities to provide services and supports as described in this subrule.
  - (2) Determine the amount to be paid for services. Reimbursement rates shall be consistent with rates paid by others in the community for the same or substantially similar services. Reimbursement rates for the independent support broker and the financial management service are subject to the limits in 441—subrule 79.1(2).
  - (3) Schedule the provision of services.
  - (4) Authorize payment for optional service components identified in the individual budget.
  - (5) Reallocate funds among services included in the budget. Every purchase of a good or service must be identified and approved in the individual budget before the purchase is made.
- h. Delegation of budget authority.* The member may delegate responsibility for the individual budget to a representative in addition to the independent support broker.
  - (1) The representative must be at least 18 years old.
  - (2) The representative shall not be a current provider of service to the member.
  - (3) The member shall sign a consent form that designates who the member has chosen as a representative and what responsibilities the representative shall have.
  - (4) The representative shall not be paid for this service.
- i. Employer authority.* The member shall have the authority to be the common-law employer of employees providing services and support under the consumer choices option. A common-law employer has the right to direct and control the performance of the services. The member may perform the following functions:
  - (1) Recruit employees.
  - (2) Select employees from a worker registry.
  - (3) Verify employee qualifications.
  - (4) Specify additional employee qualifications.
  - (5) Determine employee duties.

- (6) Determine employee wages and benefits.
- (7) Schedule employees.
- (8) Train and supervise employees.

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

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

- (1) Assist the member with developing the member's initial and subsequent individual budgets and with making any changes to the individual budget.
- (2) Have monthly contact with the member for the first four months of implementation of the initial individual budget and have quarterly contact thereafter.
- (3) Complete the required employment packet with the financial management service.
- (4) Assist with interviewing potential employees and entities providing services and supports if requested by the member.
- (5) Assist the member with determining whether a potential employee meets the qualifications necessary to perform the job.
- (6) Assist the member with obtaining a signed consent from a potential employee to conduct background checks if requested by the member.
- (7) Assist the member with negotiating with entities providing services and supports if requested by the member.
- (8) Assist the member with contracts and payment methods for services and supports if requested by the member.
- (9) Assist the member with developing an emergency backup plan. The emergency backup plan shall address any health and safety concerns.
- (10) Review expenditure reports from the financial management service to ensure that services and supports in the individual budget are being provided.
- (11) Document in writing on the independent support broker timecard every contact the broker has with the member. Contact documentation shall include information on the extent to which the member's individual budget has addressed the member's needs and the satisfaction of the member.

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

- (1) Receive Medicaid funds in an electronic transfer.
- (2) Process and pay invoices for approved goods and services included in the individual budget.
- (3) Enter the individual budget into the Web-based tracking system chosen by the department and enter expenditures as they are paid.
- (4) Provide real-time individual budget account balances for the member, the independent support broker, and the department, available at a minimum during normal business hours (9 a.m. to 5 p.m., Monday through Friday).
- (5) Conduct criminal background checks on potential employees pursuant to 441—Chapter 119.
- (6) Verify for the member an employee's citizenship or alien status.
- (7) Assist the member with fiscal and payroll-related responsibilities including, but not limited to:
  1. Verifying that hourly wages comply with federal and state labor rules.
  2. Collecting and processing timecards.
  3. Withholding, filing, and paying federal, state and local income taxes, Medicare and Social Security (FICA) taxes, and federal (FUTA) and state (SUTA) unemployment and disability insurance taxes, as applicable.
  4. Computing and processing other withholdings, as applicable.
  5. Processing all judgments, garnishments, tax levies, or other withholding on an employee's pay as may be required by federal, state, or local laws.
  6. Preparing and issuing employee payroll checks.
  7. Preparing and disbursing IRS Forms W-2 and W-3 annually.

8. Processing federal advance earned income tax credit for eligible employees.
9. Refunding over-collected FICA, when appropriate.
10. Refunding over-collected FUTA, when appropriate.
- (8) Assist the member in completing required federal, state, and local tax and insurance forms.
- (9) Establish and manage documents and files for the member and the member's employees.
- (10) Monitor timecards, receipts, and invoices to ensure that they are consistent with the individual budget. Keep records of all timecards and invoices for each member for a total of five years.
- (11) Provide to the department, the independent support broker, and the member monthly and quarterly status reports that include a summary of expenditures paid and amount of budget unused.
- (12) Establish an accessible customer service system and a method of communication for the member and the independent support broker that includes alternative communication formats.
- (13) Establish a customer services complaint reporting system.
- (14) Develop a policy and procedures manual that is current with state and federal regulations and update as necessary.
- (15) Develop a business continuity plan in the case of emergencies and natural disasters.
- (16) Provide to the department an annual independent audit of the financial management service.
- (17) Assist in implementing the state's quality management strategy related to the financial management service.

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

- a. Reimbursement shall not be available under the waiver for any services that the member can obtain as other nonwaiver Medicaid services or through any other funding source.
- b. All services provided under the waiver must be delivered in the least restrictive environment possible and in conformity with the member's service plan.
- c. Services must be billed in whole units.
- d. 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]

**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.

**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.

(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 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 78.41(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 \$7,262 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 individualized services associated with obtaining and maintaining competitive paid employment in the least restrictive environment possible, provided to individuals for whom competitive employment at or above minimum wage is unlikely and who, because of their disability, need intense and ongoing support to perform in a work setting. Individual placements are the preferred service model. Covered services are those listed in paragraphs "a" and "b" that address the disability-related challenges to securing and keeping a job.

a. *Activities to obtain a job.* Covered services directed to obtaining a job must be provided to or on behalf of a member for whom competitive employment is reasonably expected within less than one year. Services must be focused on job placement, not on teaching generalized employment skills or rehabilitative goals. Three conditions must be met before services are provided. First, the member and the interdisciplinary team described in 441—subrule 83.67(1) must complete the form that Iowa vocational rehabilitation services uses to identify the supported employment services appropriate to meet a person's employment needs. Second, the member's interdisciplinary team must determine that the identified services are necessary. Third, the member's case manager must approve the services. Available components of activities to obtain a job are as follows:

(1) *Job development services.* Job development services are directed toward obtaining competitive employment. A unit of service is a job placement that the member holds for 30 consecutive calendar days or more. Payment is available once the service is authorized in the member's service plan. A member may receive two units of job development services during a 12-month period. The activities provided to the member may include:

1. Job procurement training, including grooming and hygiene, application, résumé development, interviewing skills, follow-up letters, and job search activities.
2. Job retention training, including promptness, coworker relations, transportation skills, disability-related supports, job benefits, and an understanding of employee rights and self-advocacy.
3. Customized job development services specific to the member.

(2) Employer development services. The focus of employer development services is to support employers in hiring and retaining members in their workforce and to communicate expectations of the employers to the interdisciplinary team described in 441—subrule 83.67(1). Employer development services may be provided only to members who are reasonably expected to work for no more than 10 hours per week. A unit of service is one job placement that the member holds for 30 consecutive calendar days or more. Payment for this service may be made only after the member holds the job for 30 days. A member may receive two units of employer development services during a 12-month period if the member is competitively employed for 30 or more consecutive calendar days and the other conditions for service approval are met. The services provided may include:

1. Developing relationships with employers and providing leads for individual members when appropriate.
2. Job analysis for a specific job.
3. Development of a customized training plan identifying job-specific skill requirements, employer expectations, teaching strategies, time frames, and responsibilities.
4. Identifying and arranging reasonable accommodations with the employer.
5. Providing disability awareness and training to the employer when it is deemed necessary.
6. Providing technical assistance to the employer regarding the training progress as identified on the member's customized training plan.

(3) Enhanced job search activities. Enhanced job search activities are associated with obtaining initial employment after job development services have been provided for a minimum of 30 days or with assisting the member in changing jobs due to layoff, termination, or personal choice. The interdisciplinary team must review and update the Iowa vocational rehabilitation services supported employment readiness analysis form to determine if this service remains appropriate for the member's employment goals. A unit of service is 15 minutes. A maximum of 104 units may be provided in a 12-month period. The services provided may include:

1. Job opening identification with the member.
2. Assistance with applying for a job, including completion of applications or interviews.
3. Work site assessment and job accommodation evaluation.
- b. Supports to maintain employment.

(1) Covered services provided to or on behalf of the member associated with maintaining competitive paid employment are the following:

1. Individual work-related behavioral management.
  2. Job coaching.
  3. On-the-job or work-related crisis intervention.
  4. Assisting the member to use skills related to sustaining competitive paid employment, including assistance with communication skills, problem solving, and safety.
  5. Consumer-directed attendant care services as defined in subrule 78.41(8).
  6. Assistance with time management.
  7. Assistance with appropriate grooming.
  8. Employment-related supportive contacts.
  9. Employment-related transportation between work and home and to or from activities related to employment and disability. Other forms of community transportation (including car pools, coworkers, self or public transportation, families, and volunteers) must be attempted before transportation is provided as a supported employment service.
  10. On-site vocational assessment after employment.
  11. Employer consultation.
- (2) Services for maintaining employment may include services associated with sustaining members in a team of no more than eight individuals with disabilities in a teamwork or "enclave" setting.
- (3) A unit of service is 15 minutes.
  - (4) A maximum of 160 units may be received per week.
  - c. The following requirements apply to all supported employment services:

(1) Employment-related adaptations required to assist the member within the performance of the member's job functions shall be provided by the provider as part of the services.

(2) Employment-related transportation between work and home and to or from activities related to employment and disability shall be provided by the provider as part of the services. Other forms of community transportation (car pools, coworkers, self or public transportation, families, volunteers) must be attempted before the service provider provides transportation.

(3) The majority of coworkers at any employment site with more than two employees where members seek, obtain, or maintain employment must be persons without disabilities. In the performance of job duties at any site where members seek, obtain, or maintain employment, the member must have daily contact with other employees or members of the general public who do not have disabilities, unless the absence of daily contact with other employees or the general public is typical for the job as performed by persons without disabilities.

(4) All supported employment services shall provide individualized and ongoing support contacts at intervals necessary to promote successful job retention. Each provider contact shall be documented.

(5) Documentation that services provided are not currently available under a program funded under the Rehabilitation Act of 1973 or Public Law 94-142 shall be maintained in the provider file of each member.

(6) All services shall be identified in the member's service plan maintained pursuant to rule 441—83.67(249A).

(7) The following services are not covered:

1. Services involved in placing or maintaining members in day activity programs, work activity programs or sheltered workshop programs;

2. Supports for volunteer work or unpaid internships;

3. Tuition for education or vocational training; or

4. Individual advocacy that is not member specific.

(8) Services to maintain employment shall not be provided simultaneously with day activity programs, work activity programs, sheltered workshop programs, other HCBS services, or other Medicaid services. However, services to obtain a job and services to maintain employment may be provided simultaneously for the purpose of job advancement or job change.

**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.* 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.

*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 only in the member's home; in a registered child development home; in 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 receive medical services when not reimbursed through nonemergency medical transportation, 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 intellectual disability waiver supported community living service when the transportation costs are included within the supported community living reimbursement rate.

**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), 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.

**78.41(13) *Prevocational services.*** Prevocational services are services that are aimed at preparing a member for paid or unpaid employment, but that are not job-task oriented. These services include teaching the member concepts necessary for job readiness, such as following directions, attending to tasks, task completion, problem solving, and safety and mobility training.

*a.* Prevocational services are intended to have a more generalized result as opposed to vocational training for a specific job or supported employment. Services include activities that are not primarily directed at teaching specific job skills but at more generalized habilitative goals, and are reflected in a habilitative plan that focuses on general habilitative rather than specific employment objectives.

*b.* Prevocational services do not include:

(1) Services defined in Section 4(a)(4) of the 1975 amendments to the Education of the Handicapped Act (20 U.S.C. 1404(16) and (17)) that are otherwise available to the member through a state or local education agency.

(2) Vocational rehabilitation services that are otherwise available to the member through a program funded under Section 110 of the Rehabilitation Act of 1973 (29 U.S.C. 730).

*c.* A unit of service is a full day (4.25 to 8 hours) or an hour (for up to 4 hours per day).

**78.41(14) *Day habilitation services.***

*a. Scope.* Day habilitation services are services that assist or support the member in developing or maintaining life skills and community integration. Services must enable or enhance the member's intellectual functioning, physical and emotional health and development, language and communication development, cognitive functioning, socialization and community integration, functional skill development, behavior management, responsibility and self-direction, daily living activities, self-advocacy skills, or mobility.

*b. Family training option.* Day habilitation services may include training families in treatment and support methodologies or in the care and use of equipment. Family training may be provided in the member's home. The unit of service is 15 minutes. The units of services payable are limited to a maximum of 40 units per month.

*c. Unit of service.* Except as provided in paragraph 78.41(14) "b," the unit of service is 15 minutes (for up to 16 units per day) or a full day (4.25 to 8 hours per day).

*d. Exclusions.*

(1) Services shall not be provided in the member's home, except as provided in paragraph "b." For this purpose, services provided in a residential care facility where the member lives are not considered to be provided in the member's home.

- (2) Services shall not include vocational or prevocational services and shall not involve paid work.
- (3) Services shall not duplicate or replace education or related services defined in Public Law 94-142, the Education of the Handicapped Act.
- (4) Services shall not be provided simultaneously with other Medicaid-funded services.

**78.41(15) Consumer choices option.** The consumer choices option provides a member with a flexible monthly individual budget that is based on the member's service needs. With the individual budget, the member shall have the authority to purchase goods and services to meet the member's assessed needs and may choose to employ providers of services and supports. The services, supports, and items that are purchased with an individual budget must be directly related to a member's assessed need or goal established in the member's service plan. Components of this service are set forth below.

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

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

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

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

(2) The department shall determine an average unit cost for each service listed in subparagraph 78.41(15) "b"(1) based on actual unit costs from the previous fiscal year plus a cost-of-living adjustment.

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

(4) The department shall compute the utilization adjustment factor for each service by dividing the net costs of all claims paid for the service by the total of the authorized costs for that service, using at least 12 consecutive months of aggregate service data. The utilization adjustment factor shall be no lower than 60 percent. The department shall analyze and adjust the utilization adjustment factor at least annually in order to maintain cost neutrality.

(5) Individual budgets for respite services shall be computed based on the average cost for services identified in subparagraph 78.41(15) "b"(2). Respite services are not subject to the utilization adjustment factor in subparagraph 78.41(15) "b"(3).

(6) Anticipated costs for home and vehicle modification and supported employment services to obtain a job are not subject to the average cost in subparagraph 78.41(15) "b"(2) or the utilization adjustment factor in subparagraph 78.41(15) "b"(3). Anticipated costs for these services shall not include the costs of the financial management services or the independent support broker. Costs for home and vehicle modification and supported employment services to obtain a job may be paid to the financial management services provider in a one-time payment. Before becoming part of the individual budget, all home and vehicle modifications and supported employment services to obtain a job shall be identified in the member's service plan and approved by the case manager or service worker.

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

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

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

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

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

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

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

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

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

(3) The costs of any optional service component chosen by the member as described in paragraph 78.41(15) "d." Costs of the following items and services shall not be covered by the individual budget:

1. Child care services.
2. Clothing not related to an assessed medical need.
3. Conference, meeting or similar venue expenses other than the costs of approved services the member needs while attending the conference, meeting or similar venue.
4. Costs associated with shipping items to the member.
5. Experimental and non-FDA-approved medications, therapies, or treatments.
6. Goods or services covered by other Medicaid programs.
7. Home furnishings.
8. Home repairs or home maintenance.
9. Homeopathic treatments.
10. Insurance premiums or copayments.
11. Items purchased on installment payments.
12. Motorized vehicles.
13. Nutritional supplements.
14. Personal entertainment items.
15. Repairs and maintenance of motor vehicles.

16. Room and board, including rent or mortgage payments.
17. School tuition.
18. Service animals.
19. Services covered by third parties or services that are the responsibility of a non-Medicaid program.
20. Sheltered workshop services.
21. Social or recreational purchases not related to an assessed need or goal identified in the member's service plan.
22. Vacation expenses, other than the costs of approved services the member needs while on vacation.

(4) The costs of any approved home or vehicle modification. When authorized, the budget may include an amount allocated for a home or vehicle modification. Before becoming part of the individual budget, all home and vehicle modifications shall be identified in the member's service plan and approved by the case manager or service worker. The authorized amount shall not be used for anything other than the specific modification.

(5) Any amount set aside in a savings plan to reserve funds for the future purchase of self-directed personal care, individual-directed goods and services, or self-directed community supports and services as defined in paragraph 78.41(15)“d.” The savings plan shall meet the requirements in paragraph 78.41(15)“f.”

*f. Savings plan.* A member savings plan must be in writing and be approved by the department before the start of the savings plan. Amounts allocated to the savings plan must result from efficiencies in meeting identified needs of the member.

- (1) The savings plan shall identify:
  1. The specific goods, services, supports or supplies to be purchased through the savings plan.
  2. The amount of the individual budget allocated each month to the savings plan.
  3. The amount of the individual budget allocated each month to meet the member's identified service needs.
  4. How the member's assessed needs will continue to be met through the individual budget when funds are placed in savings.

(2) With the exception of funds allocated for respite care, the savings plan shall not include funds budgeted for direct services that were not received. The budgeted amount associated with unused direct services other than respite care shall revert to the Medicaid program at the end of each month. Funds from unused respite services may be allocated to the savings plan but shall not be used for anything other than future respite care.

(3) Funds accumulated under a savings plan shall be used only to purchase items that increase independence or substitute for human assistance to the extent that expenditures would otherwise be made for human assistance, including additional goods, supports, services or supplies. The self-directed personal care, individual-directed goods and services, or self-directed community supports and services purchased with funds from a savings plan must:

1. Be used to meet a member's identified need,
  2. Be medically necessary, and
  3. Be approved by the member's case manager or service worker.
- (4) All funds allocated to a savings plan that are not expended by December 31 of each year shall revert to the Medicaid program.

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

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

- (1) Contract with entities to provide services and supports as described in this subrule.
- (2) Determine the amount to be paid for services. Reimbursement rates shall be consistent with rates paid by others in the community for the same or substantially similar services. Reimbursement

rates for the independent support broker and the financial management service are subject to the limits in 441—subrule 79.1(2).

(3) Schedule the provision of services.

(4) Authorize payment for optional service components identified in the individual budget.

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

*h. Delegation of budget authority.* The member may delegate responsibility for the individual budget to a representative in addition to the independent support broker.

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

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

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

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

*i. Employer authority.* The member shall have the authority to be the common-law employer of employees providing services and support under the consumer choices option. A common-law employer has the right to direct and control the performance of the services. The member may perform the following functions:

(1) Recruit employees.

(2) Select employees from a worker registry.

(3) Verify employee qualifications.

(4) Specify additional employee qualifications.

(5) Determine employee duties.

(6) Determine employee wages and benefits.

(7) Schedule employees.

(8) Train and supervise employees.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

- (1) Receive Medicaid funds in an electronic transfer.
- (2) Process and pay invoices for approved goods and services included in the individual budget.
- (3) Enter the individual budget into the Web-based tracking system chosen by the department and enter expenditures as they are paid.
- (4) Provide real-time individual budget account balances for the member, the independent support broker, and the department, available at a minimum during normal business hours (9 a.m. to 5 p.m., Monday through Friday).
- (5) Conduct criminal background checks on potential employees pursuant to 441—Chapter 119.
- (6) Verify for the member an employee's citizenship or alien status.
- (7) Assist the member with fiscal and payroll-related responsibilities including, but not limited to:
  1. Verifying that hourly wages comply with federal and state labor rules.
  2. Collecting and processing timecards.
  3. Withholding, filing, and paying federal, state and local income taxes, Medicare and Social Security (FICA) taxes, and federal (FUTA) and state (SUTA) unemployment and disability insurance taxes, as applicable.
  4. Computing and processing other withholdings, as applicable.
  5. Processing all judgments, garnishments, tax levies, or other withholding on an employee's pay as may be required by federal, state, or local laws.
  6. Preparing and issuing employee payroll checks.
  7. Preparing and disbursing IRS Forms W-2 and W-3 annually.
  8. Processing federal advance earned income tax credit for eligible employees.
  9. Refunding over-collected FICA, when appropriate.
  10. Refunding over-collected FUTA, when appropriate.
- (8) Assist the member in completing required federal, state, and local tax and insurance forms.
- (9) Establish and manage documents and files for the member and the member's employees.
- (10) Monitor timecards, receipts, and invoices to ensure that they are consistent with the individual budget. Keep records of all timecards and invoices for each member for a total of five years.
- (11) Provide to the department, the independent support broker, and the member monthly and quarterly status reports that include a summary of expenditures paid and amount of budget unused.
- (12) Establish an accessible customer service system and a method of communication for the member and the independent support broker that includes alternative communication formats.
- (13) Establish a customer services complaint reporting system.
- (14) Develop a policy and procedures manual that is current with state and federal regulations and update as necessary.
- (15) Develop a business continuity plan in the case of emergencies and natural disasters.
- (16) Provide to the department an annual independent audit of the financial management service.
- (17) Assist in implementing the state's quality management strategy related to the financial management service.

**78.41(16) General service standards.** All intellectual disability waiver services must be provided in accordance with the following standards:

- a.* Reimbursement shall not be available under the waiver for any services that the member can obtain as other nonwaiver Medicaid services or through any other funding source.
- b.* All services provided under the waiver must be delivered in the least restrictive environment possible and in conformity with the member's service plan.
- c.* Services must be billed in whole units.
- d.* 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]

**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.

**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 service excludes transportation to and from work or day programs.

(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 individualized services associated with obtaining and maintaining competitive paid employment in the least restrictive environment possible, provided to individuals for whom competitive employment at or above minimum wage is unlikely and who, because of their disability, need intense and ongoing support to perform in a work setting. Individual placements are the preferred service model. Covered services are those listed in paragraphs “a” and “b” that address the disability-related challenges to securing and keeping a job.

a. Activities to obtain a job. Covered services directed to obtaining a job must be provided to or on behalf of a member for whom competitive employment is reasonably expected within less than one year. Services must be focused on job placement, not on teaching generalized employment skills or habilitative goals. Three conditions must be met before services are provided. First, the member and the interdisciplinary team described in rule 441—83.87(249A) must complete the form that Iowa vocational rehabilitation services uses to identify the supported employment services appropriate to meet the member's employment needs. Second, the member's interdisciplinary team must determine that the identified services are necessary. Third, the member's case manager must approve the services. Available components of activities to obtain a job are as follows:

(1) Job development services. Job development services are directed toward obtaining competitive employment. A unit of service is a job placement that the member holds for 30 consecutive calendar days or more. Payment is available once the service is authorized in the member's service plan. A member may receive two units of job development services during a 12-month period. The activities provided to the member may include:

1. Job procurement training, including grooming and hygiene, application, résumé development, interviewing skills, follow-up letters, and job search activities.

2. Job retention training, including promptness, coworker relations, transportation skills, disability-related supports, job benefits, and an understanding of employee rights and self-advocacy.

3. Customized job development services specific to the member.

(2) Employer development services. The focus of employer development services is to support employers in hiring and retaining members in their workforce and to communicate expectations of the employers to the interdisciplinary team described in rule 441—83.87(249A). Employer development services may be provided only to members who are reasonably expected to work for no more than 10 hours per week. A unit of service is one job placement that the member holds for 30 consecutive calendar days or more. Payment for this service may be made only after the member holds the job for 30 days. A member may receive two units of employer development services during a 12-month period if the member is competitively employed for 30 or more consecutive calendar days and the other conditions for service approval are met. The services provided may include:

1. Developing relationships with employers and providing leads for individual members when appropriate.

2. Job analysis for a specific job.

3. Development of a customized training plan identifying job-specific skill requirements, employer expectations, teaching strategies, time frames, and responsibilities.

4. Identifying and arranging reasonable accommodations with the employer.

5. Providing disability awareness and training to the employer when it is deemed necessary.

6. Providing technical assistance to the employer regarding the training progress as identified on the member's customized training plan.

(3) Enhanced job search activities. Enhanced job search activities are associated with obtaining initial employment after job development services have been provided to the member for a minimum of 30 days or with assisting the member in changing jobs due to layoff, termination, or personal choice. The interdisciplinary team must review and update the Iowa vocational rehabilitation services supported employment readiness analysis form to determine if this service remains appropriate for the member's employment goals. A unit of service is 15 minutes. A maximum of 104 units may be provided in a 12-month period. The services provided may include:

1. Job opening identification with the member.

2. Assistance with applying for a job, including completion of applications or interviews.

3. Work site assessment and job accommodation evaluation.

- b. Supports to maintain employment.

(1) Covered services provided to or on behalf of the member associated with maintaining competitive paid employment are the following:

1. Individual work-related behavioral management.

2. Job coaching.

3. On-the-job or work-related crisis intervention.

4. Assisting the member to use skills related to sustaining competitive paid employment, including assistance with communication skills, problem solving, and safety.

5. Consumer-directed attendant care services as defined in subrule 78.43(13).

6. Assistance with time management.

7. Assistance with appropriate grooming.

8. Employment-related supportive contacts.

9. Employment-related transportation between work and home and to or from activities related to employment and disability. Other forms of community transportation (including car pools, coworkers,

self or public transportation, families, and volunteers) must be attempted before transportation is provided as a supported employment service.

10. On-site vocational assessment after employment.

11. Employer consultation.

(2) Services for maintaining employment may include services associated with sustaining members in a team of no more than eight individuals with disabilities in a teamwork or “enclave” setting.

(3) A unit of service is 15 minutes.

(4) A maximum of 160 units may be received per week.

c. The following requirements apply to all supported employment services:

(1) Employment-related adaptations required to assist the member within the performance of the member’s job functions shall be provided by the provider as part of the services.

(2) Employment-related transportation between work and home and to or from activities related to employment and disability shall be provided by the provider as part of the services. Other forms of community transportation (car pools, coworkers, self or public transportation, families, volunteers) must be attempted before the service provider provides transportation.

(3) The majority of coworkers at any employment site with more than two employees where members seek, obtain, or maintain employment must be persons without disabilities. In the performance of job duties at any site where members seek, obtain, or maintain employment, the member must have daily contact with other employees or members of the general public who do not have disabilities, unless the absence of daily contact with other employees or the general public is typical for the job as performed by persons without disabilities.

(4) All supported employment services shall provide individualized and ongoing support contacts at intervals necessary to promote successful job retention. Each provider contact shall be documented.

(5) Documentation that services provided are not currently available under a program funded under the Rehabilitation Act of 1973 or Public Law 94-142 shall be maintained in the provider file of each member.

(6) All services shall be identified in the member’s service plan maintained pursuant to rule 441—83.67(249A).

(7) The following services are not covered:

1. Services involved in placing or maintaining members in day activity programs, work activity programs or sheltered workshop programs;

2. Supports for volunteer work or unpaid internships;

3. Tuition for education or vocational training; or

4. Individual advocacy that is not member specific.

(8) Services to maintain employment shall not be provided simultaneously with day activity programs, work activity programs, sheltered workshop programs, other HCBS services, or other Medicaid services. However, services to obtain a job and services to maintain employment may be provided simultaneously for the purpose of job advancement or job change.

**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. The case manager or service worker may encumber a portion of the cost of a modification every month within the monthly dollar cap allowed for the member until the entire cost of the modification is encumbered within a consecutive 12-month period.
- 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 receive medical services when not reimbursed through nonemergency medical transportation, 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 \$6,060 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 services which are aimed at preparing a member for paid or unpaid employment, but which are not job-task oriented. These services include teaching the member concepts necessary for job readiness, such as following directions, attending to tasks, task completion, problem solving, and safety and mobility training.

*a.* Prevocational services are intended to have a more generalized result as opposed to vocational training for a specific job or supported employment. Services include activities which are not primarily directed at teaching specific job skills but at more generalized habilitative goals and are reflected in a habilitative plan which focuses on general habilitative rather than specific employment objectives.

*b.* Prevocational services do not include:

(1) Services defined in Section 4(a)(4) of the 1975 amendments to the Education of the Handicapped Act (20 U.S.C. 1404(16) and (17)) which are otherwise available to the member through a state or local education agency, or

(2) Vocational rehabilitation services which are otherwise available to the member through a program funded under Section 110 of the Rehabilitation Act of 1973 (29 U.S.C. 730).

*c.* A unit of service is a full day (4.25 to 8 hours per day) or an hour (for up to 4 hours per day).

**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.* 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.

*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 only in the member's home; in a registered child development home; in a licensed child care center, residential care facility, or adult day care facility; or during the time when the member is being transported to and from school.

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

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

e. A unit of service is 15 minutes.

**78.43(15) Consumer choices option.** The consumer choices option provides a member with a flexible monthly individual budget that is based on the member's service needs. With the individual budget, the member shall have the authority to purchase goods and services to meet the member's assessed needs and may choose to employ providers of services and supports. The services, supports, and items that are purchased with an individual budget must be directly related to a member's assessed need or goal established in the member's service plan. Components of this service are set forth below.

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

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

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

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

(2) The department shall determine an average unit cost for each service listed in subparagraph 78.43(15) "b"(1) based on actual unit costs from the previous fiscal year plus a cost-of-living adjustment.

(3) In aggregate, costs for individual budget services shall not exceed the current costs of waiver program services. In order to maintain cost neutrality, the department shall apply a utilization adjustment

factor to the amount of service authorized in the member's service plan before calculating the value of that service to be included in the individual budget amount.

(4) The department shall compute the utilization adjustment factor for each service by dividing the net costs of all claims paid for the service by the total of the authorized costs for that service, using at least 12 consecutive months of aggregate service data. The utilization adjustment factor shall be no lower than 60 percent. The department shall analyze and adjust the utilization adjustment factor at least annually in order to maintain cost neutrality.

(5) Individual budgets for respite services shall be computed based on the average cost for services identified in subparagraph 78.43(15) "b"(2). Respite services are not subject to the utilization adjustment factor in subparagraph 78.43(15) "b"(3).

(6) Anticipated costs for home and vehicle modification, specialized medical equipment, and supported employment services to obtain a job are not subject to the average cost in subparagraph 78.43(15) "b"(2) or the utilization adjustment factor in subparagraph 78.43(15) "b"(3). Anticipated costs for these services shall not include the costs of the financial management services or the independent support broker. Before becoming part of the individual budget, all home and vehicle modifications, specialized medical equipment, and supported employment services to obtain a job shall be identified in the member's service plan and approved by the case manager or service worker. Costs for these services may be paid to the financial management services provider in a one-time payment.

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

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

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

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

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

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

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

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

- (1) The costs of the financial management service.
- (2) The costs of the independent support broker. The independent support broker may be compensated for up to 6 hours of service for assisting with the implementation of the initial individual

budget. The independent support broker shall not be paid for more than 30 hours of service for an individual member during a 12-month period without prior approval by the department.

(3) The costs of any optional service component chosen by the member as described in paragraph 78.43(15)“d.” Costs of the following items and services shall not be covered by the individual budget:

1. Child care services.
2. Clothing not related to an assessed medical need.
3. Conference, meeting or similar venue expenses other than the costs of approved services the member needs while attending the conference, meeting or similar venue.
4. Costs associated with shipping items to the member.
5. Experimental and non-FDA-approved medications, therapies, or treatments.
6. Goods or services covered by other Medicaid programs.
7. Home furnishings.
8. Home repairs or home maintenance.
9. Homeopathic treatments.
10. Insurance premiums or copayments.
11. Items purchased on installment payments.
12. Motorized vehicles.
13. Nutritional supplements.
14. Personal entertainment items.
15. Repairs and maintenance of motor vehicles.
16. Room and board, including rent or mortgage payments.
17. School tuition.
18. Service animals.
19. Services covered by third parties or services that are the responsibility of a non-Medicaid program.
20. Sheltered workshop services.
21. Social or recreational purchases not related to an assessed need or goal identified in the member’s service plan.
22. Vacation expenses, other than the costs of approved services the member needs while on vacation.

(4) The costs of any approved home or vehicle modification or specialized medical equipment. When authorized, the budget may include an amount allocated for a home or vehicle modification or specialized medical equipment. Before becoming part of the individual budget, all home and vehicle modifications and specialized medical equipment shall be identified in the member’s service plan and approved by the case manager or service worker. The authorized amount shall not be used for anything other than the specific modification or equipment.

(5) Any amount set aside in a savings plan to reserve funds for the future purchase of self-directed personal care, individual-directed goods and services, or self-directed community supports and services as defined in paragraph 78.43(15)“d.” The savings plan shall meet the requirements in paragraph 78.43(15)“f.”

*f. Savings plan.* A member savings plan must be in writing and be approved by the department before the start of the savings plan. Amounts allocated to the savings plan must result from efficiencies in meeting identified needs of the member.

- (1) The savings plan shall identify:
  1. The specific goods, services, supports or supplies to be purchased through the savings plan.
  2. The amount of the individual budget allocated each month to the savings plan.
  3. The amount of the individual budget allocated each month to meet the member’s identified service needs.
  4. How the member’s assessed needs will continue to be met through the individual budget when funds are placed in savings.
- (2) With the exception of funds allocated for respite care, the savings plan shall not include funds budgeted for direct services that were not received. The budgeted amount associated with unused direct

services other than respite care shall revert to the Medicaid program at the end of each month. Funds from unused respite services may be allocated to the savings plan but shall not be used for anything other than future respite care.

(3) Funds accumulated under a savings plan shall be used only to purchase items that increase independence or substitute for human assistance to the extent that expenditures would otherwise be made for human assistance, including additional goods, supports, services or supplies. The self-directed personal care, individual-directed goods and services, or self-directed community supports and services purchased with funds from a savings plan must:

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

(4) All funds allocated to a savings plan that are not expended by December 31 of each year shall revert to the Medicaid program.

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

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

(1) Contract with entities to provide services and supports as described in this subrule.  
(2) Determine the amount to be paid for services. Reimbursement rates shall be consistent with rates paid by others in the community for the same or substantially similar services. Reimbursement rates for the independent support broker and the financial management service are subject to the limits in 441—subrule 79.1(2).

(3) Schedule the provision of services.  
(4) Authorize payment for optional service components identified in the individual budget.  
(5) Reallocate funds among services included in the budget. Every purchase of a good or service must be identified and approved in the individual budget before the purchase is made.

*h. Delegation of budget authority.* The member may delegate responsibility for the individual budget to a representative in addition to the independent support broker.

(1) The representative must be at least 18 years old.  
(2) The representative shall not be a current provider of service to the member.  
(3) The member shall sign a consent form that designates who the member has chosen as a representative and what responsibilities the representative shall have.  
(4) The representative shall not be paid for this service.

*i. Employer authority.* The member shall have the authority to be the common-law employer of employees providing services and support under the consumer choices option. A common-law employer has the right to direct and control the performance of the services. The member may perform the following functions:

- (1) Recruit employees.
- (2) Select employees from a worker registry.
- (3) Verify employee qualifications.
- (4) Specify additional employee qualifications.
- (5) Determine employee duties.
- (6) Determine employee wages and benefits.
- (7) Schedule employees.
- (8) Train and supervise employees.

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

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

- (1) Assist the member with developing the member's initial and subsequent individual budgets and with making any changes to the individual budget.
- (2) Have monthly contact with the member for the first four months of implementation of the initial individual budget and have quarterly contact thereafter.
- (3) Complete the required employment packet with the financial management service.
- (4) Assist with interviewing potential employees and entities providing services and supports if requested by the member.
- (5) Assist the member with determining whether a potential employee meets the qualifications necessary to perform the job.
- (6) Assist the member with obtaining a signed consent from a potential employee to conduct background checks if requested by the member.
- (7) Assist the member with negotiating with entities providing services and supports if requested by the member.
- (8) Assist the member with contracts and payment methods for services and supports if requested by the member.
- (9) Assist the member with developing an emergency backup plan. The emergency backup plan shall address any health and safety concerns.
- (10) Review expenditure reports from the financial management service to ensure that services and supports in the individual budget are being provided.
- (11) Document in writing on the independent support broker timecard every contact the broker has with the member. Contact documentation shall include information on the extent to which the member's individual budget has addressed the member's needs and the satisfaction of the member.
  1. *Responsibilities of the financial management service.* The financial management service shall perform all of the following services:
    - (1) Receive Medicaid funds in an electronic transfer.
    - (2) Process and pay invoices for approved goods and services included in the individual budget.
    - (3) Enter the individual budget into the Web-based tracking system chosen by the department and enter expenditures as they are paid.
    - (4) Provide real-time individual budget account balances for the member, the independent support broker, and the department, available at a minimum during normal business hours (9 a.m. to 5 p.m., Monday through Friday).
    - (5) Conduct criminal background checks on potential employees pursuant to 441—Chapter 119.
    - (6) Verify for the member an employee's citizenship or alien status.
    - (7) Assist the member with fiscal and payroll-related responsibilities including, but not limited to:
      1. Verifying that hourly wages comply with federal and state labor rules.
      2. Collecting and processing timecards.
      3. Withholding, filing, and paying federal, state and local income taxes, Medicare and Social Security (FICA) taxes, and federal (FUTA) and state (SUTA) unemployment and disability insurance taxes, as applicable.
      4. Computing and processing other withholdings, as applicable.
      5. Processing all judgments, garnishments, tax levies, or other withholding on an employee's pay as may be required by federal, state, or local laws.
      6. Preparing and issuing employee payroll checks.
      7. Preparing and disbursing IRS Forms W-2 and W-3 annually.
      8. Processing federal advance earned income tax credit for eligible employees.
      9. Refunding over-collected FICA, when appropriate.
      10. Refunding over-collected FUTA, when appropriate.
    - (8) Assist the member in completing required federal, state, and local tax and insurance forms.
    - (9) Establish and manage documents and files for the member and the member's employees.
    - (10) Monitor timecards, receipts, and invoices to ensure that they are consistent with the individual budget. Keep records of all timecards and invoices for each member for a total of five years.

(11) Provide to the department, the independent support broker, and the member monthly and quarterly status reports that include a summary of expenditures paid and amount of budget unused.

(12) Establish an accessible customer service system and a method of communication for the member and the independent support broker that includes alternative communication formats.

(13) Establish a customer services complaint reporting system.

(14) Develop a policy and procedures manual that is current with state and federal regulations and update as necessary.

(15) Develop a business continuity plan in the case of emergencies and natural disasters.

(16) Provide to the department an annual independent audit of the financial management service.

(17) Assist in implementing the state's quality management strategy related to the financial management service.

**78.43(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.* Services must be billed in whole units.

*d.* 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]

**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 DSM-IV-TR Axis I diagnosis consistent with a severe and persistent mental illness. Members with a primary diagnosis of substance 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]

**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.

**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.* 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.

*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. The case manager or service worker shall encumber a portion of the cost of a modification every month within

the monthly dollar cap allowed for the member until the entire cost of the modification is encumbered within a consecutive 12-month period.

*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 \$6,060 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).

**78.46(5) *Transportation.*** Transportation services may be provided for members to conduct business errands and essential shopping, to receive medical services when not reimbursed through nonemergency medical transportation, to travel to and from work or day programs, and to reduce social isolation. A unit of service is one mile of transportation or one one-way trip.

**78.46(6) *Consumer choices option.*** The consumer choices option provides a member with a flexible monthly individual budget that is based on the member's service needs. With the individual budget, the member shall have the authority to purchase goods and services to meet the member's assessed needs and may choose to employ providers of services and supports. The services, supports, and items that are purchased with an individual budget must be directly related to a member's assessed need or goal established in the member's service plan. Components of this service are set forth below.

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

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

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

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

(2) The department shall determine an average unit cost for each service listed in subparagraph 78.46(6) "b"(1) based on actual unit costs from the previous fiscal year plus a cost-of-living adjustment.

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

(4) The department shall compute the utilization adjustment factor for each service by dividing the net costs of all claims paid for the service by the total of the authorized costs for that service, using at least 12 consecutive months of aggregate service data. The utilization adjustment factor shall be no lower than 60 percent. The department shall analyze and adjust the utilization adjustment factor at least annually in order to maintain cost neutrality.

(5) Individual budgets for respite services shall be computed based on the average cost for services identified in subparagraph 78.46(6) "b"(2). Respite services are not subject to the utilization adjustment factor in subparagraph 78.46(6) "b"(3).

(6) Anticipated costs for home and vehicle modification and specialized medical equipment are not subject to the average cost in subparagraph 78.46(6) "b"(2) or the utilization adjustment factor in subparagraph 78.46(6) "b"(3). Anticipated costs for home and vehicle modification and specialized medical equipment shall not include the costs of the financial management services or the independent support broker. Before becoming part of the individual budget, all home and vehicle modifications and specialized medical equipment shall be identified in the member's service plan and approved by the case manager or service worker. Costs for home and vehicle modification and specialized medical equipment may be paid to the financial management services provider in a one-time payment.

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

*c. Required service components.* To participate in the consumer choices option, a member must hire an independent support broker and must work with a financial management service that is enrolled

as a Medicaid provider. Before hiring the independent support broker, the member shall receive the results of the background check conducted pursuant to 441—Chapter 119.

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

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

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

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

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

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

(1) The costs of the financial management service.

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

(3) The costs of any optional service component chosen by the member as described in paragraph 78.46(6) "d." Costs of the following items and services shall not be covered by the individual budget:

1. Child care services.
2. Clothing not related to an assessed medical need.
3. Conference, meeting or similar venue expenses other than the costs of approved services the member needs while attending the conference, meeting or similar venue.
4. Costs associated with shipping items to the member.
5. Experimental and non-FDA-approved medications, therapies, or treatments.
6. Goods or services covered by other Medicaid programs.
7. Home furnishings.
8. Home repairs or home maintenance.
9. Homeopathic treatments.
10. Insurance premiums or copayments.
11. Items purchased on installment payments.
12. Motorized vehicles.
13. Nutritional supplements.
14. Personal entertainment items.
15. Repairs and maintenance of motor vehicles.
16. Room and board, including rent or mortgage payments.
17. School tuition.

18. Service animals.
19. Services covered by third parties or services that are the responsibility of a non-Medicaid program.
20. Sheltered workshop services.
21. Social or recreational purchases not related to an assessed need or goal identified in the member's service plan.
22. Vacation expenses, other than the costs of approved services the member needs while on vacation.

(4) The costs of any approved home or vehicle modification or specialized medical equipment. When authorized, the budget may include an amount allocated for a home or vehicle modification or specialized medical equipment. Before becoming part of the individual budget, all home and vehicle modifications and specialized medical equipment shall be identified in the member's service plan and approved by the case manager or service worker. The authorized amount shall not be used for anything other than the specific modification or equipment.

(5) Any amount set aside in a savings plan to reserve funds for the future purchase of self-directed personal care, individual-directed goods and services, or self-directed community supports and services as defined in paragraph 78.46(6) "d." The savings plan shall meet the requirements in paragraph 78.46(6) "f."

*f. Savings plan.* A member savings plan must be in writing and be approved by the department before the start of the savings plan. Amounts allocated to the savings plan must result from efficiencies in meeting identified needs of the member.

- (1) The savings plan shall identify:
  1. The specific goods, services, supports or supplies to be purchased through the savings plan.
  2. The amount of the individual budget allocated each month to the savings plan.
  3. The amount of the individual budget allocated each month to meet the member's identified service needs.
4. How the member's assessed needs will continue to be met through the individual budget when funds are placed in savings.

(2) With the exception of funds allocated for respite care, the savings plan shall not include funds budgeted for direct services that were not received. The budgeted amount associated with unused direct services other than respite care shall revert to the Medicaid program at the end of each month. Funds from unused respite services may be allocated to the savings plan but shall not be used for anything other than future respite care.

(3) Funds accumulated under a savings plan shall be used only to purchase items that increase independence or substitute for human assistance to the extent that expenditures would otherwise be made for human assistance, including additional goods, supports, services or supplies. The self-directed personal care, individual-directed goods and services, or self-directed community supports and services purchased with funds from a savings plan must:

1. Be used to meet a member's identified need,
  2. Be medically necessary, and
  3. Be approved by the member's case manager or service worker.
- (4) All funds allocated to a savings plan that are not expended by December 31 of each year shall revert to the Medicaid program.

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

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

- (1) Contract with entities to provide services and supports as described in this subrule.
- (2) Determine the amount to be paid for services. Reimbursement rates shall be consistent with rates paid by others in the community for the same or substantially similar services. Reimbursement

rates for the independent support broker and the financial management service are subject to the limits in 441—subrule 79.1(2).

(3) Schedule the provision of services.

(4) Authorize payment for waiver goods and services optional service components identified in the individual budget.

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

*h. Delegation of budget authority.* The member may delegate responsibility for the individual budget to a representative in addition to the independent support broker.

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

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

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

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

*i. Employer authority.* The member shall have the authority to be the common-law employer of employees providing services and support under the consumer choices option. A common-law employer has the right to direct and control the performance of the services. The member may perform the following functions:

(1) Recruit employees.

(2) Select employees from a worker registry.

(3) Verify employee qualifications.

(4) Specify additional employee qualifications.

(5) Determine employee duties.

(6) Determine employee wages and benefits.

(7) Schedule employees.

(8) Train and supervise employees.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

- (1) Receive Medicaid funds in an electronic transfer.
- (2) Process and pay invoices for approved goods and services included in the individual budget.
- (3) Enter the individual budget into the Web-based tracking system chosen by the department and enter expenditures as they are paid.
- (4) Provide real-time individual budget account balances for the member, the independent support broker, and the department, available at a minimum during normal business hours (9 a.m. to 5 p.m., Monday through Friday).
- (5) Conduct criminal background checks on potential employees pursuant to 441—Chapter 119.
- (6) Verify for the member an employee's citizenship or alien status.
- (7) Assist the member with fiscal and payroll-related responsibilities including, but not limited to:
  1. Verifying that hourly wages comply with federal and state labor rules.
  2. Collecting and processing timecards.
  3. Withholding, filing, and paying federal, state and local income taxes, Medicare and Social Security (FICA) taxes, and federal (FUTA) and state (SUTA) unemployment and disability insurance taxes, as applicable.
  4. Computing and processing other withholdings, as applicable.
  5. Processing all judgments, garnishments, tax levies, or other withholding on an employee's pay as may be required by federal, state, or local laws.
  6. Preparing and issuing employee payroll checks.
  7. Preparing and disbursing IRS Forms W-2 and W-3 annually.
  8. Processing federal advance earned income tax credit for eligible employees.
  9. Refunding over-collected FICA, when appropriate.
  10. Refunding over-collected FUTA, when appropriate.
- (8) Assist the member in completing required federal, state, and local tax and insurance forms.
- (9) Establish and manage documents and files for the member and the member's employees.
- (10) Monitor timecards, receipts, and invoices to ensure that they are consistent with the individual budget. Keep records of all timecards and invoices for each member for a total of five years.
- (11) Provide to the department, the independent support broker, and the member monthly and quarterly status reports that include a summary of expenditures paid and amount of budget unused.
- (12) Establish an accessible customer service system and a method of communication for the member and the independent support broker that includes alternative communication formats.
- (13) Establish a customer services complaint reporting system.
- (14) Develop a policy and procedures manual that is current with state and federal regulations and update as necessary.
- (15) Develop a business continuity plan in the case of emergencies and natural disasters.
- (16) Provide to the department an annual independent audit of the financial management service.
- (17) Assist in implementing the state's quality management strategy related to the financial management service.

**78.46(7) General service standards.** All physical disability waiver services must be provided in accordance with the following standards:

- a.* Reimbursement shall not be available under the waiver for any services that the member can obtain as other nonwaiver Medicaid services or through any other funding source.
- b.* All services provided under the waiver must be delivered in the least restrictive environment possible and in conformity with the member's service plan.
- c.* Services must be billed in whole units.
- d.* 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]

**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.

**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. Services must be billed in whole units.

d. 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]

**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]

[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>◇</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>◇</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>◇</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]
- [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>2</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>3</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>4</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>o</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>o</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]
- [Filed emergency 6/13/01—published 7/11/01, effective 7/1/01]<sup>o</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>◊</sup>
- [Filed emergency 1/9/02 after Notice 11/14/01—published 2/6/02, effective 2/1/02]<sup>◊</sup>
  - [Filed emergency 1/16/02—published 2/6/02, effective 2/1/02<sup>5</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>6</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>◊</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>◊</sup>
  - [Filed 9/22/03, Notice 7/9/03—published 10/15/03, effective 12/1/03]<sup>◊</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>◊</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>◊</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>7</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>8</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]

<sup>0</sup> Two or more ARCs

<sup>1</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>2</sup> Effective date of 4/1/90 delayed 70 days by the Administrative Rules Review Committee at its March 12, 1990, meeting.

<sup>3</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>4</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>5</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>6</sup> Effective date of 12/15/02 delayed 70 days by the Administrative Rules Review Committee at its December 10, 2002, meeting.

<sup>7</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>8</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.



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

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

**79.1(1) Types of reimbursement.**

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

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

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

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

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

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

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

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

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

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

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

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

1. The indirect administrative costs shall be limited to 23 percent of other costs. Other costs include: professional staff – direct salaries, other – direct salaries, benefits and payroll taxes associated with direct salaries, mileage and automobile rental, agency vehicle expense, automobile insurance, and other related transportation.

2. Mileage shall be reimbursed at a rate no greater than the state employee rate.

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

4. Costs of operation shall include only those costs that pertain to the provision of services which are authorized under rule 441—90.3(249A).

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

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

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

(3) The prospective rates paid to both new and established providers are subject to the maximums listed in subrule 79.1(2) and to retrospective adjustment based on the provider’s actual, current costs of operation as shown by financial and statistical reports submitted by the provider, so as not to exceed reasonable and proper costs actually incurred by more than 4.5 percent.

*f. Contractual rate.* Providers are reimbursed on a basis of costs incurred pursuant to a contract between the provider and subcontractor.

*g. Retrospectively adjusted prospective rates.* Critical access hospitals are reimbursed prospectively, with retrospective adjustments based on annual cost reports submitted by the hospital at the end of the hospital’s fiscal year. The retroactive adjustment equals the difference between the reasonable costs of providing covered services to eligible fee-for-service Medicaid members (excluding members in managed care), determined in accordance with Medicare cost principles, and the Medicaid reimbursement received. Amounts paid that exceed reasonable costs shall be recovered by the department. See paragraphs 79.1(5)“aa” and 79.1(16)“h.”

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

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

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

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
Advanced registered nurse practitioners	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.
Ambulance	Fee schedule	Ground ambulance: Fee schedule in effect 6/30/13 plus 10%. Air ambulance: Fee schedule in effect 6/30/13 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 as determined by the Iowa Plan for Behavioral Health	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%.
Chiropractors	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.
Clinics	Fee schedule	Maximum physician reimbursement rate.
Community mental health centers and providers of mental health services to county residents pursuant to a waiver approved under Iowa Code section 225C.7(3)	Retrospective cost-related. See 79.1(25)	100% of reasonable Medicaid cost as determined by Medicare cost reimbursement principles.
Dentists	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.
Durable medical equipment, prosthetic devices and medical supply dealers	Fee schedule. See 79.1(4)	Fee schedule in effect 6/30/13 plus 1%.
Family planning clinics	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.
Federally qualified health centers	Retrospective cost-related. See 441—88.14(249A)	1. Prospective payment rate as required by the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA 2000) or an alternative methodology allowed thereunder, as specified in “2” below. 2. 100% of reasonable cost as determined by Medicare cost reimbursement principles.

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
HCBS waiver service providers, including:		<p>3. In the case of services provided pursuant to a contract between an FQHC and a managed care organization (MCO), reimbursement from the MCO shall be supplemented to achieve "1" or "2" above.</p> <p>Except as noted, limits apply to all waivers that cover the named provider.</p>
1. Adult day care	Fee schedule	<p>Effective 7/1/13, for AIDS/HIV, brain injury, elderly, and ill and handicapped waivers: Provider's rate in effect 6/30/13 plus 3%, converted to a 15-minute, half-day, full-day, or extended-day rate. If no 6/30/13 rate: Veterans Administration contract rate or \$1.45 per 15-minute unit, \$23.24 per half day, \$46.26 per full day, or \$69.37 per extended day if no Veterans Administration contract.</p> <p>Effective 7/1/13, for intellectual disability waiver: County contract rate or, in the absence of a contract rate, provider's rate in effect 6/30/13 plus 3%, converted to a 15-minute, half-day, full-day, or extended-day rate. If no 6/30/13 rate, \$1.94 per 15-minute unit, \$30.96 per half day, \$61.80 per full day, or \$78.80 per extended day.</p>
2. Emergency response system:		
Personal response system	Fee schedule	<p>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.</p>
Portable locator system	Fee schedule	<p>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.</p>

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
3. Home health aides	Retrospective cost-related	For AIDS/HIV, elderly, and health and disability waivers effective 7/1/13: Lesser of maximum Medicare rate in effect 6/30/13 plus 3% or maximum Medicaid rate in effect 6/30/13 plus 3%.  For intellectual disability waiver effective 7/1/13: Lesser of maximum Medicare rate in effect 6/30/13 plus 3% or maximum Medicaid rate in effect 6/30/13 plus 3%, 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	For elderly and intellectual disability waivers: Fee schedule as determined by Medicare.	For elderly waiver effective 7/1/13, provider's rate in effect 6/30/13 plus 3%. If no 6/30/13 rate: \$87.12 per visit.  For intellectual disability waiver effective 7/1/13: Lesser of maximum Medicare rate in effect 6/30/13 plus 3% or maximum Medicaid rate in effect 6/30/13 plus 3%, converted to an hourly rate.
	For AIDS/HIV and health and disability waivers: Agency's financial and statistical cost report and Medicare percentage rate per visit.	For AIDS/HIV and health and disability waivers effective 7/1/13, provider's rate in effect 6/30/13 plus 3%. If no 6/30/13 rate: \$87.12 per visit.
6. Respite care when provided by: Home health agency: Specialized respite	Cost-based rate for nursing services provided by a home health agency	Effective 7/1/13, provider's rate in effect 6/30/13 plus 3%, converted to a 15-minute rate. If no 6/30/13 rate: Lesser of maximum Medicare rate in effect 6/30/13 plus 3%, converted to a 15-minute rate, or maximum Medicaid rate in effect 6/30/13 plus 3%, converted to a 15-minute rate, not to exceed \$311.97 per day.

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
Basic individual respite	Cost-based rate for home health aide services provided by a home health agency	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: Lesser of maximum Medicare rate in effect 6/30/13 plus 3%, converted to a 15-minute rate, or maximum Medicaid rate in effect 6/30/13 plus 3%, converted to a 15-minute rate, not to exceed \$311.97 per day.
Group respite	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: \$3.45 per 15-minute unit, not to exceed \$311.97 per day.
Home care agency: Specialized respite	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: \$8.87 per 15-minute unit, not to exceed \$311.97 per day.
Basic individual respite	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: \$4.73 per 15-minute unit, not to exceed \$311.97 per day.
Group respite	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: \$3.45 per 15-minute unit, not to exceed \$311.97 per day.
Nonfacility care: Specialized respite	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: \$8.87 per 15-minute unit, not to exceed \$311.97 per day.
Basic individual respite	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: \$4.73 per 15-minute unit, not to exceed \$311.97 per day.
Group respite	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: \$3.45 per 15-minute unit, not to exceed \$311.97 per day.

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
Facility care:		
Hospital or nursing facility providing skilled care	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: \$3.45 per 15-minute unit, not to exceed the facility's daily Medicaid rate for skilled nursing level of care.
Nursing facility	Fee schedule	Effective 7/1/13, provider's rate in effect 6/30/13 plus 3%, converted to a 15-minute rate. If no 6/30/13 rate: \$3.45 per 15-minute unit, not to exceed the facility's daily Medicaid rate.
Camps	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: \$3.45 per 15-minute unit, not to exceed \$311.97 per day.
Adult day care	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: \$3.45 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 7/1/13, provider's rate in effect 6/30/13 plus 3%, converted to a 15-minute rate. If no 6/30/13 rate: \$3.45 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 7/1/13, provider's rate in effect 6/30/13 plus 3%, converted to a 15-minute rate. If no 6/30/13 rate: \$3.45 per 15-minute unit, not to exceed contractual daily rate.
Foster group care	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: \$3.45 per 15-minute unit, not to exceed daily rate for child welfare services.
Child care facilities	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: \$3.45 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.

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
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 7/1/13, provider's rate in effect 6/30/13 plus 3%. If no 6/30/13 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 7/1/13 for non-county contract: Provider's rate in effect 6/30/13 plus 3%, converted to a 15-minute rate. If no 6/30/13 rate: \$8.67 per 15-minute unit.
13. Assistive devices	Fee schedule. See 79.1(17)	Effective 7/1/13: \$115.62 per unit.
14. Senior companion	Fee schedule	Effective 7/1/13 for non-county contract: Provider's rate in effect 6/30/13 plus 3%, converted to a 15-minute rate. If no 6/30/13 rate: \$1.87 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 7/1/13, provider's rate in effect 6/30/13 plus 3%, converted to a 15-minute rate. If no 6/30/13 rate: \$5.30 per 15-minute unit, not to exceed \$122.62 per day.

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
Assisted living program (for elderly waiver only)	Fee agreed upon by member and provider	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: \$5.30 per 15-minute unit, not to exceed \$122.62 per day.
Individual	Fee agreed upon by member and provider	Effective 7/1/13, \$3.54 per 15-minute unit, not to exceed \$82.53 per day.
16. Counseling:		
Individual	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: \$11.34 per 15-minute unit.
Group	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: \$11.33 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 for service with cost settlement. See 79.1(1) "d."	For brain injury and elderly waivers: Retrospective cost-settled rate.
18. Supported community living	Retrospectively limited prospective rates. See 79.1(15)	For intellectual disability and brain injury waiver effective 7/1/13: \$9.19 per 15-minute unit, not to exceed the maximum daily ICF/ID rate per day plus 3%.
19. Supported employment:		
Activities to obtain a job:		
Job development	Fee schedule	Effective 7/1/13, provider's rate in effect 6/30/13 plus 3%. If no 6/30/13 rate: \$955.00 per unit (job placement). Maximum of two units per 12 months.
Employer development	Fee schedule	Effective 7/1/13, provider's rate in effect 6/30/13 plus 3%. If no 6/30/13 rate: \$955.00 per unit (job placement). Maximum of two units per 12 months.
Enhanced job search	Retrospectively limited prospective rates. See 79.1(15)	Effective 7/1/13: \$9.19 per 15-minute unit. Maximum of 104 units per 12 months.

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
Supports to maintain employment	Retrospectively limited prospective rates. See 79.1(15)	Effective 7/1/13: \$9.19 per 15-minute unit for all activities other than personal care and services in an enclave setting. \$5.20 per 15-minute unit for personal care. \$1.63 per 15-minute unit for services in an enclave setting. \$3,029.62 per month for total service. Maximum of 160 units per week.
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 7/1/13, provider's rate in effect 6/30/13 plus 3%. If no 6/30/13 rate: \$11.34 per 15 minutes.
22. Family counseling and training	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: \$11.33 per 15-minute unit.
23. Prevocational services	Fee schedule	County contract rate or, in absence of a contract rate, effective 7/1/13: Lesser of provider's rate in effect 6/30/13 plus 3%, \$50.66 per day or \$13.87 per hour.
24. Interim medical monitoring and treatment:		
Home health agency (provided by home health aide)	Cost-based rate for home health aide services provided by a home health agency	Effective 7/1/13: Lesser of maximum Medicare rate in effect 6/30/13 plus 3%, converted to a 15-minute rate, or maximum Medicaid rate in effect 6/30/13 plus 3%, converted to a 15-minute rate.
Home health agency (provided by nurse)	Cost-based rate for nursing services provided by a home health agency	Effective 7/1/13: Lesser of maximum Medicare rate in effect 6/30/13 plus 3%, converted to a 15-minute rate, or maximum Medicaid rate in effect 6/30/13 plus 3%, converted to a 15-minute rate.
Child development home or center	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: \$3.45 per 15-minute unit.
Supported community living provider	Retrospectively limited prospective rate. See 79.1(15)	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: \$9.19 per 15-minute unit, not to exceed the maximum ICF/ID rate per day plus 3%.

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
25. Residential-based supported community living	Retrospectively limited prospective rates. See 79.1(15)	Effective 7/1/13: Not to exceed the maximum ICF/ID rate per day plus 3%.
26. Day habilitation	Fee schedule	Effective 7/1/13: County contract rate converted to a 15-minute or daily rate or, in the absence of a contract rate, provider's rate in effect 6/30/13 plus 3%, converted to a 15-minute or daily rate. If no 6/30/13 rate: \$3.47 per 15-minute unit or \$67.55 per day.
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 7/1/13, provider's rate in effect 6/30/13 plus 3%, converted to a 15-minute rate. If no 6/30/13 rate: \$9.19 per 15-minute unit.
29. In-home family therapy	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: \$24.60 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 7/1/13, provider's rate in effect 6/30/13 plus 3%. If no 6/30/13 rate: \$15.91 per hour.
32. Self-directed personal care	Rate negotiated by member	Determined by member's individual budget.
33. Self-directed community supports and employment	Rate negotiated by member	Determined by member's individual budget.
34. Individual-directed goods and services	Rate negotiated by member	Determined by member's individual budget.
35. Assisted living on-call service providers (elderly waiver only)	Fee agreed upon by member and provider.	\$25.75 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	See 79.1(24) "d"	Retrospective cost-settled rate.
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.

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
4. Prevocational habilitation	See 79.1(24) "d"	Effective 7/1/13: \$13.47 per hour or \$48.22 per day.
5. Supported employment:		
Activities to obtain a job:		
Job development	See 79.1(24) "d"	\$909 per unit (job placement). Maximum of two units per 12 months.
Employer development	See 79.1(24) "d"	\$909 per unit (job placement). Maximum of two units per 12 months.
Enhanced job search	See 79.1(24) "d"	Effective 7/1/13: Maximum of \$8.75 per 15-minute unit and 104 units per 12 months.
Supports to maintain employment	See 79.1(24) "d"	Effective 7/1/13: \$1.55 per 15-minute unit for services in an enclave setting; \$4.95 per 15-minute unit for personal care; and \$8.75 per 15-minute unit for all other services. Total not to exceed \$2,883.71 per month. Maximum of 160 units per week.
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 7/1/13: Medicare LUPA rates in effect on July 1, 2013, updated July 1 every two years.
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 service 638 facilities	1. Base rate as determined by the United States Office of Management and Budget for outpatient visits for American Indian and Alaskan native members.	1. Office of Management and Budget rate published in the Federal Register for outpatient visit rate.

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
	2. Fee schedule for service provided for all other Medicaid members.	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.
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.

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
2. Hospital-based, Medicare-certified nursing care	Prospective reimbursement. See 441—subrule 81.10(1) and 441—81.6(249A). The percentage of the median used to calculate the direct care excess payment allowance ceiling under 441—81.6(16)“d”(3)“1” is 95% of the patient-day-weighted median. The percentage of the difference used to calculate the direct care excess payment allowance is 0%. The percentage of the median used to calculate the direct care excess payment allowance limit is 10% of the patient-day-weighted median. The percentage of the median used to calculate the non-direct care excess payment allowance ceiling under 441—81.6(16)“d”(3)“2” is 96% of the patient-day-weighted median. The percentage of the difference used to calculate the non-direct care excess payment allowance limit is 0%. The percentage of the median used to calculate the non-direct care excess payment allowance limit is 8% of the patient-day-weighted median.	See 441—subrules 81.6(4) and 81.6(14) and paragraph 81.6(16)“f.” The direct care rate component limit under 441—81.6(16)“f”(3) is 120% of the patient-day-weighted median. The non-direct care rate component limit under 441—81.6(16)“f”(3) is 110% of the patient-day-weighted median.
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	Fee schedule in effect 6/30/13 plus 1%.
Physician-administered drugs	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
Qualified primary care services furnished in 2013 or 2014	See 79.1(7)“c”	Rate provided by 79.1(7)“c”
Podiatrists	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.
Prescribed drugs	See 79.1(8)	Amount pursuant to 79.1(8).
Psychiatric medical institutions for children:		
1. Inpatient	Retrospective cost-related	Effective 8/1/11: Actual and allowable cost not to exceed a maximum for non-state-owned providers of 103% of patient-day-weighted average costs of non-state-owned providers located within Iowa.
2. Outpatient day treatment	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.
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%.
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—88.14(249A)	1. Prospective payment rate as required by the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA 2000) or an alternative methodology allowed thereunder, as specified in “2” below. 2. 100% of reasonable cost as determined by Medicare cost reimbursement principles. 3. In the case of services provided pursuant to a contract between an RHC and a managed care organization (MCO), reimbursement from the MCO shall be supplemented to achieve “1” or “2” above.
Screening centers	Fee schedule	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	
Targeted case management providers	Fee for service with cost settlement. See 79.1(1)“d.”	Retrospective cost-settled rate.

**79.1(3) Ambulatory surgical centers.**

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

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

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

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

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

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

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

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

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

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

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

*“Disproportionate share percentage”* shall mean either (1) the product of 2½ percent multiplied by the number of standard deviations by which the hospital’s own Medicaid inpatient utilization rate

exceeds the statewide mean Medicaid inpatient utilization rate for all hospitals, or (2) 2½ percent. (See 79.1(5)“y”(7).)

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

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

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

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

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

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

“*GME/DSH fund implementation year*” means 2009.

“*Graduate medical education and disproportionate share fund*” or “*GME/DSH fund*” means a reimbursement fund developed as an adjunct reimbursement methodology to directly reimburse qualifying hospitals for the direct and indirect costs associated with the operation of graduate medical education programs and the costs associated with the treatment of a disproportionate share of poor, indigent, nonreimbursed or nominally reimbursed patients for inpatient services.

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

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

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

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

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

A separate low-income utilization rate shall be determined for any hospital qualifying or seeking to qualify for a disproportionate share payment as a children’s hospital, using only billings for patients

under 18 years of age at the time of admission in the distinct area or areas in the hospital where services are provided predominantly to children under 18 years of age.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(2) Neonatal intensive care units certified pursuant to 79.1(5)*“r.”* Three sets of weights are developed for DRGs concerning treatment of neonates. One set of weights is developed from charges associated with treating neonates in a designated level III neonatal intensive care unit for some portion of their hospitalization. The second set of weights is developed from charges associated with treating neonates in a designated level II neonatal intensive care unit for some portion of their hospitalization.

The third set of weights reflects charges associated with neonates not treated in a designated level II or level III setting. Hospitals are reimbursed using the weight that reflects the setting for neonate treatment.

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

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

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

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

(2) The hospital-specific case-mix index is computed by taking each hospital's trimmed claims that match the hospital's base year cost reporting period, summing the assigned DRG weights associated with those claims and dividing by the total number of Medicaid claims associated with that specific hospital for that period. Case-mix indices are not computed for hospitals receiving reimbursement as critical access hospitals.

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

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

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

1. The total calculated dollar expenditures based on hospitals' base-year cost reports for capital costs and medical education costs, and
2. The actual payments made for additional transfers, outliers, physical rehabilitation services, psychiatric services rendered on or after October 1, 2006, and indirect medical education.

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

(2) Calculation of hospital-specific case-mix-adjusted average cost per discharge. The hospital-specific case-mix-adjusted average cost per discharge is calculated by subtracting from the lesser of total Iowa Medicaid costs or covered reasonable charges, as determined by the hospital's base-year cost report or MMIS claims system, the actual dollar expenditures for capital costs, direct medical education costs, and the payments made for nonfull DRG transfers, outliers, physical

rehabilitation services, and psychiatric services rendered on or after October 1, 2006, if applicable. The remaining amount is case-mix adjusted, multiplied by inflation factors, and divided by the total number of Iowa Medicaid discharges from the MMIS claims system for that hospital during the applicable base year, less the nonfull DRG transfers and short stay outliers.

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

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

*e. Add-ons to the base amount.*

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

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

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

The 50/50 blend is calculated by adding the case-mix-adjusted hospital-specific per discharge capital cost to the statewide average case-mix-adjusted per discharge capital costs and dividing by two. Hospitals whose blended capital add-on exceeds one standard deviation off the mean Medicaid blended capital rate will be subject to a reduction in their capital add-on to equal the first standard deviation.

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

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

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

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

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

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

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

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

*g. Billing for patient transfers and readmissions.*

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

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

(3) Physical rehabilitation hospitals or units. When a patient requiring physical rehabilitation is discharged from an acute care hospital and admitted to a rehabilitation hospital or unit certified pursuant to 79.1(5) "r," and the admission is medically appropriate, then payment for time spent in the unit is through a per diem. The discharging hospital will receive 100 percent of the DRG payment. When a patient is discharged from a certified physical rehabilitation hospital or unit and admitted to an acute care hospital, the acute care hospital will receive 100 percent of the DRG payment.

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

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

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

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

(5) Inpatient readmissions within seven days for same condition. When an inpatient is discharged or transferred from an acute care hospital and is readmitted as an inpatient to the same hospital within seven days for the same condition, any claim for the subsequent inpatient stay shall be combined with the claim for the original inpatient stay and payment shall be under a single DRG for both stays.

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

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

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

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

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

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

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

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

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

*k. Inflation factors, rebasing, and recalibration.*

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

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

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

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

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

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

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

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

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

(3) If a hospital qualifies for reimbursement for direct medical education or indirect medical education under Medicare guidelines, it shall be reimbursed according to paragraph 79.1(5)“y.” Out-of-state hospitals do not qualify for direct medical education or indirect medical education payments pursuant to paragraph 79.1(5)“y.”

*n. Preadmission, preauthorization, or inappropriate services.* Medicaid adopts most Medicare QIO regulations to control increased admissions or reduced services. Exceptions to the Medicare review practice are that the QIO reviews Medicaid short stay outliers and all Medicaid patients readmitted within 31 days. Payment can be denied if either admissions or discharges are performed without medical justification as determined by the QIO. Inpatient or outpatient services which require preadmission or preprocedure approval by the QIO are updated yearly by the department and are listed in the provider manual. Preauthorization for any of these services is transmitted directly from the QIO to the Iowa Medicaid enterprise and no additional information needs to be submitted as part of the claim filing for inpatient or outpatient services. To safeguard against these and other inappropriate practices, the department through the QIO will monitor admission practices and quality of care. If an abuse of the prospective payment system is identified, payments for abusive practices may be reduced or denied. In reducing or denying payment, Medicaid adopts the Medicare QIO regulations.

*o. Hospital billing.* Hospitals shall normally submit claims for DRG reimbursement to the Iowa Medicaid enterprise after a patient's discharge.

(1) Payment for outlier days or costs is determined when the claim is paid by the Iowa Medicaid enterprise, as described in paragraph “f.”

(2) When a Medicaid patient requires acute care in the same facility for a period of no less than 120 days, a request for partial payment may be made. Written requests for this interim DRG payment shall be addressed to the Iowa Medicaid Enterprise, Attention: Provider Services Unit, P.O. Box 36450, Des Moines, Iowa 50315. A request for interim payment shall include:

1. The patient's name, state identification number, and date of admission;
2. A brief summary of the case;
3. A current listing of charges; and
4. A physician's attestation that the recipient has been an inpatient for 120 days and is expected to remain in the hospital for a period of no less than 60 additional days.

A departmental representative will then contact the facility to assist the facility in filing the interim claim.

*p. Determination of inpatient admission.* A person is considered to be an inpatient when a formal inpatient admission occurs, when a physician intends to admit a person as an inpatient, or when a physician determines that a person being observed as an outpatient in an observation or holding bed should be admitted to the hospital as an inpatient.

(1) In cases involving outpatient observation status, the determinant of patient status is not the length of time the patient was being observed, but rather that the observation period was medically necessary for the physician to determine whether a patient should be released from the hospital or admitted to the hospital as an inpatient.

(2) Outpatient observation lasting greater than a 24-hour period will be subject to review by the Iowa Medicaid Enterprise (IME) Medical Services Unit to determine the medical necessity of each case. For those outpatient observation cases where medical necessity is not established by the IME, reimbursement shall be denied for the services found to be unnecessary for the provision of that care, such as the use of the observation room.

*q. Inpatient admission after outpatient services.* A patient may be admitted to the hospital as an inpatient after receiving outpatient services. If the patient is admitted as an inpatient within three days of the day outpatient services were rendered, all outpatient services related to the principal diagnosis are considered inpatient services for billing purposes. The day of formal admission as an inpatient is considered as the first day of hospital inpatient services.

*r. Certification for reimbursement as a special unit or physical rehabilitation hospital.* Certification for Medicaid reimbursement as a substance abuse unit under subparagraph 79.1(5)"b"(1), a neonatal intensive care unit under subparagraph 79.1(5)"b"(2), a psychiatric unit under paragraph 79.1(5)"i," or a physical rehabilitation hospital or unit under paragraph 79.1(5)"i" shall be awarded as provided in this paragraph.

(1) Certification procedure. All hospital special units and physical rehabilitation hospitals must be certified by the Iowa Medicaid enterprise to qualify for Medicaid reimbursement as a special unit or physical rehabilitation hospital. Hospitals shall submit requests for certification to Iowa Medicaid Enterprise, Attention: Provider Services Unit, P.O. Box 36450, Des Moines, Iowa 50315, with documentation that the certification requirements are met. The provider services unit will notify the facility of any additional documentation needed after review of the submitted documentation.

Upon certification, reimbursement as a special unit or physical rehabilitation hospital shall be retroactive to the first day of the month during which the Iowa Medicaid enterprise received the request for certification. No additional retroactive payment adjustment shall be made when a hospital fails to make a timely request for certification.

(2) Certification criteria for substance abuse units. An in-state substance abuse unit may be certified for Medicaid reimbursement under 79.1(5)"b"(1) if the unit's program is licensed by the Iowa department of public health as a substance abuse treatment program in accordance with Iowa Code chapter 125 and 643—Chapter 3. In addition to documentation of the license, an in-state hospital must submit documentation of the specific substance abuse programs available at the facility with a description of their staffing, treatment standards, and population served.

An out-of-state substance abuse unit may be certified for Medicaid reimbursement under 79.1(5)"b"(1) if it is excluded from the Medicare prospective payment system as a psychiatric unit

pursuant to 42 Code of Federal Regulations, Sections 412.25 and 412.27, as amended to September 1, 1994. An out-of-state hospital requesting reimbursement as a substance abuse unit must initially submit a copy of its current Medicare prospective payment system exemption notice, unless the facility had certification for reimbursement as a substance abuse unit before July 1, 1993. All out-of-state hospitals certified for reimbursement for substance abuse units must submit copies of new Medicare prospective payment system exemption notices as they are issued, at least annually.

(3) Certification criteria for neonatal intensive care units. A neonatal intensive care unit may be certified for Medicaid reimbursement under 79.1(5) “b”(2) if it is certified as a level II or level III neonatal unit and the hospital where it is located is accredited by the Joint Commission on Accreditation of Healthcare Organizations or the American Osteopathic Association. The Iowa Medicaid enterprise shall verify the unit’s certification as a level II or level III neonatal unit in accordance with recommendations set forth by the American Academy of Pediatrics for newborn care. Neonatal units in Iowa shall be certified by the Iowa department of public health pursuant to 641—Chapter 150. Out-of-state units shall submit proof of level II or level III certification.

(4) Certification criteria for psychiatric units. A psychiatric unit may be certified for Medicaid reimbursement under paragraph 79.1(5) “i” if it is excluded from the Medicare prospective payment system as a psychiatric unit pursuant to 42 Code of Federal Regulations, Sections 412.25 and 412.27 as amended to August 1, 2002.

(5) Certification criteria for physical rehabilitation hospitals and units. A physical rehabilitation hospital or unit may be certified for Medicaid reimbursement under 79.1(5) “i” if it receives or qualifies to receive Medicare reimbursement as a rehabilitative hospital or unit pursuant to 42 Code of Federal Regulations, Sections 412.600 through 412.632 (Subpart P), as amended to January 1, 2002, and the hospital is accredited by the Joint Commission on Accreditation of Healthcare Organizations or the American Osteopathic Association.

*s. Health care access assessment inflation factor.* Effective with the implementation of the health care access assessment paid pursuant to 441—Chapter 36, Division III, a health care access assessment inflation factor shall be applied to the Medicaid DRG blended base amount as otherwise calculated pursuant to this subrule for all “participating hospitals” as defined in 441—subrule 36.10(1).

(1) Calculation of inflation factor. The health care access assessment inflation factor for participating hospitals shall be calculated by dividing the amount allowed under the Medicare inpatient upper payment limit for the fiscal year beginning July 1, 2010, by the sum of the projected expenditures for participating hospitals for the fiscal year beginning July 1, 2010, as determined by the fiscal management division of the department, and the amount allowed under the Medicare inpatient upper payment limit.

(2) Implementation date. The health care access assessment inflation factor shall not be applied until federal financial participation to match money collected from the health care access assessment pursuant to 441—Chapter 36, Division III, has been approved by the federal Centers for Medicare and Medicaid Services.

(3) End date. Application of the health care access assessment inflation factor shall terminate if the health care access assessment is terminated pursuant to rule 441—36.12(83GA,SF2388). If federal match money is unavailable for a retroactive period or the authority to collect the assessment is rescinded for a retroactive period, the department shall:

1. Recalculate Medicaid rates in effect during that period without the application of the health care access assessment inflation factor;
2. Recompute Medicaid payments due based on the recalculated Medicaid rates;
3. Recoup any previous overpayments; and
4. Determine for each hospital the amount of health care access assessment collected during that period and refund that amount to the facility.

*t. Limitations and application of limitations on payment.* Diagnosis-related group payments are subject to the upper payment limits as stated in 42 CFR 447.271 and 42 CFR 447.272 as amended to September 5, 2001.

(1) The department may not pay a provider more for inpatient hospital services under Medicaid than the provider's customary charges to the general public for the services. This limit is applied in the aggregate during the cost settlement process at the end of the hospital's fiscal year.

(2) Aggregate payments to hospitals and state-operated hospitals may not exceed the amount that can reasonably be estimated would have been paid for those services under Medicare payment principles. This limit is applied to aggregate Medicaid payments at the end of the state's fiscal year.

*u. State-owned teaching hospital disproportionate share payment.* In addition to payments from the graduate medical education and disproportionate share fund made pursuant to paragraph 79.1(5) "y," payment shall be made to Iowa hospitals qualifying for the Iowa state-owned teaching hospital disproportionate share fund. Interim monthly payments based on estimated allowable costs will be paid to qualifying hospitals under this paragraph.

(1) Qualifying criteria. A hospital qualifies for Iowa state-owned teaching hospital disproportionate share payments if it qualifies for disproportionate share payments pursuant to paragraph 79.1(5) "y" and is an Iowa state-owned hospital with more than 500 beds and eight or more distinct residency specialty or subspecialty programs recognized by the American College of Graduate Medical Education.

(2) Allocation to fund. The total amount of funding that is allocated on July 1 of each year to the Iowa state-owned teaching hospital disproportionate share fund is \$26,633,430.

(3) Amount of payment. The total amount of disproportionate share payments from the graduate medical education and disproportionate share fund and from the Iowa state-owned teaching hospital disproportionate share fund shall not exceed the amount of the state's allotment under Public Law 102-234. In addition, the total amount of all disproportionate share payments shall not exceed the hospital-specific disproportionate share limits under Public Law 103-666.

(4) Final disproportionate share adjustment. The department's total year-end disproportionate share obligations to a qualifying hospital will be calculated following completion of the desk review or audit of CMS 2552-96, Hospital and Healthcare Complex Cost Report.

*v. Non-state-owned teaching hospital disproportionate share payment.* In addition to payments from the graduate medical education and disproportionate share fund made pursuant to paragraph 79.1(5) "y," payment shall be made to Iowa hospitals qualifying for Iowa non-state-government-owned acute care teaching hospital disproportionate share payments. Interim monthly payments based on estimated allowable costs will be paid to qualifying hospitals under this paragraph.

(1) Qualifying criteria. A hospital qualifies for the Iowa non-state-government-owned acute care teaching hospital disproportionate share payments if it qualifies for disproportionate share payments pursuant to paragraph 79.1(5) "y" and is an Iowa non-state-government-owned acute care teaching hospital located in a county with a population over 350,000.

(2) Amount of payment. The total amount of disproportionate share payments pursuant to paragraph 79.1(5) "y" and the Iowa non-state-government-owned acute care teaching hospital disproportionate share payments shall not exceed the amount of the state's allotment under Public Law 102-234. In addition, the total amount of all disproportionate share payments shall not exceed the hospital-specific disproportionate share limits under Public Law 103-666.

(3) Final disproportionate share adjustment. The department's total year-end disproportionate share obligations to a qualifying hospital will be calculated following completion of the desk review or audit of CMS 2552-96, Hospital and Healthcare Complex Cost Report. The department's total year-end disproportionate share obligation shall not exceed the difference between the following:

1. The annual amount appropriated to the IowaCare account for distribution to publicly owned acute care teaching hospitals located in a county with a population over 350,000; and

2. The actual IowaCare expansion population claims submitted and paid by the Iowa Medicaid enterprise to qualifying hospitals.

*w. Rate adjustments for hospital mergers.* When one or more hospitals merge to form a distinctly different legal entity, the base rate plus applicable add-ons will be revised to reflect this new entity. Financial information from the original cost reports and original rate calculations will be added together and averaged to form the new rate for that entity.

x. For cost reporting periods beginning on or after July 1, 1993, reportable Medicaid administrative and general expenses are allowable only to the extent that they are defined as allowable using Medicare Reimbursement Principles or Health Insurance Reimbursement Manual 15 (HIM-15). Appropriate, reportable costs are those that meet the Medicare (or HIM-15) principles, are reasonable, and are directly related to patient care. In instances where costs are not directly related to patient care or are not in accord with Medicare Principles of Reimbursement, inclusion of those costs in the cost report would not be appropriate. Examples of administrative and general costs that must be related to patient care to be included as a reportable cost in the report are:

- (1) Advertising.
- (2) Promotional items.
- (3) Feasibility studies.
- (4) Administrative travel and entertainment.
- (5) Dues, subscriptions, or membership costs.
- (6) Contributions made to other organizations.
- (7) Home office costs.
- (8) Public relations items.
- (9) Any patient convenience items.
- (10) Management fees for administrative services.
- (11) Luxury employee benefits (i.e., country club dues).
- (12) Motor vehicles for other than patient care.
- (13) Reorganization costs.

y. *Graduate medical education and disproportionate share fund.* Payment shall be made to hospitals qualifying for direct medical education, indirect medical education, or disproportionate share payments directly from the graduate medical education and disproportionate share fund. The requirements to receive payments from the fund, the amounts allocated to the fund, and the methodology used to determine the distribution amounts from the fund are as follows:

(1) Qualifying for direct medical education. Iowa hospitals qualify for direct medical education payments if direct medical education costs that qualify for payment as medical education costs under the Medicare program are contained in the hospital's base year cost report and in the most recent cost report submitted before the start of the state fiscal year for which payments are being made. Out-of-state hospitals do not qualify for direct medical education payments.

(2) Allocation to fund for direct medical education. The total state fiscal year annual amount of funding that is allocated to the graduate medical education and disproportionate share fund for direct medical education related to inpatient services is \$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, is a voting member of the National Association of Children's Hospitals and Related Institutions, and has Medicaid utilization and low-income utilization rates of 1 percent or greater for children under 18 years of age at the time of admission in all distinct areas of the hospital where services are provided predominantly to children under 18 years of age.

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

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

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

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

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

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

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

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

(1) The base rate upon which the DRG payment is built shall be changed after any retrospective adjustment to reflect, as accurately as is possible, the reasonable costs of providing the covered service to eligible fee-for-service Medicaid members for the coming year using the most recent utilization as submitted to the Iowa Medicaid enterprise provider cost audit and rate setting unit and Medicare cost principles.

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

*ab. Nonpayment for preventable conditions.* Preventable conditions identified pursuant to this rule that develop during inpatient hospital treatment shall not be considered in determining reimbursement for such treatment.

(1) Coding. All diagnoses included on an inpatient hospital claim must include one of the following codes indicating whether the condition was present or developing at the time of the order for inpatient admission:

Present on Admission (POA) Indicator Codes

Code Explanation

- |   |  |
|---|--|
| Y | The condition was present or developing at the time of the order for inpatient admission.  |
| N | The condition was not present or developing at the time of the order for inpatient admission.  |
| U | Documentation is insufficient to determine whether the condition was present or developing at the time of the order for inpatient admission.                                     |
| W | Clinically undetermined. The provider is clinically unable to determine whether or not the condition was present or developing at the time of the order for inpatient admission. |

(2) Payment processing. Claims will be processed according to the DRG methodology without consideration of any diagnosis identified by the Secretary of the United States Department of Health and Human Services pursuant to Section 1886(d)(4)(D)(iv) of the Social Security Act (42 U.S.C. 1395ww(d)(4)(D)(iv)) if the condition was not present or developing at the time of the order for inpatient admission.

**79.1(6) Independent laboratories.** The maximum payment for clinical diagnostic laboratory tests performed by an independent laboratory will be the areawide fee schedule established by the Centers for Medicare and Medicaid Services (CMS). The fee schedule is based on the definition of laboratory procedures from the Physician's Current Procedural Terminology (CPT) published by the American Medical Association. The fee schedules are adjusted annually by CMS to reflect changes in the Consumer Price Index for All Urban Consumers.

**79.1(7) Physicians.**

*a. Fee schedule.* The fee schedule is based on the definitions of medical and surgical procedures given in the most recent edition of Physician's Current Procedural Terminology (CPT). Refer to 441—paragraph 78.1(2)“e” for the guidelines for immunization replacement.

*b. Payment reduction for services rendered in facility settings.* The fee schedule amount paid to physicians based on paragraph 79.1(7)“a” shall be reduced by an adjustment factor as determined by the department. For the purpose of this provision, a “facility” place of service (POS) is defined as any of the following:

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

*c. Payment for primary care services furnished in 2013 or 2014.* To the extent required by 42 U.S.C. § 1396a(a)(13)(C), primary care services furnished in calendar years 2013 or 2014 by a qualified primary care physician or under the supervision of a qualified primary care physician shall be paid as provided pursuant to this paragraph (79.1(7)“c”).

(1) Primary care services eligible for payment pursuant to this paragraph (79.1(7)“c”) include:

1. Evaluation and management (E & M) services covered by Iowa Medicaid and designated in the healthcare common procedure coding system (HCPCS) as codes 99201 through 99499, or their successor codes; and

2. Vaccine administration services covered by Iowa Medicaid and designated in the healthcare common procedure coding system (HCPCS) as codes 90460, 90461, 90471, 90472, 90473 and 90474, or their successor codes.

(2) For purposes of this paragraph (79.1(7)“c”), a qualified primary care physician is a physician who:

1. Is certified by the American Board of Medical Specialties (ABMS), the American Board of Physician Specialties (ABPS) or the American Osteopathic Association (AOA) with a specialty designation of family medicine, general internal medicine, or pediatric medicine or with a subspecialty designation recognized by the certifying organization as a subspecialty of family medicine, general internal medicine, or pediatric medicine; or

2. Has furnished primary care services eligible for payment pursuant to this paragraph (79.1(7)“c”) equal to at least 60 percent of the Iowa Medicaid services for which the qualified primary care physician has submitted claims during the most recently completed calendar year or, for newly eligible physicians, the prior month (excluding claims not paid and claims for which Medicare is the primary payer).

(3) For payment to be made under this paragraph (79.1(7)“c”), the qualified primary care physician must have certified that the physician is a qualified primary care physician by submitting Form 470-5138, Iowa Medicaid Primary Care Physician Certification and Attestation for Primary Care Rate Increase, prior to the date of service or by April 1, 2013, for services rendered January 1, 2013, through April 1, 2013.

(4) Primary care services eligible for payment pursuant to this rule shall be paid at the greater of:

1. The otherwise applicable Iowa Medicaid rate;

2. The applicable rate under Medicare Part B, in effect for services rendered on the first day of the calendar year;

3. The rate that would be applicable under Medicare Part B, in effect for services rendered on the first day of the calendar year, if the conversion factor under 42 U.S.C. § 1395w-4(d) were the conversion factor for 2009; or

4. If there is no applicable rate under Medicare Part B, the rate specified in a fee schedule established and announced by the federal Centers for Medicare and Medicaid Services, pursuant to 42 CFR § 447.405(A)(1).

(5) Notwithstanding the foregoing provisions of this paragraph (79.1(7)“c”), payment for the administration of vaccines provided under the vaccines for children program in calendar years 2013 or 2014 shall be limited to the lesser of:

1. The regional maximum administration fee under the vaccines for children program; or

2. The applicable Medicare fee schedule rate for HCPCS code 90460 (or, if higher, the Medicare fee schedule rate for HCPCS code 90460 that would apply if the conversion factor under 42 U.S.C. § 1395w-4(d) were the conversion factor for 2009).

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

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

(1) The estimated acquisition cost, defined:

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

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

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

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

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

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

(1) The estimated acquisition cost, defined:

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

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

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

*c.* Effective February 1, 2013, or upon federal approval, whichever is later, reimbursement for covered generic prescription drugs and for covered nonprescription drugs shall be the lowest of the following, as of the date of dispensing:

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

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

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

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

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

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

*e.* No payment shall be made for sales tax.

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

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

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

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

*j.* For services rendered on or after February 1, 2013, the professional dispensing fee for all drugs shall be \$10.02. Contingent on federal approval, the professional dispensing fee for services rendered on or after July 1, 2013, shall be increased to \$10.12. Future dispensing fees shall be amounts determined by the department based on a survey of Iowa Medicaid retail pharmacy providers’ costs of dispensing drugs to Medicaid beneficiaries, performed every two years beginning in state fiscal year 2014-2015.

*k.* For purposes of this rule, average actual acquisition cost (AAC) is defined as retail pharmacies’ average prices paid to acquire drug products. Average AAC shall be determined by the department based on a survey of invoice prices paid by Iowa Medicaid retail pharmacies. Surveys shall be conducted at least once every six months, or more often at the department’s discretion. The average AAC shall be calculated as a statistical mean based on one reported cost per drug per pharmacy. The average AAC determined by the department shall be published on the Iowa Medicaid enterprise Web site. If no current average AAC has been determined for a drug, the wholesale acquisition cost (WAC) published by Medi-Span shall be used as the average AAC.

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

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

*n.* Payment to physicians for physician-administered drugs billed with healthcare common procedure coding system (HCPCS) Level II “J” codes, as a physician service, shall be pursuant to physician payment policy under subrule 79.1(2).

**79.1(9) HCBS consumer choices financial management.**

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

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

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

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

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

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

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

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

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

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

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

the service is reasonably related to the cost of processing the billings and is not related on a percentage or other basis to the dollar amounts to be billed or collected.

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

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

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

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

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

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

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

(3) One dollar for nonpreferred brand-name drugs for which the cost to the state is less than \$25.

(4) Two dollars for nonpreferred brand-name drugs for which the cost to the state is \$25.01 to \$50.

(5) Three dollars for nonpreferred brand-name drugs for which the cost to the state is \$50.01 or more.

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

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

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

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

(1) Total covered service rendered on a given date for dental services and hearing aids.

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

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

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

*g.* Copayment charges are not applicable for a member receiving inpatient care in a hospital, nursing facility, state mental health institution, or other medical institution if the person is required, as a condition of receiving services in the institution, to spend for costs of necessary medical care all but a minimal amount of income for personal needs.

*h.* The member shall pay \$1 for each federal Medicare Part B crossover claim submitted to the Medicaid program when the services provided have a Medicaid copayment as set forth above.

*i.* Copayment charges are not applicable to services furnished pregnant women.

*j.* All providers are prohibited from offering or providing copayment related discounts, rebates, or similar incentives for the purpose of soliciting the patronage of Medicaid members.

*k.* Copayment charges are not applicable for emergency services. Emergency services are defined as services provided in a hospital, clinic, office, or other facility that is equipped to furnish the required care, after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain), that the absence of immediate medical attention could reasonably be expected to result in:

- (1) Placing the patient's health in serious jeopardy,
- (2) Serious impairment to bodily functions, or
- (3) Serious dysfunction of any bodily organ or part.

*l.* Copayment charges are not applicable for services rendered by a health maintenance organization in which the member is enrolled.

*m.* No provider of service participating in the Medicaid program may deny care or services to a person eligible for care or services under the program because of the person's inability to pay a copayment. However, this rule does not change the fact that a member is liable for the charges and it does not preclude the provider from attempting to collect them.

*n.* The member shall pay a \$3 copayment for each visit to a hospital emergency room for treatment that does not meet the criteria for an emergency service as defined in paragraph 79.1(13) "k." This \$3 copayment shall not apply if the visit to the emergency room results in a hospital admission.

**79.1(14) Reimbursement for hospice services.**

*a.* Medicaid hospice rates. The Medicaid hospice rates are based on the methodology used in setting Medicare rates, adjusted to disregard cost offsets attributable to Medicare coinsurance amounts, and with application of the appropriate area wage adjustments for the categories of care provided.

Hospices are reimbursed at one of four predetermined rates based on the level of care furnished to the individual for that day. Payments to a hospice for inpatient care are subject to the limitations imposed by Medicare. The levels of care into which each day of care is classified are as follows:

- (1) Routine home care.
- (2) Continuous home care.
- (3) Inpatient respite care.
- (4) General inpatient care.

*b.* Adjustment to hospice rates. An adjustment to hospice reimbursement is made when a recipient residing in a nursing facility elects the hospice benefit. The adjustment will be a room and board rate that is equal to the rate at which the facility is paid for reserved bed days or 95 percent of the facility's Medicaid reimbursement rate, whichever is greater. Room and board services include the performance of personal care services, including assistance in activities of daily living, socializing activities, administration of medication, maintaining the cleanliness of a resident's room and supervising and assisting in the use of durable medical equipment and prescribed therapies.

For hospice recipients entering a nursing facility the adjustment will be effective the date of entry. For persons in nursing facilities prior to hospice election, the adjustment rate shall be effective the date of election.

For individuals who have client participation amounts attributable to their cost of care, the adjustment to the hospice will be reduced by the amount of client participation as determined by the department. The hospice will be responsible for collecting the client participation amount due the hospice unless the hospice and the nursing facility jointly determine the nursing facility is to collect the client participation.

*c.* Payment for day of discharge. For the day of discharge from an inpatient unit, the appropriate home care rate is to be paid unless the recipient dies as an inpatient. When the recipient is discharged as deceased, the inpatient rate (general or respite) is to be paid for the discharge date.

*d.* Hospice cap. Overall aggregate payments made to a hospice during a hospice cap period are limited or capped. The hospice cap year begins November 1 and ends October 31 of the next year.

The cap amount for each hospice is calculated by multiplying the number of beneficiaries electing hospice care from that hospice during the cap period by the base statutory amount, adjusted to reflect the percentage increase or decrease in the medical care expenditure category of the Consumer Price Index for all urban consumers published by the Bureau of Labor Statistics. Payments made to a hospice but not included in the cap include room and board payment to a nursing home. Any payment in excess of the cap must be refunded to the department by the hospice.

*e.* Limitation of payments for inpatient care. Payments to a hospice for inpatient care shall be limited according to the number of days of inpatient care furnished to Medicaid patients. During the 12-month period beginning November 1 of each year and ending October 31, the aggregate number of inpatient days (both for general inpatient care and inpatient respite care) shall not exceed 20 percent of the aggregate total number of days of hospice care provided to all Medicaid recipients during that same period. Medicaid recipients afflicted with acquired immunodeficiency syndrome (AIDS) are excluded in calculating this inpatient care limitation. This limitation is applied once each year, at the end of the hospices' "cap period" (November 1 to October 31). For purposes of this computation, if it is determined that the inpatient rate should not be paid, any days for which the hospice receives payment at a home care rate will not be counted as inpatient days. The limitation is calculated as follows:

(1) The maximum allowable number of inpatient days will be calculated by multiplying the total number of days of Medicaid hospice care by 0.2.

(2) If the total number of days of inpatient care furnished to Medicaid hospice patients is less than or equal to the maximum, no adjustment will be necessary.

(3) If the total number of days of inpatient care exceeded the maximum allowable number, the limitation will be determined by:

1. Calculating a ratio of the maximum allowable days to the number of actual days of inpatient care, and multiplying this ratio by the total reimbursement for inpatient care (general inpatient and inpatient respite reimbursement) that was made.

2. Multiplying excess inpatient care days by the routine home care rate.

3. Adding together the amounts calculated in "1" and "2."

4. Comparing the amount in "3" with interim payments made to the hospice for inpatient care during the "cap period."

Any excess reimbursement shall be refunded by the hospice.

*f.* Location of services. Claims must identify the geographic location where the service is provided (as distinct from the location of the hospice).

**79.1(15) HCBS retrospectively limited prospective rates.** This methodology applies to reimbursement for HCBS supported community living; HCBS family and community support services; HCBS supported employment enhanced job search activities; 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.

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

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

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

*c. Prospective rates for new providers.*

(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) Revenues exceeding adjusted actual costs by more than 4.5 percent shall be remitted to the department. Payment will be due upon notice of the new rates and retrospective rate adjustment.

(3) Providers who do not reimburse revenues exceeding 104.5 percent of actual costs 30 days after notice is given by the department will have the revenues over 104.5 percent of the actual costs deducted from future payments.

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

**79.1(16) Outpatient reimbursement for hospitals.**

*a. Definitions.*

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

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

"Ambulatory payment classification relative weight" or "APC relative weight" means the relative value assigned to each APC.

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

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

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

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

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

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

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

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

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

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

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

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

*“GME/DSH fund implementation year”* means 2009.

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

*“Healthcare common procedures coding system”* or *“HCPCS”* means the national uniform coding method that is maintained by the Centers for Medicare and Medicaid Services (CMS) and that incorporates the American Medical Association publication Physicians Current Procedural Terminology (CPT) and the three HCPCS unique coding levels I, II, and III.

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

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

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

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

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

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

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

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

*“Outpatient prospective payment system”* or *“OPPS”* means the payment methodology for hospital outpatient services established by this subrule and based on Medicare’s outpatient prospective payment

system mandated by the Balanced Budget Refinement Act of 1999 and the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000.

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

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

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

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

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

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

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

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

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

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

*c. Payment for outpatient hospital services.*

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

1. Any specific rate or methodology established by rule for the particular service.

2. The OPPS APC rates established pursuant to this subrule.
3. Fee schedule rates established pursuant to paragraph 79.1(1)“c.”
- (2) Except as provided in paragraph 79.1(16)“h,” outpatient hospital services that have been assigned to an APC with an assigned weight shall be reimbursed based on the APC to which the services provided are assigned. The department adopts and incorporates by reference the OPPS APCs and relative weights effective January 1, 2008, published on November 27, 2007, as final by the Centers for Medicare and Medicaid Services in the Federal Register at Volume 72, No. 227, page 66579. Relative weights and APCs shall be updated pursuant to paragraph 79.1(16)“j.”
- (3) The APC payment is calculated as follows:
  1. The applicable APC relative weight is multiplied by the blended base APC rate determined according to paragraph 79.1(16)“e.”
  2. The resulting APC payment is multiplied by a discount factor of 50 percent and by units of service when applicable.
  3. For a procedure started but discontinued before completion, the department will pay 50 percent of the APC for the service.
- (4) The OPPS APC payment status indicators show whether a service represented by a CPT or HCPCS code is payable under an OPPS APC or under another payment system and whether particular OPPS policies apply to the code. The following table lists the status indicators and definitions for both services that are paid under an OPPS APC and services that are not paid under an OPPS APC.

Indicator	Item, Code, or Service	OPPS Payment Status
A	Services furnished to a hospital outpatient that are paid by Medicare under a fee schedule or payment system other than OPPS, such as: <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>	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.”  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).
B	Codes that are not paid by Medicare on an outpatient hospital basis	Not paid under OPPS APC. <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	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.”  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.
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>
F	<p>Certified registered nurse anesthetist services</p> <p>Corneal tissue acquisition</p> <p>Hepatitis B vaccines</p>	<p>If covered by Iowa Medicaid, the item or service is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)“c.”</p> <p>If not covered by Iowa Medicaid, the item or service is not paid under OPPS APC or any other Medicaid payment system.</p>
G	<p>Pass-through drugs and biologicals</p>	<p>If covered by Iowa Medicaid, the item is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)“c.”</p> <p>If not covered by Iowa Medicaid, the item is not paid under OPPS APC or any other Medicaid payment system.</p>
H	<p>Pass-through device categories</p>	<p>If covered by Iowa Medicaid, the device is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)“c.”</p> <p>If not covered by Iowa Medicaid, the device is not paid under OPPS APC or any other Medicaid payment system.</p>
K	<p>Non-pass-through drugs and biologicals</p> <p>Therapeutic radiopharmaceuticals</p>	<p>If covered by Iowa Medicaid, the item is:</p> <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> <p>If not covered by Iowa Medicaid, the item is not paid under OPPS APC or any other Medicaid payment system.</p>

L	Influenza vaccine Pneumococcal pneumonia vaccine	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.
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 OPSS APC with separate APC payment subject to multiple reduction.  If not covered by Iowa Medicaid, the procedure is not paid under OPSS APC or any other Medicaid payment system.
U	Brachytherapy sources	If covered by Iowa Medicaid, the procedure is paid under OPSS APC with separate APC payment.  If not covered by Iowa Medicaid, the procedure is not paid under OPSS APC or any other Medicaid payment system.
V	Clinic or emergency department visit	If covered by Iowa Medicaid, the service is paid under OPSS APC with separate APC payment, subject to limits on nonemergency services provided in an emergency room pursuant to 79.1(16)“r.”  If not covered by Iowa Medicaid, the service is not paid under OPSS APC or any other Medicaid payment system.
X	Ancillary services	If covered by Iowa Medicaid, the service is paid under OPSS APC with separate APC payment.  If not covered by Iowa Medicaid, the service is not paid under OPSS APC or any other Medicaid payment system.
Y	Nonimplantable durable medical equipment	For items covered by Iowa Medicaid as an outpatient hospital service, the item is not paid under OPSS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)“c.”  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).

*d. Calculation of case-mix indices.* Hospital-specific and statewide case-mix indices shall be calculated using the Medicaid claim set.

(1) Hospital-specific case-mix indices are calculated by summing the relative weights for each APC service at that hospital and dividing the total by the number of APC services for that hospital.

(2) The statewide case-mix index is calculated by summing the relative weights for each APC service for all claims and dividing the total by the statewide total number of APC services. Claims for hospitals receiving reimbursement as critical access hospitals during any of the period included in the base-year cost report are not used in calculating the statewide case-mix index.

*e. Calculation of the hospital-specific base APC rates.*

(1) Using the hospital’s base-year cost report, hospital-specific outpatient cost-to-charge ratios are calculated for each ancillary and outpatient cost center of the Medicare cost report, Form CMS 2552-96.

(2) The cost-to-charge ratios are applied to each line item charge reported on claims from the Medicaid claim set to calculate the Medicaid cost per service. The hospital’s total outpatient Medicaid cost is the sum of the Medicaid cost per service for all line items.

(3) The following items are subtracted from the hospital’s total outpatient Medicaid costs:

1. The total calculated Medicaid direct medical education cost for interns and residents based on the hospital's base-year cost report.

2. The total calculated Medicaid cost for services listed at 441—subrule 78.31(1), paragraphs “g” to “n.”

3. The total calculated Medicaid cost for ambulance services.

4. The total calculated Medicaid cost for services paid based on the Iowa Medicaid fee schedule.

- (4) The remaining amount is multiplied by a factor to limit aggregate expenditures to available funding, divided by the hospital-specific case-mix index, and then divided by the total number of APC services for that hospital from the Medicaid claim set.

- (5) Hospital-specific base APC rates are not computed for hospitals receiving reimbursement as critical access hospitals during any of the period included in the base-year cost report.

*f. Calculation of statewide base APC rate.*

- (1) The statewide average base APC rate is calculated by summing the outpatient Medicaid cost for all hospitals and subtracting the following:

1. The total calculated Medicaid direct medical education cost for interns and residents for all hospitals.

2. The total calculated Medicaid cost for services listed at 441—subrule 78.31(1), paragraphs “g” to “n,” for all hospitals.

3. The total calculated Medicaid cost for ambulance services for all hospitals.

4. The total calculated Medicaid cost for services paid based on the Iowa Medicaid fee schedule for all hospitals.

- (2) The resulting amount is multiplied by a factor to limit aggregate expenditures to available funding, divided by the statewide case-mix index, and then divided by the statewide total number of APC services from the Medicaid claim set.

- (3) Data for hospitals receiving reimbursement as critical access hospitals during any of the period included in the base-year cost report is not used in calculating the statewide average base APC rate.

*g. Cost outlier payment policy.* Additional payment is made for services provided during a single visit that exceed the following Medicaid criteria of cost outliers for each APC. Outlier payments are determined on an APC-by-APC basis.

- (1) An APC qualifies as a cost outlier when the cost of the service exceeds both the multiple threshold and the fixed-dollar threshold.

- (2) The multiple threshold is met when the cost of furnishing an APC service exceeds 1.75 times the APC payment amount.

- (3) The fixed-dollar threshold is met when the cost of furnishing an APC service exceeds the APC payment amount plus \$2,000.

- (4) If both the multiple threshold and the fixed-dollar threshold are met, the outlier payment is calculated as 50 percent of the amount by which the hospital's cost of furnishing the APC service or procedure exceeds the multiple threshold.

- (5) The cost of furnishing the APC service or procedure is calculated using a single overall hospital-specific cost-to-charge ratio determined from the base-year cost report. Costs appearing on a claim that are attributable to packaged APC services for which no separate payment is made are allocated to all nonpackaged APC services that appear on that claim. The amount allocated to each nonpackaged APC service is based on the proportion the APC payment rate for that APC service bears to the total APC rates for all nonpackaged APC services on the claim.

*h. Payment to critical access hospitals.* Initial, interim payments to critical access hospitals as defined in paragraph 79.1(5)“a” shall be the hospital's line-item charge multiplied by the hospital's Medicaid outpatient cost-to-charge ratio. These interim payments are subject to annual retrospective adjustment equal to the difference between the reasonable costs of covered services provided to eligible fee-for-service Medicaid members (excluding members in managed care) and the Medicaid reimbursement received. The department shall determine the reasonable costs of services based on the hospital's annual cost reports and Medicare cost principles. When the interim amounts paid exceed reasonable costs, the department shall recover the difference.

(1) After any retrospective adjustment, the department shall update the cost-to-charge ratio to reflect as accurately as is possible the reasonable costs of providing the covered service to eligible fee-for-service Medicaid members for the coming year. The department shall base these changes on the most recent utilization as submitted to the Iowa Medicaid enterprise provider cost audit and rate setting unit and Medicare cost principles.

(2) Once a hospital begins receiving reimbursement as a critical access hospital, the cost-to-charge ratio is not subject to rebasing as provided in paragraph 79.1(16) "j."

*i. Cost-reporting requirements.* Hospitals shall prepare annual cost reports in accordance with generally accepted accounting principles as defined by the American Institute of Certified Public Accountants and in accordance with Medicare Provider Reimbursement Manual, CMS Publication 15, subject to the exceptions and limitations provided in this rule.

(1) Using electronic media, each hospital shall submit the following:

1. The hospital's Medicare cost report (Form CMS 2552-96, Hospitals and Healthcare Complex Cost Report);

2. Either Form 470-4515, Critical Access Hospital Supplemental Cost Report, or Form 470-4514, Hospital Supplemental Cost Report; and

3. A copy of the revenue code crosswalk used to prepare the Medicare cost report.

(2) The cost reports and supporting documentation shall be sent to the Iowa Medicaid Enterprise, Provider Cost Audit and Rate Setting Unit, 100 Army Post Road, P.O. Box 36450, Des Moines, Iowa 50315.

(3) The cost reports shall be submitted on or before the last day of the fifth calendar month following the close of the period covered by the report. For fiscal periods ending on a day other than the last day of the month, cost reports are due 150 days after the last day of the cost-reporting period. Extensions of the due date for filing a cost report granted by the Medicare fiscal intermediary shall be accepted by Iowa Medicaid.

*j. Rebasing.*

(1) Effective January 1, 2009, and annually thereafter, the department shall update the OPPS APC relative weights using the most current calendar update as published by the Centers for Medicare and Medicaid Services.

(2) Effective January 1, 2009, and every three years thereafter, blended base APC rates shall be rebased. Cost reports used in rebasing shall be the hospital fiscal year-end Form CMS 2552-96, Hospital and Healthcare Complex Cost Report, as submitted to Medicare in accordance with Medicare cost report submission time lines for the hospital fiscal year ending during the preceding calendar year. If a hospital does not provide this cost report, including the Medicaid cost report and revenue code crosswalk, to the Iowa Medicaid enterprise provider cost audit and rate setting unit by May 31 of a year in which rebasing occurs, the most recent submitted cost report will be used.

(3) Effective January 1, 2009, and every three years thereafter, case-mix indices shall be recalculated using valid claims most nearly matching each hospital's fiscal year end.

(4) The graduate medical education and disproportionate share fund shall be updated as provided in subparagraph 79.1(16) "v"(3).

*k. Payment to out-of-state hospitals.* Out-of-state hospitals providing care to members of Iowa's Medicaid program shall be reimbursed in the same manner as Iowa hospitals, except as provided in subparagraphs (1) and (2).

(1) For out-of-state hospitals that submit a cost report no later than May 31 in the most recent rebasing year, APC payment amounts will be based on the blended base APC rate using hospital-specific, Iowa-only Medicaid data. For other out-of-state hospitals, APC payment amounts will be based on the Iowa statewide base APC rate.

(2) Out-of-state hospitals do not qualify for direct medical education payments pursuant to paragraph 79.1(16) "v."

*l. Preadmission, preauthorization or inappropriate services.* Inpatient or outpatient services that require preadmission or preprocedure approval by the quality improvement organization (QIO) are updated yearly and are available from the QIO.

(1) The hospital shall provide the QIO authorization number on the claim form to receive payment. Claims for services requiring preadmission or preprocedure approval that are submitted without this authorization number will be denied.

(2) To safeguard against other inappropriate practices, the department, through the QIO, will monitor admission practices and quality of care. If an abuse of the prospective payment system is identified, payments for abusive practices may be reduced or denied. In reducing or denying payment, Medicaid adopts the Medicare QIO regulations.

*m. Health care access assessment inflation factor.* Effective with the implementation of the health care access assessment paid pursuant to 441—Chapter 36, Division III, a health care access assessment inflation factor shall be applied to the Medicaid blended base APC rate as otherwise calculated pursuant to this subrule for all “participating hospitals” as defined in 441—subrule 36.10(1).

(1) Calculation of inflation factor. The health care access assessment inflation factor for participating hospitals shall be calculated by dividing the amount allowed under the Medicare outpatient upper payment limit for the fiscal year beginning July 1, 2010, by the sum of the projected expenditures for participating hospitals for the fiscal year beginning July 1, 2010, as determined by the fiscal management division of the department, and the amount allowed under the Medicare outpatient upper payment limit.

(2) Implementation date. The health care access assessment inflation factor shall not be implemented until federal financial participation to match money collected from the health care access assessment pursuant to 441—Chapter 36, Division III, has been approved by the federal Centers for Medicare and Medicaid Services.

(3) End date. Application of the health care access assessment inflation factor shall terminate if the health care access assessment is terminated pursuant to rule 441—36.12(83GA,SF2388). If federal match money is unavailable for a retroactive period or the authority to collect the assessment is rescinded for a retroactive period, the department shall:

1. Recalculate Medicaid rates in effect during that period without the application of the health care access assessment inflation factor;
2. Recompute Medicaid payments due based on the recalculated Medicaid rates;
3. Recoup any previous overpayments; and
4. Determine for each hospital the amount of health care access assessment collected during that period and refund that amount to the facility.

*n. Determination of inpatient admission.* A person is considered to be an inpatient when a formal inpatient admission occurs, when a physician intends to admit a person as an inpatient, or when a physician determines that a person being observed as an outpatient in an observation or holding bed should be admitted to the hospital as an inpatient. In cases involving outpatient observation status, the determinant of patient status is not the length of time the patient was being observed, rather whether the observation period was medically necessary to determine whether a patient should be admitted to the hospital as an inpatient. Outpatient observation lasting greater than a 24-hour period will be subject to review by the QIO to determine the medical necessity of each case. For those outpatient observation cases where medical necessity is not established, reimbursement shall be denied for the services found to be unnecessary for the provision of that care, such as the use of the observation room.

*o. Inpatient admission after outpatient services.* If a patient is admitted as an inpatient within three days of the day in which outpatient services were rendered, all outpatient services related to the principal diagnosis are considered inpatient services for billing purposes. The day of formal admission as an inpatient is considered as the first day of hospital inpatient services. EXCEPTION: This requirement does not apply to critical access hospitals.

*p. Cost report adjustments.* Rescinded IAB 6/11/03, effective 7/16/03.

*q. Determination of payment amounts for mental health noninpatient (NIP) services.* Mental health NIP services are limited as set forth at 441—subparagraph 78.31(4)“d”(7) and are reimbursed on a fee schedule basis. Mental health NIP services are the responsibility of the managed mental health care and substance abuse (Iowa Plan) contractor for persons eligible for managed mental health care.

*r. Services delivered in the emergency room.* Payment to a hospital for assessment of any Medicaid member in an emergency room shall be made pursuant to fee schedule. Payment for treatment of a Medicaid member in an emergency room shall be made as follows:

(1) If the emergency room visit results in an inpatient hospital admission, the treatment provided in the emergency room is paid for as part of the payment for the inpatient services provided.

(2) If the emergency room visit does not result in an inpatient hospital admission but involves emergency services as defined in paragraph 79.1(13) "k," payment for treatment provided in the emergency room shall be made at the full APC payment for the treatment provided.

(3) If the emergency room visit does not result in an inpatient hospital admission and does not involve emergency services as defined in paragraph 79.1(13) "k," payment for treatment provided in the emergency room depends on whether the member had a referral to the emergency room and on whether the member is participating in the MediPASS program.

1. For members not participating in the MediPASS program who were referred to the emergency room by appropriate medical personnel and for members participating in the MediPASS program who were referred to the emergency room by their MediPASS primary care physician, payment for treatment provided in the emergency room shall be made at 75 percent of the APC payment for the treatment provided.

2. For members not participating in the MediPASS program who were not referred to the emergency room by appropriate medical personnel, payment for treatment provided in the emergency room shall be made at 50 percent of the APC payment for the treatment provided.

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

*s. Limit on payments.* Payments under the ambulatory payment classification (APC) methodology, as well as other payments for outpatient services, are subject to upper limit rules set forth in 42 CFR 447.321 as amended to September 5, 2001, and 447.325 as amended to January 26, 1993. Requirements under these sections state that, in general, Medicaid may not make payments to providers that would exceed the amount that would be payable to providers under comparable circumstances under Medicare.

*t. Government-owned facilities.* Rescinded IAB 6/30/10, effective 7/1/10.

*u. QIO review.* The QIO will review a yearly random sample of hospital outpatient service cases performed for Medicaid members and identified on claims data from all Iowa and bordering state hospitals in accordance with the terms in the contract between the department and the QIO. The QIO contract is available for review at the Iowa Medicaid Enterprise Office, 100 Army Post Road, Des Moines, Iowa 50315.

*v. Graduate medical education and disproportionate share fund.* Payment shall be made to hospitals qualifying for direct medical education directly from the graduate medical education and disproportionate share fund. The requirements to receive payments from the fund, the amount allocated to the fund and the methodology used to determine the distribution amounts from the fund are as follows:

(1) Qualifying for direct medical education. Iowa hospitals qualify for direct medical education payments if direct medical education costs that qualify for payment as medical education costs under the Medicare program are contained in the hospital's base year cost report and in the most recent cost report submitted before the start of the state fiscal year for which payments are being made. Out-of-state hospitals do not qualify for direct medical education payments.

(2) Allocation to fund for direct medical education. The total annual state fiscal year funding that is allocated to the graduate medical education and disproportionate share fund for direct medical education related to outpatient services is \$2,766,718.25. 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 Dental Terminology, Third Edition (CDT-3).

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

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

*a. Definitions.* For purposes of this subrule:

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

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

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

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

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

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

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

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

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

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

**79.1(23) Reimbursement for remedial services.** Reimbursement for remedial services provided before July 1, 2011, shall be made on the basis of a unit rate that is calculated retrospectively for each provider, considering reasonable and proper costs of operation. The unit rate shall not exceed the established unit-of-service limit on reasonable costs pursuant to subparagraph 79.1(23)“c”(1). The unit of service may be a quarter hour, a half hour, an hour, a half day, or a day, depending on the service provided.

*a. Interim rate.* Providers shall be reimbursed through a prospective interim rate equal to the previous year’s retrospectively calculated unit-of-service rate. On an interim basis, pending determination of remedial services provider costs, the provider may bill for and shall be reimbursed at a unit-of-service rate that the provider and the Iowa Medicaid enterprise may reasonably expect to produce total payments to the provider for the provider’s fiscal year that are consistent with Medicaid’s obligation to reimburse that provider’s reasonable costs. The interim unit-of-service rate is subject to the established unit-of-service limit on reasonable costs pursuant to subparagraph 79.1(23)“c”(1).

*b. Cost reports.* Reasonable and proper costs of operation shall be determined based on cost reports submitted by the provider.

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

(2) The provider shall complete Form 470-4414, Financial and Statistical Report for Remedial Services, and submit it to the IME Provider Cost Audit and Rate Setting Unit, P.O. Box 36450, Des Moines, Iowa 50315, within three months of the end of the provider’s fiscal year.

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

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

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

(1) A reasonable cost for a member is one that does not exceed 110 percent of the average allowable costs reported by Iowa Medicaid providers for providing similar remedial services to members who have similar diagnoses and live in similar settings, less 5 percent.

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

**79.1(24) Reimbursement for home- and community-based habilitation services.** Reimbursement for case management, job development, and employer development services provided prior to July 1, 2013, is based on a fee schedule developed using the methodology described in paragraph 79.1(1) "d." Reimbursement for home-based habilitation, day habilitation, prevocational habilitation, enhanced job search and supports to maintain employment services provided prior to July 1, 2013, is based on a retrospective cost-related rate calculated using the methodology in paragraphs 79.1(24) "b" and "c." Reimbursement for all home- and community-based habilitation services provided on or after July 1, 2013, 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 prevocational habilitation is an hour (for up to 4 units per day) or a full day (4.25 to 8 hours).

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

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

2. A 15-minute unit for enhanced job search.

(6) 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 July 1, 2013.*

(1) For dates of services July 1, 2013, through December 31, 2013, providers shall be reimbursed by the Iowa Plan for Behavioral Health contractor at the fee schedule or interim rate for the service and the provider in effect on June 30, 2013, with no retrospective adjustment or cost settlement. However, if a provider fails to submit a cost report for services provided prior to July 1, 2013, that meets the requirements of paragraph 79.1(24)"b," the Iowa Plan for Behavioral Health contractor shall reduce the provider's reimbursement rate to 76 percent of the rate in effect on June 30, 2013. The reduced rate shall be paid until acceptable cost reports for all services provided prior to July 1, 2013, have been received.

(2) For dates of services on or after January 1, 2014, providers shall be reimbursed by the Iowa Plan for Behavioral Health contractor at the rate negotiated by the provider and the contractor. However, if a provider fails to submit a cost report for services provided prior to July 1, 2013, that meets the requirements of paragraph 79.1(24)"b," the Iowa Plan for Behavioral Health contractor shall reduce the

provider's reimbursement rate to 76 percent of the negotiated rate. The reduced rate shall be paid until acceptable cost reports for all services provided prior to July 1, 2013, have been received.

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

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

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

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

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

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

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

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

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

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

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

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

(4) Providers shall submit completed cost reports to the IME Provider Cost Audit and Rate Setting Unit, P.O. Box 36450, Des Moines, Iowa 50315. A provider that is not hospital-based shall submit Form 470-4419 on or before the last day of the third month after the end of the provider's fiscal year. A hospital-based provider shall submit both Form 470-4419 and CMS Form 2552-96 on or before the last day of the fifth month after the end of the provider's fiscal year.

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

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

**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 e-mailed 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.

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 9588B, 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 9966B, 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]

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

**79.2(1) Definitions.**

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

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

“*Person*” means any natural person, company, firm, association, corporation, or other legal entity.

“*Probation*” means a specified period of conditional participation in the medical assistance program.

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

“*Suspension from participation*” means an exclusion from participation for a specified period of time.

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

“*Termination from participation*” means a permanent exclusion from participation in the medical assistance program.

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

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

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

b. Submitting or causing to be submitted false information for the purpose of obtaining greater compensation than that to which the provider is legally entitled, including charges in excess of usual and customary charges.

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

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

- a.* A term of probation for participation in the medical assistance program.
- b.* Termination from participation in the medical assistance program.
- c.* Suspension from participation in the medical assistance program. This includes when the department is notified by the Centers for Medicare and Medicaid Services, Department of Health and Human Services, that a practitioner has been suspended from participation under the Medicare program. These practitioners shall be suspended from participation in the medical assistance program effective on the date established by the Centers for Medicare and Medicaid Services and at least for the period of time of the Medicare suspension.
- d.* Suspension or withholding of payments to provider.
- e.* Referral to peer review.
- f.* Prior authorization of services.
- g.* One hundred percent review of the provider's claims prior to payment.
- h.* Referral to the state licensing board for investigation.
- i.* Referral to appropriate federal or state legal authorities for investigation and prosecution under applicable federal or state laws.
- j.* Providers with a total Medicaid credit balance of more than \$500 for more than 60 consecutive days without repaying or reaching written agreement to repay the balance shall be charged interest at 10

percent per year on each overpayment. The interest shall begin to accrue retroactively to the first full month that the provider had a credit balance over \$500.

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

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

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

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

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

**79.2(5) Scope of sanction.**

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

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

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

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

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

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

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

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

final determination. Where the department intends to withhold or suspend payments it shall notify the provider in writing.

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

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

1. The specific procedures or treatments performed.

2. The complete date of the service, including the beginning and ending date if the service is rendered over more than one day.

3. The complete time of the service, including the beginning and ending time if the service is billed on a time-related basis. For those time-related services billed using Current Procedural Terminology (CPT) codes, the total time of the service shall be recorded, rather than the beginning and ending time.

4. The location where the service was provided if otherwise required on the billing form or in 441—paragraph 77.30(5) "c" or "d," 441—paragraph 77.33(6) "d," 441—paragraph 77.34(5) "d," 441—paragraph 77.37(15) "d," 441—paragraph 77.39(13) "e," 441—paragraph 77.39(14) "d," or 441—paragraph 77.46(5) "i," or 441—subparagraph 78.9(10) "a"(1).

5. The name, dosage, and route of administration of any medication dispensed or administered as part of the service.

6. Any supplies dispensed as part of the service.

7. The first and last name and professional credentials, if any, of the person providing the service.

8. The signature of the person providing the service, or the initials of the person providing the service if a signature log indicates the person's identity.

9. For 24-hour care, documentation for every shift of the services provided, the member's response to the services provided, and the person who provided the services.

(4) Outcome of service. The medical record shall indicate the member's progress in response to the services rendered, including any changes in treatment, alteration of the plan of care, or revision of the diagnosis.

*d. Basis for service requirements for specific services.* The medical record for the following services must include, but is not limited to, the items specified below (unless the listed item is not routinely received or created in connection with the particular service or activity and is not required to document the reason for performing the service or activity, its medical necessity, or the level of care associated with it). These items will be specified on Form 470-4479, Documentation Checklist, when the Iowa Medicaid enterprise program integrity unit requests providers to submit records for review. (See paragraph 79.4(2) "b.")

(1) Physician (MD and DO) services:

1. Service or office notes or narratives.
2. Procedure, laboratory, or test orders and results.

(2) Pharmacy services:

1. Prescriptions.
2. Nursing facility physician order.
3. Telephone order.
4. Pharmacy notes.
5. Prior authorization documentation.

(3) Dentist services:

1. Treatment notes.
2. Anesthesia notes and records.
3. Prescriptions.

(4) Podiatrist services:

1. Service or office notes or narratives.
2. Certifying physician statement.
3. Prescription or order form.

- (5) Certified registered nurse anesthetist services:
  1. Service notes or narratives.
  2. Preanesthesia physical examination report.
  3. Operative report.
  4. Anesthesia record.
  5. Prescriptions.
- (6) Other advanced registered nurse practitioner services:
  1. Service or office notes or narratives.
  2. Procedure, laboratory, or test orders and results.
- (7) Optometrist and optician services:
  1. Notes or narratives supporting eye examinations, medical services, and auxiliary procedures.
  2. Original prescription or updated prescriptions for corrective lenses or contact lenses.
  3. Prior authorization documentation.
- (8) Psychologist services:
  1. Service or office psychotherapy notes or narratives.
  2. Psychological examination report and notes.
- (9) Clinic services:
  1. Service or office notes or narratives.
  2. Procedure, laboratory, or test orders and results.
  3. Nurses' notes.
  4. Prescriptions.
  5. Medication administration records.
- (10) Services provided by rural health clinics or federally qualified health centers:
  1. Service or office notes or narratives.
  2. Form 470-2942, Prenatal Risk Assessment.
  3. Procedure, laboratory, or test orders and results.
  4. Immunization records.
- (11) Services provided by community mental health centers:
  1. Service referral documentation.
  2. Initial evaluation.
  3. Individual treatment plan.
  4. Service or office notes or narratives.
  5. Narratives related to the peer review process and peer review activities related to a member's treatment.
  6. Written plan for accessing emergency services.
- (12) Screening center services:
  1. Service or office notes or narratives.
  2. Immunization records.
  3. Laboratory reports.
  4. Results of health, vision, or hearing screenings.
- (13) Family planning services:
  1. Service or office notes or narratives.
  2. Procedure, laboratory, or test orders and results.
  3. Nurses' notes.
  4. Immunization records.
  5. Consent forms.
  6. Prescriptions.
  7. Medication administration records.
- (14) Maternal health center services:
  1. Service or office notes or narratives.
  2. Procedure, laboratory, or test orders and results.
  3. Form 470-2942, Prenatal Risk Assessment.

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

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

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

1. Service or office notes or narratives.
2. Immunization records.
3. Results of communicable disease testing.

*e. Corrections.* A provider may correct the medical record before submitting a claim for reimbursement.

(1) Corrections must be made or authorized by the person who provided the service or by a person who has first-hand knowledge of the service.

(2) A correction to a medical record must not be written over or otherwise obliterate the original entry. A single line may be drawn through erroneous information, keeping the original entry legible. In the case of electronic records, the original information must be retained and retrievable.

(3) Any correction must indicate the person making the change and any other person authorizing the change, must be dated and signed by the person making the change, and must be clearly connected with the original entry in the record.

(4) If a correction made after a claim has been submitted affects the accuracy or validity of the claim, an amended claim must be submitted.

**79.3(3) Maintenance requirement.** The provider shall maintain records as required by this rule:

*a.* During the time the member is receiving services from the provider.

*b.* For a minimum of five years from the date when a claim for the service was submitted to the medical assistance program for payment.

*c.* As may be required by any licensing authority or accrediting body associated with determining the provider's qualifications.

**79.3(4) Availability.** Rescinded IAB 1/30/08, effective 4/1/08.

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

[ARC 7957B, IAB 7/15/09, effective 7/1/09; ARC 8262B, IAB 11/4/09, effective 12/9/09; ARC 9440B, IAB 4/6/11, effective 4/1/11; ARC 9487B, IAB 5/4/11, effective 7/1/11; ARC 0198C, IAB 7/11/12, effective 7/1/12; ARC 0358C, IAB 10/3/12, effective 11/7/12; ARC 0711C, IAB 5/1/13, effective 7/1/13]

#### **441—79.4(249A) Reviews and audits.**

##### **79.4(1) Definitions.**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

b. Requests for provider records by the Iowa Medicaid enterprise surveillance and utilization review services unit shall include Form 470-4479, Documentation Checklist, which is available at [www.ime.state.ia.us/Providers/Forms.html](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, in the following format:

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

Date of Request: \_\_\_\_\_  
 Reviewer Name & Phone Number: \_\_\_\_\_  
 Provider Name: \_\_\_\_\_  
 Provider Number: \_\_\_\_\_  
 Provider Type: \_\_\_\_\_

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

**Please send copies. Do not send original records.**

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

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

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

Signature	Title	Telephone Number
-----------	-------	------------------

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]

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

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

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

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

In these agreements, the provider agrees to the following:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**79.7(5) Procedures.**

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

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

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

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

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

**79.7(6) Duties.**

a. *Executive committee.* Based upon the deliberations of the medical assistance advisory council and the executive committee, the executive committee shall make recommendations to the director regarding the budget, policy, and administration of the medical assistance program. Such recommendations may include:

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

b. *Council.* The medical assistance advisory council shall:

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

**79.7(7) Responsibilities.**

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

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

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

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

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

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

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

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

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

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

**79.8(1) Making the request.**

a. Providers may submit requests for prior authorization for any items or procedures by mail or by facsimile transmission (fax) using Form 470-0829, Request for Prior Authorization, or electronically

using the Accredited Standards Committee (ASC) X12N 278 transaction, Health Care Services Request for Review and Response. Requests for prior authorization for drugs may also be made by telephone.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

*e.* The advice of an appropriate professional consultant.

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

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

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

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

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

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

**79.9(2)** The services covered by Medicaid shall:

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

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

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

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

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

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

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

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

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

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

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

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

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

**79.11(1)** The physician must request approval from the IME medical services unit when the physician expects to perform a surgical procedure appearing on the department's preprocedure surgical review list published in the Medicaid provider manual. All requests for preprocedure surgical review

shall be made according to instructions issued to physicians, hospitals and ambulatory surgical centers appearing in the Medicaid provider manual and instructions issued to providers by the IME medical services unit.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

laboratory services are defined as services to examine human specimens for the diagnosis, prevention or treatment of any disease or impairment of, or assessment of, the health of human beings.

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

**441—79.14(249A) Provider enrollment.**

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

*a.* Providers of home- and community-based waiver services shall submit Form 470-2917, Medicaid HCBS Provider Application, at least 90 days before the planned service implementation date.

*b.* Providers enrolling as ordering or referring providers shall submit Form 470-5111, Iowa Medicaid Ordering/Referring Provider Enrollment Application.

*c.* All other providers shall submit Form 470-0254, Iowa Medicaid Provider Enrollment Application.

*d.* A nursing facility shall also complete the process set forth in 441—subrule 81.13(1).

*e.* An intermediate care facility for persons with an intellectual disability shall also complete the process set forth in 441—subrule 82.3(1).

**79.14(2)** Submittal of application. The provider shall submit the appropriate application forms to the Iowa Medicaid enterprise provider services unit by personal delivery, by e-mail, via online enrollment systems, or by mail to P.O. Box 36450, Des Moines, Iowa 50315.

*a.* The application shall include the provider's national provider identifier number or shall indicate that the provider is an atypical provider that is not issued a national provider identifier number.

*b.* With the application form, an assertive community treatment program shall submit Form 470-4842, Assertive Community Services (ACT) Provider Agreement Addendum, and agree to file with the department an annual report containing information to be used for rate setting, including:

(1) Data by practitioner on the utilization by Medicaid members of all the services included in assertive community treatment, and

(2) Cost information by practitioner type and by type of service actually delivered as part of assertive community treatment.

*c.* With the application form, or as a supplement to a previously submitted application, providers of health home services shall submit Form 470-5100, Health Home Provider Agreement.

**79.14(3)** Program integrity information requirements.

*a.* All providers, including but not limited to managed care organizations and Medicaid fiscal agents, applying for participation in the Iowa Medicaid program must disclose all information required to be submitted pursuant to 42 CFR Part 455. In addition, all providers shall disclose any current, or previous, direct or indirect affiliation with a present or former Iowa Medicaid provider that:

(1) Has any uncollected debt owed to Medicaid or any other health care program funded by any governmental entity, including but not limited to the federal and state of Iowa governments;

(2) Has been or is subject to a payment suspension under a federally funded health care program;

(3) Has been excluded from participation under Medicaid, Medicare, or any other federally funded health care program;

(4) Has had its billing privileges denied or revoked;

(5) Has been administratively dissolved by the Iowa secretary of state, or similar action has been taken by a comparable agency in another state; or

(6) Shares a national provider identification (NPI) number or tax ID number with another provider that meets the criteria specified in subparagraph 79.14(3)“a”(1), (2), (3), (4), or (5).

*b.* The Iowa Medicaid enterprise may deny enrollment to a provider applicant or disenroll a current provider that has any affiliation as set forth in this rule if the department determines that the affiliation poses a risk of fraud, waste, or abuse. Such denial or disenrollment is appealable under 441—Chapter 7 but, notwithstanding any provision to the contrary in that chapter, the provider shall bear the burden to prove by clear and convincing evidence that the affiliation does not pose any risk of fraud, waste, or abuse.

c. For purposes of this rule, the term “direct or indirect affiliation” includes but is not limited to relationships between individuals, business entities, or a combination of the two. The term includes but is not limited to direct or indirect business relationships that involve:

- (1) A compensation arrangement;
- (2) An ownership arrangement;
- (3) Managerial authority over any member of the affiliation;
- (4) The ability of one member of the affiliation to control any other; or
- (5) The ability of a third party to control any member of the affiliation.

**79.14(4)** Screening procedures and requirements. Providers applying for participation in the Iowa Medicaid program shall be subject to the “limited,” “moderate,” or “high” categorical risk screening procedures and requirements in accordance with 42 CFR §455.450.

a. For the types of providers that are recognized as a provider under the Medicare program, the Iowa Medicaid enterprise shall use the same categorical risk screening procedures and requirements assigned to that provider type by Medicare pursuant to 42 CFR §424.518.

b. Provider types not assigned a screening level by the Medicare program shall be subject to the procedures of the “limited” risk screening level pursuant to 42 CFR §455.450.

c. Adjustment of risk level. The Iowa Medicaid enterprise shall adjust the categorical risk screening procedures and requirements from “limited” or “moderate” to “high” when any of the following occurs:

(1) The Iowa Medicaid enterprise imposes a payment suspension on a provider based on a credible allegation of fraud, waste, or abuse; the provider has an existing Medicaid overpayment; or within the previous ten years, the provider has been excluded by the Office of the Inspector General or another state’s Medicaid program; or

(2) The Iowa Medicaid enterprise or the Centers for Medicare and Medicaid Services in the previous six months lifted a temporary moratorium for the particular provider type, and a provider that was prevented from enrolling based on the moratorium applies for enrollment as a provider at any time within six months from the date the moratorium was lifted.

**79.14(5)** Notification. A provider shall be notified of the decision on the provider’s application within 30 calendar days of receipt by the Iowa Medicaid enterprise provider services unit of a complete and correct application with all required documents, including, but not limited to, if applicable, any application fees or screening results.

**79.14(6)** A provider that is not approved as the Medicaid provider type requested shall have the right to appeal under 441—Chapter 7.

**79.14(7)** Effective date of approval. An application shall be approved retroactive to the date requested by the provider or the date the provider meets the applicable participation criteria, whichever is later, not to exceed 12 months retroactive from the receipt of the application with all required documents by the Iowa Medicaid enterprise provider services unit.

**79.14(8)** A provider approved for certification as a Medicaid provider shall complete a provider participation agreement as required by rule 441—79.6(249A).

**79.14(9)** No payment shall be made to a provider for care or services provided prior to the effective date of the Iowa Medicaid enterprise’s approval of an application.

**79.14(10)** Payment rates dependent on the nature of the provider or the nature of the care or services provided shall be based on information on the application, together with information on claim forms, or on rates paid the provider prior to April 1, 1993.

**79.14(11)** An amendment to an application shall be submitted to the Iowa Medicaid enterprise provider services unit and shall be approved or denied within 30 calendar days. Approval of an amendment shall be retroactive to the date requested by the provider or the date the provider meets all applicable criteria, whichever is later, not to exceed 30 days prior to the receipt of the amendment by the Iowa Medicaid enterprise provider services unit. Denial of an amendment may be appealed under 441—Chapter 7.

**79.14(12)** A provider that has not submitted a claim in the last 24 months will be sent a notice asking if the provider wishes to continue participation. A provider that fails to reply to the notice within 30

calendar days of the date on the notice will be terminated as a provider. Providers that do not submit any claims in 48 months will be terminated as providers without further notification.

**79.14(13) Report of changes.** The provider shall inform the Iowa Medicaid enterprise of all pertinent changes to enrollment information within 35 days of the change. Pertinent changes include, but are not limited to, changes to the business entity name, individual provider name, tax identification number, mailing address, telephone number, or any information required to be disclosed by subrule 79.14(3).

*a.* When a provider reports false, incomplete, or misleading information on any application or reapplication, or fails to provide current information within the 35-day period, the Iowa Medicaid enterprise may immediately terminate the provider's Medicaid enrollment. The termination may be appealed under 441—Chapter 7. Such termination remains in effect notwithstanding any pending appeal.

*b.* When the department incurs an informational tax-reporting fine or is required to repay the federal share of medical assistance paid to the provider because a provider submitted inaccurate information or failed to submit changes to the Iowa Medicaid enterprise in a timely manner, the fine or repayment shall be the responsibility of the individual provider to the extent that the fine or repayment relates to or arises out of the provider's failure to keep all provider information current.

(1) The provider shall remit the amount of the fine or repayment to the department within 30 days of notification by the department that the fine has been imposed.

(2) Payment of the fine or repayment may be appealed under 441—Chapter 7.

**79.14(14) Provider termination or denial of enrollment.** The Iowa Medicaid enterprise must terminate or deny any provider enrollment when the provider has violated any requirements identified in 42 CFR §455.416.

**79.14(15) Temporary moratoria.** The Iowa Medicaid enterprise must impose any temporary moratorium as identified in 42 CFR §455.470.

**79.14(16) Provider revalidation.** Providers are required to complete the application process and screening requirements as detailed in this rule every five years.

**79.14(17) Recoupment.** A provider is strictly liable for any failure to disclose the information required by subrule 79.14(3) or any failure to report a change required by subrule 79.14(13). The department shall recoup as incorrectly paid all funds paid to the provider before a complete disclosure or report of change was made. The department shall also recoup as incorrectly paid all funds to any provider that billed the Iowa Medicaid enterprise while the provider was administratively dissolved by the Iowa secretary of state or comparable agency of another state, even if the provider subsequently obtains a retroactive reinstatement from the Iowa secretary of state or similar action was taken against the provider by a comparable agency of another state.

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

[ARC 9440B, IAB 4/6/11, effective 4/1/11; ARC 0198C, IAB 7/11/12, effective 7/1/12; ARC 0580C, IAB 2/6/13, effective 4/1/13]

**441—79.15(249A) Education about false claims recovery.** The provisions in this rule apply to any entity that has received medical assistance payments totaling at least \$5 million during a federal fiscal year (ending on September 30). For entities whose payments reach this threshold, compliance with this rule is a condition of receiving payments under the medical assistance program during the following calendar year.

**79.15(1) Policy requirements.** Any entity whose medical assistance payments meet the threshold shall:

*a.* Establish written policies for all employees of the entity and for all employees of any contractor or agent of the entity, including management, which provide detailed information about:

(1) The False Claims Act established under Title 31, United States Code, Sections 3729 through 3733;

(2) Administrative remedies for false claims and statements established under Title 31, United States Code, Chapter 38;

(3) Any state laws pertaining to civil or criminal penalties for false claims and statements;

(4) Whistle blower protections under the laws described in subparagraphs (1) to (3) with respect to the role of these laws in preventing and detecting fraud, waste, and abuse in federal health care programs, as defined in Title 42, United States Code, Section 1320a-7b(f); and

(5) The entity's policies and procedures for detecting and preventing fraud, waste, and abuse.

*b.* Include in any employee handbook a specific discussion of:

(1) The laws described in paragraph 79.15(1) "a";

(2) The rights of employees to be protected as whistle blowers; and

(3) The entity's policies and procedures for detecting and preventing fraud, waste, and abuse.

**79.15(2) Reporting requirements.**

*a.* Any entity whose medical assistance payments meet the specified threshold during a federal fiscal year shall provide the following information to the Iowa Medicaid enterprise by the following December 31:

(1) The name, address, and national provider identification numbers under which the entity receives payment;

(2) Copies of written or electronic policies that meet the requirements of subrule 79.15(1); and

(3) A written description of how the policies are made available and disseminated to all employees of the entity and to all employees of any contractor or agent of the entity.

*b.* The information may be provided by:

(1) Mailing the information to the IME Program Integrity Unit, P.O. Box 36390, Des Moines, Iowa 50315; or

(2) Faxing the information to (515)725-1354.

**79.15(3) Enforcement.** Any entity that fails to comply with the requirements of this rule shall be subject to sanction under rule 441—79.2(249A), including probation, suspension or withholding of payments, and suspension or termination from participation in the medical assistance program.

This rule is intended to implement Iowa Code section 249A.4 and Public Law 109-171, Section 6032.

[ARC 9440B, IAB 4/6/11, effective 4/1/11]

**441—79.16(249A) Electronic health record incentive program.** The department has elected to participate in the electronic health record (EHR) incentive program authorized under Section 4201 of the American Recovery and Reinvestment Act of 2009 (ARRA), Public Law No. 111-5. The electronic health record incentive program provides incentive payments to eligible hospitals and professionals participating in the Iowa Medicaid program that adopt and successfully demonstrate meaningful use of certified electronic health record technology.

**79.16(1) State elections.** In addition to the statutory provisions in ARRA Section 4201, the electronic health record incentive program is governed by federal regulations at 42 CFR Part 495 as 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 Web site, 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 Web site at [www.imeincentives.com](http://www.imeincentives.com). The applicant shall use the Web site to:
  - (1) Attest to the applicant’s qualifications to receive the incentive payment, and
  - (2) Digitally sign Form 470-4976, Iowa Electronic Health Record Incentive Program Provider Agreement.
- b. For the second year of participation, 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 Web site.

- 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]
- [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>o</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>o</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>2</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>o</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>3</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>4</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]◇
- [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]◇
- [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]◊
- [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]◊
- [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>5</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>6</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>8</sup>
- [Filed emergency 6/12/03—published 7/9/03, effective 7/1/03]◊
- [Filed 9/22/03, Notice 7/9/03—published 10/15/03, effective 12/1/03]◊
- [Filed 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]◊
- [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]◊
- [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]◊
- [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◊—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>7</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>8</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]

◊ Two or more ARCs

- <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> 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>3</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>4</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>5</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>6</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>7</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>8</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).

CHAPTER 80  
PROCEDURE AND METHOD OF PAYMENT  
[Prior to 7/1/83, Social Services[770] Ch 80]

**441—80.1(249A) The fiscal agent function in medical assistance.** Rescinded IAB 5/25/05, effective 7/1/05.

**441—80.2(249A) Submission of claims.** Providers of medical and remedial care participating in the program shall submit claims for services rendered to the Iowa Medicaid enterprise on at least a monthly basis. All nursing facilities and providers of home- and community-based services shall submit claims for services after end of the calendar month in which the services are provided. Following audit of the claim, the Iowa Medicaid enterprise will make payment to the provider of care.

**80.2(1) Electronic submission.** Providers are encouraged to submit claims electronically whenever possible.

*a.* Ambulance service providers may bill electronically only when the procedures performed are identified by codes based on the ones that Medicare recognizes as emergency and support medical necessity without a review by the Iowa Medicaid enterprise.

*b.* When filing electronic claims, pharmacies shall use the format prescribed by the National Council for Prescription Drug Programs.

*c.* Claims submitted electronically after implementation of the Health Insurance Portability and Accountability Act of 1996 shall be filed on the Accredited Standards Committee (ASC) X12N 837 transaction, Health Care Claim. The department shall send all providers written notice when the Act is implemented.

(1) Providers listed as filing claims on Form CMS-1500 or on the Claim for Targeted Medical Care shall file claims on the professional version of the Health Care Claim.

(2) Providers listed as filing claims on Form CMS-1450 or on the Iowa Medicaid Long-Term Care Claim shall file the institutional version of the Health Care Claim.

(3) Dentists shall file the dental version of the Health Care Claim.

(4) Pharmacists providing drugs and injections shall use the format prescribed by the National Council for Prescription Drug Programs.

*d.* If a claim submitted electronically requires attachments or supporting clinical documentation and a national electronic attachment has not been adopted, the provider shall:

(1) Use Form 470-3969, Claim Attachment Control, as the cover sheet for the paper attachments or supporting clinical documentation; and

(2) Reference on Form 470-3969 the attachment control number submitted on the ASC X12N 837 electronic transaction.

**80.2(2) Claim forms.** Claims for payment for services provided recipients shall be submitted on Form CMS-1500, Health Insurance Claim Form, except as noted below.

*a.* The following providers shall submit claims on Form UB-92, CMS-1450:

(1) Home health agencies providing services other than home- and community-based services.

(2) Hospitals providing inpatient care or outpatient services, including inpatient psychiatric hospitals.

(3) Psychiatric medical institutions for children.

(4) Rehabilitation agencies.

(5) Hospice providers.

(6) Medicare-certified nursing facilities.

(7) Nursing facilities for the mentally ill.

(8) Special population nursing facilities as defined in rule 441—81.6(249A).

(9) Out-of-state nursing facilities.

*b.* All other nursing facilities and intermediate care facilities for the mentally retarded shall file claims on Form 470-0039, Iowa Medicaid Long-Term Care Claim.

c. Pharmacies shall submit claims on the Universal Pharmacy Claim Form when filing paper claims.

d. Dentists shall submit claims on the dental claim form approved by the American Dental Association.

e. Rescinded IAB 8/1/07, effective 9/5/07.

f. Providers of home- and community-based waiver services, including home health agencies, shall submit claims on Form 470-2486, Claim for Targeted Medical Care. In the event of the death of the member, the case manager or service worker shall sign and date the claim form if the services were delivered.

g. Case management providers shall submit claims on Form 470-2486, Claim for Targeted Medical Care, for services provided pursuant to 441—Chapter 90 and on FACS-generated claims for services provided pursuant to 441—Chapter 186.

h. Providers billing claims for Medicare beneficiaries that do not cross over electronically to the Iowa Medicaid enterprise shall submit:

(1) Form 470-4707, Medicare Crossover Invoice (Institutional), along with the Explanation of Medicare Benefits (EOMB) for institutional services.

(2) Form 470-4708, Medicare Crossover Invoice (Professional), along with the Explanation of Medicare Benefits (EOMB) for professional services.

**80.2(3)** Providers shall purchase or copy their supplies of forms CMS-1450 and CMS-1500 for use in billing.

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

[ARC 9403B, IAB 3/9/11, effective 5/1/11; ARC 9724B, IAB 9/7/11, effective 9/1/11; ARC 9889B, IAB 11/30/11, effective 1/4/12]

#### **441—80.3(249A) Payment from other sources.**

**80.3(1) *Payments deducted.*** The amount of any payment made directly to the provider of care by the recipient, relatives, or any source shall be deducted from the established cost standard for the service provided to establish the amount of payment to be made by Iowa Medicaid.

**80.3(2) *Third-party liability.*** When a third-party liability for medical expenses exists, this resource shall be utilized before the Medicaid program makes payment unless:

a. The department pays the total amount allowed under the Medicaid payment schedule and then seeks reimbursement from the liable third party. This “pay and chase” provision applies to claims for:

- (1) Prenatal care,
- (2) Preventive pediatric services, and
- (3) All services provided to a person for whom there is court-ordered medical support.

b. Otherwise authorized by the department.

**80.3(3) *Recovery from third parties legally responsible to pay for health care.*** Parties that are, by statute, contract, or agreement, legally responsible for payment of a claim for a health care item or service shall:

a. Respond to any inquiry by the state regarding a claim for payment for any health care item or service that is submitted no later than three years after the date of the provision of the item or service.

b. Agree not to deny any claim submitted by the state solely because of the date of submission of the claim, the type or format of the claim form, or a failure to present proper documentation at the point of sale that is the basis of the claim, if both of the following conditions are met:

(1) The claim is submitted to the entity by the state within the three-year period beginning on the date on which the item or service was furnished.

(2) Any action by the state to enforce its rights with respect to the claim is commenced within six years of the date that the claim was submitted by the state.

c. Reimburse the Medicaid program within 90 days of the request for repayment.

This rule is intended to implement Iowa Code chapter 249A.

[ARC 7547B, IAB 2/11/09, effective 3/18/09]

**441—80.4(249A) Time limit for submission of claims and claim adjustments.**

**80.4(1) *Submission of claims.*** Payment will not be made on any claim where the amount of time that has elapsed between the date the service was rendered and the date the initial claim is received by the Iowa Medicaid enterprise exceeds 365 days. The department shall consider claims submitted beyond the 365-day limit for payment only if retroactive eligibility on newly approved cases is made that exceeds 365 days or if attempts to collect from a third-party payer delay the submission of a claim.

**80.4(2) *Claim adjustments.*** A provider's request for an adjustment to a paid claim must be received by the Iowa Medicaid enterprise within one year from the date the claim was paid in order to have the adjustment considered.

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

**441—80.5(249A) Authorization process.**

**80.5(1) *Identification cards.*** The department shall issue Form 470-1911, Medical Assistance Eligibility Card, to members for use in securing medical and health services available under the program except as provided in 441—76.6(249A).

*a.* The department shall issue the Medical Assistance Eligibility Card:

- (1) When the member's eligibility is initially determined.
- (2) Annually thereafter.
- (3) Upon the member's request for replacement of a lost, stolen, or damaged card.

*b.* The Medical Assistance Eligibility Card is valid only for months in which the member has established eligibility, as indicated on the department's eligibility verification system (ELVS). Payment will be made for services provided to an ineligible person when ELVS indicates that the person was eligible for the period in which the service was provided.

**80.5(2) *Third-party liability.*** Rescinded IAB 2/11/09, effective 3/18/09.  
[ARC 7547B, IAB 2/11/09, effective 3/18/09]

**441—80.6(249A) Payment to provider—exception.** Payments for medical services may be made only to the provider of the services except as provided below:

**80.6(1) *Medical assistance corrective payments.*** Payment may be made to the client or county relief agency in accordance with rule 441—75.8(249A).

**80.6(2) *Assignment.*** Payment may be made in accordance with an assignment to a county for medical services received while the recipient was receiving interim assistance or while an appeal of a denial of medical assistance was pending.

**80.6(3) *Business agent of provider.*** Payment may be made to a business agent that furnishes statements and receives payments in the name of the provider if the agent's compensation is:

- a.* Related to the cost of processing the billing.
- b.* Not related on a percentage or other basis to the amount that is billed or collected.
- c.* Not dependent upon the collection of the payment.

**441—80.7(249A) Health care data match program.** As a condition of doing business in Iowa, health insurers shall provide, upon the request of the state, information with respect to individuals who are eligible for or are provided medical assistance under the state's medical assistance state plan to determine (1) during what period the member or the member's spouse or dependents may be or may have been covered by a health insurer and (2) the nature of the coverage that is or was provided by the health insurer. This requirement applies to self-insured plans, group health plans as defined in the federal Employee Retirement Income Security Act of 1974 (Public Law 93-406), service benefit plans, managed care organizations, pharmacy benefits managers, and other parties that are, by statute, contract, or agreement, legally responsible for payment of a claim for a health care item or service.

**80.7(1) *Agreement required.*** The parties shall sign a data use agreement for the purposes of this rule. The agreement shall prescribe the manner in which information shall be provided to the department of human services and the acceptable uses of the information provided.

a. The initial provision of data shall include the data necessary to enable the department to match covered persons and identify third-party payers for the two-year period before the initial provision of the data. The data shall include the name, address, and identifying number of the plan.

b. Ongoing monthly matches may be limited to changes in the data previously provided, including additional covered persons, with the effective dates of the changes.

**80.7(2) Agreement form.**

a. An agreement with the department shall be in substantially the same form as Form 470-4415, Agreement for Use of Data.

b. An agreement with the department's designee shall be in a form approved by the designee, which shall include privacy protections equivalent to those provided in Form 470-4415, Agreement for Use of Data.

**80.7(3) Confidentiality of data.** The exchange of information carried out under this rule shall be consistent with all laws, regulations, and rules relating to the confidentiality or privacy of personal information or medical records, including but not limited to:

a. The federal Health Insurance Portability and Accountability Act of 1996, Public Law 104-191; and

b. Regulations promulgated in accordance with that Act and published in 45 CFR Parts 160 through 164.

[ARC 1070C, IAB 10/2/13, effective 10/1/13]

These rules are intended to implement Iowa Code section 249A.4.

[Filed March 11, 1970; amended September 5, 1973]

[Filed 6/25/76, Notice 5/17/76—published 7/12/76, effective 8/16/76]

[Filed 12/9/76, Notice 11/3/76—published 12/29/76, effective 2/2/77]

[Filed 8/2/79, Notice 5/30/79—published 8/22/79, effective 9/26/79]

[Filed 1/28/82, Notice 11/11/81—published 2/17/82, effective 4/1/82]

[Filed 4/29/82, Notice 12/9/81—published 5/26/82, effective 7/1/82]

[Filed emergency 5/20/83—published 6/8/83, effective 6/1/83]

[Filed emergency 10/7/83—published 10/26/83, effective 11/1/83]

[Filed without Notice 10/7/83—published 10/26/83, effective 12/1/83]

[Filed 11/18/83, Notice 10/12/83—published 12/7/83, effective 2/1/84]

[Filed emergency 5/31/84 after Notice 4/11/84—published 6/20/84, effective 7/1/84]

[Filed 1/22/86, Notice 12/4/85—published 2/12/86, effective 4/1/86]

[Filed 4/28/86, Notice 2/26/86—published 5/21/86, effective 7/1/86]

[Filed emergency 1/15/87—published 2/11/87, effective 1/15/87]

[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 11/23/88 after Notices 7/13/88, 9/21/88—published 12/14/88, effective 1/1/89]

[Filed emergency 12/8/88 after Notices 10/19/88, 11/2/88—published 12/28/88, effective 1/1/89]

[Filed 7/14/89, Notices 4/19/89, 5/31/89—published 8/9/89, effective 10/1/89]

[Filed 9/15/89, Notice 8/9/89—published 10/4/89, effective 12/1/89]

[Filed emergency 12/15/89 after Notice 10/4/89—published 1/10/90, effective 1/1/90]

[Filed 4/13/90, Notice 11/29/90—published 5/2/90, effective 8/1/90]

[Filed 7/13/90, Notice 5/30/90—published 8/8/90, effective 10/1/90]

[Filed 10/12/90, Notice 8/8/90—published 10/31/90, effective 2/1/91]

[Filed emergency 1/17/91—published 2/6/91, effective 2/1/91]

[Filed 3/14/91, Notice 2/6/91—published 4/3/91, effective 6/1/91]

[Filed 8/8/91, Notice 6/26/91—published 9/4/91, effective 11/1/91]

[Filed 9/18/91, Notice 7/10/91—published 10/16/91, effective 12/1/91]

[Filed emergency 1/16/92 after Notice 11/29/91—published 2/5/92, effective 3/1/92]

[Filed 3/12/92, Notice 2/5/92—published 4/1/92, effective 7/1/92]

[Filed 1/14/93, Notice 11/11/92—published 2/3/93, effective 4/1/93]

[Filed without Notice 8/12/93—published 9/1/93, effective 11/1/93]

[Filed 12/16/93, Notice 9/1/93—published 1/5/94, effective 3/1/94]  
[Filed 4/14/94, Notice 2/16/94—published 5/11/94, effective 7/1/94]  
[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 6/12/97, Notice 4/23/97—published 7/2/97, effective 9/1/97]  
[Filed 6/8/00, Notice 4/19/00—published 6/28/00, effective 8/2/00]  
[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 emergency 6/13/01—published 7/11/01, effective 7/1/01]<sup>◊</sup>  
[Filed 7/11/01, Notice 5/16/01—published 8/8/01, effective 10/1/01]  
[Filed 12/12/01, Notice 7/11/01—published 1/9/02, effective 3/1/02]  
[Filed emergency 1/9/02 after Notice 11/14/01—published 2/6/02, effective 2/1/02]  
[Filed 2/14/02, Notice 1/9/02—published 3/6/02, effective 5/1/02]  
[Filed emergency 12/12/02 after Notice 10/16/02—published 1/8/03, effective 1/1/03]  
[Filed 5/16/03, Notice 4/2/03—published 6/11/03, effective 7/16/03]  
[Filed without Notice 5/4/05—published 5/25/05, effective 7/1/05]  
[Filed 5/16/07, Notice 2/14/07—published 6/6/07, effective 8/1/07]  
[Filed 7/12/07, Notice 5/23/07—published 8/1/07, effective 9/5/07]  
[Filed ARC 7547B (Notice ARC 7355B, IAB 11/19/08), IAB 2/11/09, effective 3/18/09]  
[Filed ARC 9403B (Notice ARC 9170B, IAB 10/20/10), IAB 3/9/11, effective 5/1/11]  
[Filed Emergency ARC 9724B, IAB 9/7/11, effective 9/1/11]  
[Filed ARC 9889B (Notice ARC 9725B, IAB 9/7/11), IAB 11/30/11, effective 1/4/12]  
[Filed Emergency After Notice ARC 1070C (Notice ARC 0909C, IAB 8/7/13), IAB 10/2/13, effective 10/1/13]

<sup>◊</sup> Two or more ARCs



CHAPTER 83  
MEDICAID WAIVER SERVICES

PREAMBLE

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

DIVISION I—HCBS HEALTH AND DISABILITY WAIVER SERVICES

**441—83.1(249A) Definitions.**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

[ARC 0306C, IAB 9/5/12, effective 11/1/12; ARC 0757C, IAB 5/29/13, effective 8/1/13]

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

**83.2(1) Eligibility criteria.**

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

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

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

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

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

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

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

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

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

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

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

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

(1) Under the age of 21;

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

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

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

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

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

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

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

**83.2(2) Need for services.**

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

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

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

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

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

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

<u>Skilled level of care</u>	<u>Nursing level of care</u>	<u>ICF/ID</u>
\$2,765	\$950	\$3,365

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

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

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

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

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

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

(4) Search for employment.

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

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

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

[ARC 0306C, IAB 9/5/12, effective 11/1/12; ARC 0548C, IAB 1/9/13, effective 1/1/13; ARC 0665C, IAB 4/3/13, effective 6/1/13; ARC 0757C, IAB 5/29/13, effective 8/1/13; ARC 0842C, IAB 7/24/13, effective 7/1/13; ARC 1056C, IAB 10/2/13, effective 11/6/13]

#### **441—83.3(249A) Application.**

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

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

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

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

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

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

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

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

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

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

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

(4) Applicants who do not fall within the available slots shall have their application rejected, and their names shall be maintained on the waiting list. They shall be contacted to reapply as slots become available based on their order on the waiting list so that the number of approved persons on the program

is maintained. The bureau of long-term care shall contact the county department office when a slot becomes available.

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

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

**83.3(3)** *Approval of application.*

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

(1) An application has been filed and is pending for federal supplemental security income benefits.

(2) The application is pending because the department has not received information which is beyond the control of the client or the department.

(3) The application is pending due to the disability determination process performed through the department.

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

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

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

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

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

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

**83.3(4)** *Effective date of eligibility.*

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

*b.* The effective date of eligibility for the health and disability waiver for persons who qualify for Medicaid due to eligibility for the waiver services and to whom paragraphs 83.3(4) "a" and "c" do not apply is the date on which the income eligibility and level of care determinations and the case plan are completed.

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

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

**83.3(5) Attribution of resources.** For the purposes of attributing resources as provided in rule 441—75.5(249A), the date on which the waiver applicant met the level of care criteria in a medical institution as established by the peer review organization shall be used as the date of entry to the medical institution. Only one attribution of resources shall be completed per person. Attributions completed for prior institutionalizations shall be applied to the waiver application.

[ARC 0306C, IAB 9/5/12, effective 11/1/12; ARC 0757C, IAB 5/29/13, effective 8/1/13]

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

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

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

**83.4(3) Maintenance needs of spouse and other dependents.** Rescinded IAB 4/9/97, effective 6/1/97.  
[ARC 0757C, IAB 5/29/13, effective 8/1/13]

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

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

[ARC 0757C, IAB 5/29/13, effective 8/1/13]

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

[ARC 0757C, IAB 5/29/13, effective 8/1/13]

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

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

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

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

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

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

[ARC 0757C, IAB 5/29/13, effective 8/1/13]

**441—83.8(249A) Adverse service actions.**

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

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

b. Needed services are not available or received from qualified providers.  
 c. Service needs exceed the aggregate monthly costs established in 83.2(2) “b,” or are not met by the services provided.

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

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

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

b. The costs of the health and disability waiver service for the person exceed the aggregate monthly costs established in 83.2(2) “b.”

c. The member receives care in a hospital, nursing facility, or intermediate care facility for persons with an intellectual disability for 30 days in any one stay for purposes other than respite care.

d. The member receives health and disability waiver services and the physical or mental condition of the member requires more care than can be provided in the member’s own home as determined by the service worker or targeted case manager.

e. Service providers are not available.

**83.8(3)** Reduction of services shall apply as in 441—subrule 130.5(3), paragraphs “a” and “b.”  
 [ARC 0306C, IAB 9/5/12, effective 11/1/12; ARC 0757C, IAB 5/29/13, effective 8/1/13]

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

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

**441—83.11(249A) Conversion to the X-PERT system.** Rescinded IAB 8/7/02, effective 10/1/02.

These rules are intended to implement Iowa Code sections 249A.3 and 249A.4.

**441—83.12 to 83.20** Reserved.

#### DIVISION II—HCBS ELDERLY WAIVER SERVICES

**441—83.21(249A) Definitions.**

“*Attorney in fact under a durable power of attorney for health care*” means an individual who is designated by a durable power of attorney for health care, pursuant to Iowa Code chapter 144B, as an agent to make health care decisions on behalf of an individual and who has consented to act in that capacity.

“*Basic individual respite*” means respite provided on a staff-to-consumer ratio of one to one or higher to individuals without specialized needs requiring the care of a licensed registered nurse or licensed practical nurse.

“*Client participation*” means the amount of the recipient income that the person must contribute to the cost of elderly waiver services exclusive of medical vendor payments before Medicaid will participate.

“*Group respite*” is respite provided on a staff-to-consumer ratio of less than one to one.

“*Guardian*” means a guardian appointed in probate court.

“*Interdisciplinary team*” means a collection of persons with varied professional backgrounds who develop one plan of care to meet a client’s need for services.

“*Medical institution*” means a nursing facility which has been approved as a Medicaid vendor.

“*Service plan*” means a written consumer-centered, outcome-based plan of services developed using an interdisciplinary process, which addresses all relevant services and supports being provided. It may involve more than one provider.

“*Specialized respite*” means respite provided on a staff-to-consumer ratio of one to one or higher to individuals with specialized medical needs requiring the care, monitoring or supervision of a licensed registered nurse or licensed practical nurse.

“*Third-party payments*” means payments from an individual, institution, corporation, or public or private agency which is liable to pay part or all of the medical costs incurred as a result of injury, disease or disability by or on behalf of an applicant or a past or present recipient of medical assistance.

“*Usual caregiver*” means a person or persons who reside with the consumer and are available on a 24-hour-per-day basis to assume responsibility for the care of the consumer.

**441—83.22(249A) Eligibility.** To be eligible for elderly waiver services a person must meet certain eligibility criteria and be determined to need a service(s) allowable under the program.

**83.22(1) Eligibility criteria.** All of the following criteria must be met. The person must be:

- a. Sixty-five years of age or older.
- b. A resident of the state of Iowa.
- c. Eligible for Medicaid as if in a medical institution pursuant to 441—Chapter 75. When a husband and wife who are living together both apply for the waiver, income and resource guidelines as specified at 441—paragraphs 75.5(2)“b” and 75.5(4)“c” shall be applied.

d. Certified as being in need of the intermediate or skilled level of care based on information submitted on Form 470-4392, Level of Care Certification for HCBS Waiver Program.

(1) A physician, doctor of osteopathy, registered nurse practitioner, or physician assistant shall complete Form 470-4392 when the person applies for waiver services, upon request to report a change in the person’s condition, and annually for reassessment of the person’s level of care.

(2) The IME medical services unit shall be responsible for approval of the certification of the level of care.

(3) Elderly waiver services will not be provided when the person is an inpatient in a medical institution.

e. Determined to need services as described in subrule 83.22(2).

f. Rescinded IAB 10/11/06, effective 10/1/06.

g. For the consumer choices option as set forth in rule 441—subrule 78.37(16), residing in a living arrangement other than a residential care facility.

**83.22(2) Need for services, service plan, and cost.**

a. *Case management.* Consumers under the elderly waiver shall receive case management services from a provider qualified pursuant to 441—subrule 77.33(21). Case management services shall be provided as set forth in rules 441—90.5(249A) and 441—90.8(249A).

b. *Interdisciplinary team.* The case manager shall establish an interdisciplinary team for the consumer.

(1) *Composition.* The interdisciplinary team shall include the case manager and the consumer and, if appropriate, the consumer’s legal representative, family, service providers, and others directly involved in the consumer’s care.

(2) *Role.* The team shall identify:

1. The consumer’s need for services based on the consumer’s needs and desires.
2. Available and appropriate services to meet the consumer’s needs.
3. Health and safety issues for the consumer that indicate the need for an emergency plan, based on a risk assessment conducted before the team meeting.
4. Emergency backup support and a crisis response system to address problems or issues arising when support services are interrupted or delayed or when the consumer’s needs change.

c. *Service plan.* An applicant for elderly waiver services shall have a service plan developed by a qualified provider of case management services under the elderly waiver.

(1) Services included in the service plan shall be appropriate to the problems and specific needs or disabilities of the consumer.

(2) Services must be the least costly available to meet the service needs of the member. The total monthly cost of the elderly waiver services exclusive of case management services shall not exceed the established monthly cost of the level of care. Aggregate monthly costs are limited as follows:

<u>Skilled level of care</u>	<u>Nursing level of care</u>
\$2,765	\$1,339

(3) The service plan must be completed before services are provided.

(4) The service plan must be reviewed at least annually and when there is any significant change in the consumer's needs.

*d. Content of service plan.* The service plan shall include the following information based on the consumer's current assessment and service needs:

(1) Observable or measurable individual goals.

(2) Interventions and supports needed to meet those goals.

(3) Incremental action steps, as appropriate.

(4) The names of staff, people, businesses, or organizations responsible for carrying out the interventions or supports.

(5) The desired individual outcomes.

(6) The identified activities to encourage the consumer to make choices, to experience a sense of achievement, and to modify or continue participation in the service plan.

(7) Description of any restrictions on the consumer's rights, including the need for the restriction and a plan to restore the rights. For this purpose, rights include maintenance of personal funds and self-administration of medications.

(8) A list of all Medicaid and non-Medicaid services that the consumer received at the time of waiver program enrollment that includes:

1. The name of the service provider responsible for providing the service.

2. The funding source for the service.

3. The amount of service that the consumer is to receive.

(9) Indication of whether the consumer has elected the consumer choice option and, if so, the independent support broker and the financial management service that the consumer has selected.

(10) The determination that the services authorized in the service plan are the least costly.

(11) A plan for emergencies that identifies the supports available to the consumer in situations for which no approved service plan exists and which, if not addressed, may result in injury or harm to the consumer or other persons or in significant amounts of property damage. Emergency plans shall include:

1. The consumer's risk assessment and the health and safety issues identified by the consumer's interdisciplinary team.

2. The emergency backup support and crisis response system identified by the interdisciplinary team.

3. Emergency, backup staff designated by providers for applicable services.

**83.22(3) Providers—standards.** Rescinded IAB 10/11/06, effective 10/1/06.

[ARC 7957B, IAB 7/15/09, effective 7/1/09; ARC 0191C, IAB 7/11/12, effective 7/1/12; ARC 0306C, IAB 9/5/12, effective 11/1/12; ARC 0359C, IAB 10/3/12, effective 12/1/12; ARC 0548C, IAB 1/9/13, effective 1/1/13; ARC 0665C, IAB 4/3/13, effective 6/1/13; ARC 0842C, IAB 7/24/13, effective 7/1/13; ARC 1056C, IAB 10/2/13, effective 11/6/13]

#### **441—83.23(249A) Application.**

**83.23(1) Application for HCBS elderly waiver.** The application process as specified in rules 441—76.1(249A) to 441—76.6(249A) shall be followed.

**83.23(2) Application for services.** Rescinded IAB 12/6/95, effective 2/1/96.

**83.23(3) Approval of application.**

*a.* Applications for the elderly waiver program shall be processed in 30 days unless the worker can document difficulty in locating and arranging services or circumstances beyond the worker's control. In these cases a decision shall be made as soon as possible.

*b.* Decisions shall be mailed or given to the applicant on the date when both service and income maintenance eligibility determinations are completed.

*c.* An applicant must be given the choice between elderly waiver services and institutional care. The applicant, guardian, or attorney in fact under a durable power of attorney for health care shall sign Form 470-4694, Case Management Comprehensive Assessment, indicating that the applicant has elected waiver services.

*d.* Waiver services provided prior to approval of eligibility for the waiver cannot be paid.

**83.23(4) Effective date of eligibility.**

*a.* The effective date of eligibility cannot precede the date the case manager signs the case plan.

*b.* Eligibility for persons whose income exceeds supplemental security income guidelines shall not exist until the persons require care in a medical institution for a period of 30 consecutive days and shall be effective no earlier than the first day of the month in which the 30-day period begins.

*c.* Eligibility continues until the consumer has been in a medical institution for 30 consecutive days for other than respite care or fails to meet eligibility criteria listed in rule 441—83.22(249A). Consumers who are inpatients in a medical institution for 30 or more consecutive days for other than respite care shall be terminated from elderly waiver services and reviewed for eligibility for other Medicaid coverage groups. The consumer will be notified of that decision through Form 470-0602, Notice of Decision. If the consumer returns home before the effective date of the notice of decision and the consumer's condition has not substantially changed, the denial may be rescinded and eligibility may continue.

**83.23(5) Attribution of resources.** For the purposes of attributing resources as provided in rule 441—75.5(249A), the date on which the waiver applicant met the level of care criteria in a medical institution as established by the peer review organization shall be used as the date of entry to the medical institution. Only one attribution of resources shall be completed per person. Attributions completed for prior institutionalizations shall be applied to the waiver application.

[ARC 0306C, IAB 9/5/12, effective 11/1/12]

**441—83.24(249A) Client participation.** Persons must contribute their predetermined client participation to the cost of elderly waiver services.

**83.24(1) Computation of client participation.** Client participation shall be computed by deducting an amount for the maintenance needs of the individual which is 300 percent of the maximum SSI grant for an individual from the client's total income.

**83.24(2) Limitation on payment.** If the sum of the third-party payment and client participation equals or exceeds the reimbursement established by the service worker, Medicaid will make no payments for elderly waiver service providers. However, Medicaid will make payments to other medical vendors.

**441—83.25(249A) Redetermination.** A complete redetermination of eligibility for elderly waiver services shall be done at least once every 12 months.

A redetermination of continuing eligibility factors shall be made when a change in circumstances occurs that affects eligibility in accordance with rule 441—83.22(249A). A redetermination shall contain the components listed in rule 441—83.27(249A).

**441—83.26(249A) Allowable services.** Services allowable under the elderly waiver are case management, adult day care, emergency response system, homemaker, home health aide, nursing, respite care, chore, home-delivered meals, home and vehicle modification, mental health outreach, transportation, nutritional counseling, assistive devices, senior companions, consumer-directed attendant care, financial management, independent support brokerage, self-directed personal care, self-directed community supports and employment, and individual-directed goods and services as set forth in rule 441—78.37(249A).

**441—83.27(249A) Service plan.** The service plan shall be completed jointly by the consumer, the elderly waiver case manager, and any other person identified by the consumer.

**83.27(1)** The service plan shall indicate whether the consumer has elected the consumer choices option. If the consumer has elected the consumer choices option, the service plan shall identify:

- a. The independent support broker selected by the consumer; and
- b. The financial management service selected by the consumer.

**83.27(2)** The service plan shall identify a plan for emergencies and the supports available to the consumer in an emergency.

**441—83.28(249A) Adverse service actions.**

**83.28(1) Denial.** An application for services shall be denied when it is determined by the department that:

- a. The client is not eligible for or in need of services.
- b. Except for respite care, the elderly waiver services are not needed on a regular basis.
- c. Service needs exceed the aggregate monthly costs established in 83.22(2) “b,” or are not met by services provided.
- d. Needed services are not available or received from qualifying providers.
- e. Rescinded IAB 3/2/94, effective 3/1/94.

**83.28(2) Termination.** A particular service may be terminated when the department determines that:

- a. The provisions of 441—subrule 130.5(2), paragraph “a,” “b,” “c,” “d,” “g,” or “h” apply.
- b. The costs of the elderly waiver services for the person exceed the aggregate monthly costs established in 83.22(2) “b.”
- c. The client receives care in a hospital or nursing facility for 30 days in any one stay for purposes other than respite care.
- d. The client receives elderly waiver services and the physical or mental condition of the client requires more care than can be provided in the client’s own home as determined by the case manager and the interdisciplinary team.
- e. Service providers are not available.

**83.28(3)** Reduction of services shall apply as in 441—subrule 130.5(3), paragraphs “a” and “b.”

**441—83.29(249A) Appeal rights.** Notice of adverse action and right to appeal shall be given in accordance with 441—Chapter 7 and rule 441—130.5(234).  
[ARC 0306C, IAB 9/5/12, effective 11/1/12]

**441—83.30(249A) Enhanced services.** When a household has one person receiving service in accordance with rules set forth in 441—Chapter 24 and another receiving elderly waiver services, the persons providing case management shall cooperate to make the best plan for both clients. When a person is eligible for services as set forth in 441—Chapter 24 and eligible for services under the elderly waiver, the person’s primary diagnosis will determine which services shall be used.

**441—83.31(249A) Conversion to the X-PERT system.** Rescinded IAB 8/7/02, effective 10/1/02.

These rules are intended to implement Iowa Code sections 249A.3 and 249A.4.

**441—83.32 to 83.40** Reserved.

DIVISION III—HCBS AIDS/HIV WAIVER SERVICES

**441—83.41(249A) Definitions.**

“*AIDS*” means a medical diagnosis of acquired immunodeficiency syndrome based on the Centers for Disease Control “Revision of the CDC Surveillance Case Definition for Acquired Immunodeficiency Syndrome,” August 14, 1987, Vol. 36, No. 1S issue of “Morbidity and Mortality Weekly Report.”

“*Attorney in fact under a durable power of attorney for health care*” means an individual who is designated by a durable power of attorney for health care, pursuant to Iowa Code chapter 144B, as an agent to make health care decisions on behalf of an individual and who has consented to act in that capacity.

“*Basic individual respite*” means respite provided on a staff-to-consumer ratio of one to one or higher to individuals without specialized needs requiring the care of a licensed registered nurse or licensed practical nurse.

“*Client participation*” means the amount of the recipient’s income that the person must contribute to the cost of AIDS/HIV waiver services exclusive of medical vendor payments before Medicaid will participate.

“*Deeming*” means the specified amount of parental or spousal income and resources considered in determining eligibility for a child or spouse according to current supplemental security income guidelines.

“*Financial participation*” means client participation and medical payments from a third party including veterans’ aid and attendance.

“*Group respite*” is respite provided on a staff-to-consumer ratio of less than one to one.

“*Guardian*” means a guardian appointed in probate court.

“*HIV*” means a medical diagnosis of human immunodeficiency virus infection based on a positive HIV-related test.

“*Medical institution*” means a nursing facility or hospital which has been approved as a Medicaid vendor.

“*Service plan*” means a written consumer-centered, outcome-based plan of services developed using an interdisciplinary process, which addresses all relevant services and supports being provided. It may involve more than one provider.

“*Specialized respite*” means respite provided on a staff-to-consumer ratio of one to one or higher to individuals with specialized medical needs requiring the care, monitoring or supervision of a licensed registered nurse or licensed practical nurse.

“*Third-party payments*” means payments from an attorney, individual, institution, corporation, or public or private agency which is liable to pay part or all of the medical costs incurred as a result of injury, disease or disability by or on behalf of an applicant or a past or present recipient of medical assistance.

“*Usual caregiver*” means a person or persons who reside with the consumer and are available on a 24-hour-per-day basis to assume responsibility for the care of the consumer.

**441—83.42(249A) Eligibility.** To be eligible for AIDS/HIV waiver services a person must meet certain eligibility criteria and be determined to need a service(s) allowable under the program.

**83.42(1) Eligibility criteria.** All of the following criteria must be met. The person must:

- a. Be diagnosed by a physician as having AIDS or HIV infection.
- b. Be certified in need of the level of care that, but for the waiver, would otherwise be provided in a nursing facility or hospital based on information submitted on Form 470-4392, Level of Care Certification for HCBS Waiver Program.

(1) A physician, doctor of osteopathy, registered nurse practitioner, or physician assistant shall complete Form 470-4392 when the person applies for waiver services, upon request to report a change in the person’s condition, and annually for reassessment of the person’s level of care.

(2) The IME medical services unit shall be responsible for approval of the certification of the level of care.

(3) AIDS/HIV waiver services shall not be provided when the person is an inpatient in a medical institution.

c. Be eligible for medical assistance under SSI, SSI-related, FMAP, or FMAP-related coverage groups; medically needy at hospital level of care; or a special income level (300 percent group); or become eligible through application of the institutional deeming rules.

d. Require, and use at least quarterly, one service available under the waiver as determined through an evaluation of need described in subrule 83.42(2).

e. Have service needs such that the costs of the waiver services are not likely to exceed the costs of care that would otherwise be provided in a medical institution.

f. Have income which does not exceed 300 percent of the maximum monthly payment for one person under supplemental security income.

g. For the consumer choices option as set forth in 441—subrule 78.38(9), not be living in a residential care facility.

**83.42(2) Need for services.**

a. The department service worker shall perform an assessment of the person's need for waiver services and determine the availability and appropriateness of services. This assessment shall be based, in part, on information in the completed Service Worker Comprehensive Assessment, Form 470-5044. Form 470-5044 shall be completed annually.

b. The total monthly cost of the AIDS/HIV waiver services shall not exceed the established aggregate monthly cost for level of care. The monthly cost of AIDS/HIV waiver services cannot exceed the established limit of \$1,840.

[ARC 0306C, IAB 9/5/12, effective 11/1/12; ARC 0548C, IAB 1/9/13, effective 1/1/13; ARC 0665C, IAB 4/3/13, effective 6/1/13; ARC 0842C, IAB 7/24/13, effective 7/1/13; ARC 1056C, IAB 10/2/13, effective 11/6/13]

**441—83.43(249A) Application.**

**83.43(1) Application for HCBS AIDS/HIV waiver services.** The application process as specified in rules 441—76.1(249A) to 441—76.6(249A) shall be followed.

**83.43(2) Application for services.** Rescinded IAB 12/6/95, effective 2/1/96.

**83.43(3) Approval of application.**

a. Applications for the HCBS AIDS/HIV waiver program shall be processed in 30 days unless one or more of the following conditions exist:

(1) The application is pending because the department has not received information, which is beyond the control of the client or the department.

(2) The application is pending because a level of care determination has not been made although the completed Form 470-4392, Level of Care Certification for HCBS Waiver Program, has been submitted to the IME medical services unit.

(3) Rescinded IAB 3/7/01, effective 5/1/01.

b. Decisions shall be mailed or given to the applicant on the date when income maintenance eligibility and level of care determinations and the consumer service plan are completed.

c. An applicant must be given the choice between HCBS AIDS/HIV waiver services and institutional care. The applicant, parent, guardian, or attorney in fact under a durable power of attorney for health care shall sign Form 470-5044, Service Worker Comprehensive Assessment, and indicate that the applicant has elected home- and community-based services.

d. Waiver services provided prior to approval of eligibility for the waiver cannot be paid.

**83.43(4) Effective date of eligibility.**

a. The effective date of eligibility for the AIDS/HIV waiver for persons who are already determined eligible for Medicaid is the date on which the income and resource eligibility and level of care determinations and the service plan are completed.

b. The effective date of eligibility for the AIDS/HIV waiver for persons who qualify for Medicaid due to eligibility for the waiver services and to whom 441—subrule 75.1(7) and rule 441—75.5(249A) do not apply is the date on which income and resource eligibility and level of care determinations and the service plan are completed.

c. Eligibility for the waiver continues until the recipient has been in a medical institution for 30 consecutive days for other than respite care or fails to meet eligibility criteria listed in rule 441—83.42(249A). Recipients who are inpatients in a medical institution for 30 or more consecutive days for other than respite care shall be reviewed for eligibility for other Medicaid coverage groups and terminated from AIDS/HIV waiver services if found eligible under another coverage group. The recipient will be notified of that decision through Form 470-0602, Notice of Decision. If the consumer returns home before the effective date of the notice of decision and the person's condition has not substantially changed, the denial may be rescinded and eligibility may continue.

d. The effective date of eligibility for the AIDS/HIV waiver for persons who qualify for Medicaid due to eligibility for the waiver services and to whom the eligibility factors set forth in 441—subrule 75.1(7) and, for married persons, in rule 441—75.5(249A) have been satisfied is the date on which the

income eligibility and level of care determinations and the service plan are completed, but shall not be earlier than the first of the month following the date of application.

**83.43(5) Attribution of resources.** For the purposes of attributing resources as provided in rule 441—75.5(249A), the date on which the waiver applicant met the level of care criteria in a medical institution as established by the peer review organization shall be used as the date of entry to the medical institution. Only one attribution of resources shall be completed per person. Attributions completed for prior institutionalizations shall be applied to the waiver application.  
[ARC 0306C, IAB 9/5/12, effective 11/1/12]

**441—83.44(249A) Financial participation.** Persons must contribute their predetermined financial participation to the cost of AIDS/HIV waiver services or other Medicaid services, as applicable.

**83.44(1) Maintenance needs of the individual.** The maintenance needs of the individual shall be computed by deducting an amount which is 300 percent of the maximum monthly payment for one person under supplemental security income (SSI) from the client's total income.

**83.44(2) Limitation on payment.** If the amount of the financial participation equals or exceeds the reimbursement established by the service worker for AIDS/HIV services, Medicaid will make no payments to AIDS/HIV waiver service providers. Medicaid will, however, make payments to other medical vendors.

**83.44(3) Maintenance needs of spouse and other dependents.** Rescinded IAB 4/9/97, effective 6/1/97.

**441—83.45(249A) Redetermination.** A complete redetermination of eligibility for AIDS/HIV waiver services shall be completed at least once every 12 months or when there is significant change in the person's situation or condition. A redetermination of continuing eligibility factors shall be made in accordance with rules 441—76.7(249A) and 441—83.42(249A). A redetermination shall include the components listed in rule 441—83.47(249A).

**441—83.46(249A) Allowable services.** Services allowable under the AIDS/HIV waiver are counseling, home health aide, homemaker, nursing care, respite care, home-delivered meals, adult day care, consumer-directed attendant care, financial management, independent support brokerage, self-directed personal care, self-directed community supports and employment, and individual-directed goods and services as set forth in rule 441—78.38(249A).

**441—83.47(249A) Service plan.** A service plan shall be prepared for AIDS/HIV waiver consumers in accordance with rule 441—130.7(234) except that service plans for both children and adults shall be completed every 12 months or when there is significant change in the person's situation or condition.

**83.47(1)** The service plan shall include the frequency of the AIDS/HIV waiver services and the types of providers who will deliver the services.

**83.47(2)** The service plan shall indicate whether the consumer has elected the consumer choices option. If the consumer has elected the consumer choices option, the service plan shall identify:

- a. The independent support broker selected by the consumer; and
- b. The financial management service selected by the consumer.

**83.47(3)** Service plans for consumers aged 20 or under must be developed to reflect use of all appropriate nonwaiver Medicaid services so as not to replace or duplicate those services.

**83.47(4)** The service plan shall identify a plan for emergencies and the supports available to the consumer in an emergency.

**441—83.48(249A) Adverse service actions.**

**83.48(1) Denial.** An application for services shall be denied when it is determined by the department that:

- a. The client is not eligible for or in need of services.
- b. Except for respite care, the AIDS/HIV waiver services are not needed on a regular basis.

*c.* Service needs exceed the aggregate monthly costs established in 83.42(2) “*b*” or cannot be met by the services provided under the waiver.

*d.* Needed services are not available from qualified providers.

**83.48(2) Termination.** Participation in the AIDS/HIV waiver program may be terminated when the department determines that:

*a.* The provisions of 441—subrule 130.5(2), paragraph “*a*,” “*b*,” “*c*,” “*d*,” “*g*,” or “*h*” apply.

*b.* The costs of the AIDS/HIV waiver services for the person exceed the aggregate monthly costs established in 83.42(2) “*b*.”

*c.* The client receives care in a hospital or nursing facility for 30 days or more in any one stay for purposes other than respite care.

*d.* The client receives AIDS/HIV waiver services and the physical or mental condition of the client requires more care than can be provided in the client’s own home as determined by the service worker.

*e.* Service providers are not available.

**83.48(3) Reduction of services** shall apply as in 441—subrule 130.5(3), paragraphs “*a*” and “*b*.”

**441—83.49(249A) Appeal rights.** Notice of adverse action and right to appeal shall be given in accordance with 441—Chapter 7 and rule 441—130.5(234).

[ARC 0306C, IAB 9/5/12, effective 11/1/12]

**441—83.50(249A) Conversion to the X-PERT system.** Rescinded IAB 8/7/02, effective 10/1/02.

These rules are intended to implement Iowa Code section 249A.4.

**441—83.51 to 83.59** Reserved.

#### DIVISION IV—HCBS INTELLECTUAL DISABILITY WAIVER SERVICES

**441—83.60(249A) Definitions.**

“*Adaptive*” means age-appropriate skills related to taking care of one’s self and one’s ability to relate to others in daily living situations. These skills include limitations that occur in the areas of communication, self-care, home-living, social skills, community use, self-direction, safety, functional activities of daily living, leisure or work.

“*Adult*” means a person with an intellectual disability aged 18 or over.

“*Appropriate*” means that the services or supports or activities provided or undertaken by the organization are relevant to the consumer’s needs, situation, problems, or desires.

“*Assessment*” means the review of the consumer’s current functioning in regard to the consumer’s situation, needs, strengths, abilities, desires and goals.

“*Attorney in fact under a durable power of attorney for health care*” means an individual who is designated by a durable power of attorney for health care, pursuant to Iowa Code chapter 144B, as an agent to make health care decisions on behalf of an individual and who has consented to act in that capacity.

“*Basic individual respite*” means respite provided on a staff-to-consumer ratio of one to one or higher to individuals without specialized needs requiring the care of a licensed registered nurse or licensed practical nurse.

“*Behavior*” means skills related to regulating one’s own behavior including coping with demands from others, making choices, controlling impulses, conforming conduct to laws, and displaying appropriate sociosexual behavior.

“*Case management services*” means those services established pursuant to Iowa Code chapter 225C.

“*Child*” means a person with an intellectual disability aged 17 or under.

“*Client participation*” means the posteligibility amount of the consumer’s income that persons eligible through a special income level must contribute to the cost of the home and community-based waiver service.

“*Counseling*” means face-to-face mental health services provided to the consumer and caregiver by a qualified intellectual disability professional (QIDP) to facilitate home management of the consumer and prevent institutionalization.

“*Deemed status*” means acceptance of certification or licensure of a program or service by another certifying body in place of certification based on review and evaluation.

“*Department*” means the Iowa department of human services.

“*Direct service*” means services involving face-to-face assistance to a consumer such as transporting a consumer or providing therapy.

“*Fiscal accountability*” means the development and maintenance of budgets and independent fiscal review.

“*Group respite*” is respite provided on a staff-to-consumer ratio of less than one to one.

“*Guardian*” means a guardian appointed in probate court.

“*Health*” means skills related to the maintenance of one’s health including eating; illness identification, treatment and prevention; basic first aid; physical fitness; regular physical checkups and personal habits.

“*Immediate jeopardy*” means circumstances where the life, health, or safety of a person will be severely jeopardized if the circumstances are not immediately corrected.

“*Intellectual disability*” means a diagnosis of mental retardation which shall be made only when the onset of the person’s condition was before the age of 18 years and shall be based on an assessment of the person’s intellectual functioning and level of adaptive skills. The diagnosis shall be made by a person who is a psychologist or psychiatrist who is professionally trained to administer the tests required to assess intellectual functioning and to evaluate a person’s adaptive skills. A diagnosis of mental retardation shall be made in accordance with the criteria provided in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision, published by the American Psychiatric Association.

“*Intermediate care facility for persons with an intellectual disability (ICF/ID)*” means an institution that is primarily for the diagnosis, treatment, or rehabilitation of persons with an intellectual disability or persons with related conditions and that provides, in a protected residential setting, ongoing evaluation, planning, 24-hour supervision, coordination and integration of health or related services to help each person function at the greatest ability and is an approved Medicaid vendor.

“*Intermittent supported community living service*” means supported community living service provided not more than 52 hours per month.

“*Maintenance needs*” means costs associated with rent or mortgage, utilities, telephone, food and household supplies.

“*Managed care*” means a system that provides the coordinated delivery of services and supports that are necessary and appropriate, delivered in the least restrictive settings and in the least intrusive manner. Managed care seeks to balance three factors:

1. Achieving high-quality outcomes for participants.
2. Coordinating access.
3. Containing costs.

“*Medical assessment*” means a visual and physical inspection of the consumer, noting deviations from the norm, and a statement of the consumer’s mental and physical condition that can be amendable to or resolved by appropriate actions of the provider.

“*Medical institution*” means a nursing facility, intermediate care facility for persons with an intellectual disability, or hospital which has been approved as a Medicaid vendor.

“*Medical intervention*” means consumer care in the areas of hygiene, mental and physical comfort, assistance in feeding and elimination, and control of the consumer’s care and treatment to meet the physical and mental needs of the consumer in compliance with the plan of care in areas of health, prevention, restoration, and maintenance.

“*Medical monitoring*” means observation for the purpose of assessing, preventing, maintaining, and treating disease or illness based on the consumer’s plan of care.

*“Natural supports”* means services and supports identified as wanted or needed by the consumer and provider by persons not for pay (family, friends, neighbors, coworkers, and others in the community) and organizations or entities that serve the general public.

*“Organization”* means the entity being certified.

*“Organizational outcome”* means a demonstration by the organization of actions taken by the organization to provide for services or supports to consumers.

*“Outcome”* means an action or event that follows as a result or consequence of the provision of a service or support.

*“Procedures”* means the steps to be taken to implement a policy.

*“Process”* means service or support provided by an agency to a consumer that will allow the consumer to achieve an outcome. This can include a written, formal, consistent trackable method or an informal process that is not written but is trackable.

*“Program”* means a set of related resources and services directed to the accomplishment of a fixed set of goals and objectives for the population of a specified geographic area or for special target populations. It can mean an agency, organization, or unit of an agency, organization or institution.

*“Qualified intellectual disability professional”* means a person who has at least one year of experience working directly with persons with an intellectual disability or other developmental disabilities and who is one of the following:

1. A doctor of medicine or osteopathy.
2. A registered nurse.
3. An occupational therapist eligible for certification as an occupational therapist by the American Occupational Therapy Association or another comparable body.
4. A physical therapist eligible for certification as a physical therapist by the American Physical Therapy Association or another comparable body.
5. A speech-language pathologist or audiologist eligible for certification of Clinical Competence in Speech-Language Pathology or Audiology by the American Speech-Language Hearing Association or another comparable body or who meets the educational requirements for certification and who is in the process of accumulating the supervised experience required for certification.
6. A psychologist with a master’s degree in psychology from an accredited school.
7. A social worker with a graduate degree from a school of social work, accredited or approved by the Council on Social Work Education or another comparable body or who holds a bachelor of social work degree from a college or university accredited or approved by the Council of Social Work Education or another comparable body.
8. A professional recreation staff member with a bachelor’s degree in recreation or in a specialty area such as art, dance, music or physical education.
9. A professional dietitian who is eligible for registration by the American Dietetics Association.
10. A human services professional who must have at least a bachelor’s degree in a human services field including, but not limited to, sociology, special education, rehabilitation counseling and psychology.

*“Related condition”* means a severe, chronic disability that meets all the following conditions:

1. It is attributable to cerebral palsy, epilepsy, or any other condition, other than mental illness, found to be closely related to intellectual disability because the condition results in impairment of general intellectual functioning or adaptive behavior similar to that of a person with an intellectual disability and requires treatment or services similar to those required for a person with an intellectual disability.

2. It is manifested before the age of 22.

3. It is likely to continue indefinitely.

4. It results in substantial functional limitations in three or more of the following areas of major life activity:

- Self-care.
- Understanding and use of language.
- Learning.
- Mobility.
- Self-direction.

- Capacity for independent living.

“*Service plan*” means a written consumer-centered, outcome-based plan of services developed using an interdisciplinary process, which addresses all relevant services and supports being provided. It may involve more than one provider.

“*Specialized respite*” means respite provided on a staff-to-consumer ratio of one to one or higher to individuals with specialized medical needs requiring the care, monitoring or supervision of a licensed registered nurse or licensed practical nurse.

“*Staff*” means a person under the direction of the organization to perform duties and responsibilities of the organization.

“*Third-party payments*” means payments from an attorney, individual, institution, corporation, insurance company, or public or private agency which is liable to pay part or all of the medical costs incurred as a result of injury, disease or disability by or on behalf of an applicant or a past or present recipient of Medicaid.

“*Usual caregiver*” means a person or persons who reside with the consumer and are available on a 24-hour-per-day basis to assume responsibility for the care of the consumer.

[ARC 9650B, IAB 8/10/11, effective 10/1/11; ARC 0306C, IAB 9/5/12, effective 11/1/12]

**441—83.61(249A) Eligibility.** To be eligible for HCBS intellectual disability waiver services a person must meet certain eligibility criteria and be determined to need a service(s) available under the program.

**83.61(1) Eligibility criteria.** All of the following criteria must be met. The person must:

a. Have a diagnosis of mental retardation or, for residential-based supported community living services only, be a person with a related condition as defined in rule 441—83.60(249A). The diagnosis shall be initially established and recertified as follows:

Age	Initial application to HCBS intellectual disability waiver program	Recertification for persons with a diagnosis of moderate, severe or profound mental retardation	Recertification for persons with a diagnosis of mild or unspecified mental retardation
0 through 17 years	Psychological documentation within three years of the application date substantiating a diagnosis of mental retardation or, for residential-based supported community living services, a diagnosis of a related condition as defined in rule 441—83.60(249A)	After the initial psychological evaluation, substantiate a diagnosis of mental retardation or, for residential-based supported community living services, a diagnosis of a related condition as defined in rule 441—83.60(249A) every six years and when a significant change occurs	After the initial psychological evaluation, substantiate a diagnosis of mental retardation or, for residential-based supported community living services, a diagnosis of a related condition as defined in rule 441—83.60(249A) every three years and when a significant change occurs
18 through 21 years	<ul style="list-style-type: none"> <li>• Psychological documentation substantiating diagnosis of mental retardation within three years before the application date, or</li> <li>• Diagnosis of mental retardation made before age 18 and current psychological documentation substantiating a diagnosis of mental retardation</li> </ul>	Psychological documentation substantiating a diagnosis of mental retardation every ten years and whenever a significant change occurs	Psychological documentation substantiating a diagnosis of mental retardation every five years and whenever a significant change occurs
22 years and above	Diagnosis made before age 18 and current psychological documentation substantiating a diagnosis of mental retardation if the last testing date was (1) more than five years ago for an applicant with a diagnosis of mild or unspecified mental retardation, or (2) more than ten years ago for an applicant with a diagnosis of moderate, severe or profound mental retardation	Psychological documentation substantiating a diagnosis of mental retardation made since the member reached 18 years of age	Psychological documentation substantiating a diagnosis of mental retardation every six years and whenever a significant change occurs

*b.* Be eligible for Medicaid under SSI, SSI-related, FMAP, or FMAP-related coverage groups; eligible under the special income level (300 percent) coverage group; or become eligible through application of the institutional deeming rules or would be eligible for Medicaid if in a medical institution.

*c.* Be certified as being in need for long-term care that, but for the waiver, would otherwise be provided in an ICF/ID. The IME medical services unit shall be responsible for annual approval of the certification of the level of care based on the data collected by the case manager and interdisciplinary team on a tool designated by the department.

(1) to (3) Rescinded IAB 3/7/01, effective 5/1/01.

*d.* Be a recipient of the Medicaid case management services or be identified to receive Medicaid case management services immediately following program enrollment.

*e.* Have service needs that can be met by this waiver program. At a minimum, a consumer must receive one billable unit of service per calendar quarter under this program.

*f.* Have a service plan completed annually and approved by the department in accordance with rule 441—83.67(249A).

*g.* For supported employment services:

(1) Be at least age 16.

(2) Rescinded IAB 7/1/98, effective 7/1/98.

(3) Not be eligible for supported employment service funding under Public Law 94-142 or for the Rehabilitation Act of 1973.

(4) Not reside in a medical institution.

*h.* Choose HCBS intellectual disability waiver services rather than ICF/ID services.

*i.* To be eligible for interim medical monitoring and treatment services the consumer must be:

(1) Under the age of 21;

(2) Currently receiving home health agency services under rule 441—78.9(249A) and require medical assessment, medical monitoring, and regular medical intervention or intervention in a medical emergency during those services. (The home health aide services for which the consumer is eligible must be maximized before the consumer accesses interim medical monitoring and treatment.);

(3) Residing in the consumer's family home or foster family home; and

(4) In need of interim medical monitoring and treatment as ordered by a physician.

*j.* Be assigned an HCBS intellectual disability payment slot pursuant to subrule 83.61(4).

*k.* For residential-based supported community living services, meet all of the following additional criteria:

(1) Be less than 18 years of age.

(2) Be preapproved as appropriate for residential-based supported community living services by the bureau of long-term care. Requests for approval shall be submitted in writing to the DHS Bureau of Long-Term Care, 1305 East Walnut Street, Des Moines, Iowa 50319-0114, and shall include the following:

1. Social history;

2. Case history that includes previous placements and service programs;

3. Medical history that includes major illnesses and current medications;

4. Current psychological evaluations and consultations;

5. Summary of all reasonable and appropriate service alternatives that have been tried or considered;

6. Any current court orders in effect regarding the child;

7. Any legal history;

8. Whether the child is at risk of out-of-home placement or the proposed placement would be less restrictive than the child's current placement for services;

9. Whether the proposed placement would be safe for the child and for other children living in that setting; and

10. Whether the interdisciplinary team is in agreement with the proposed placement.

(3) Either:

1. Be residing in an ICF/ID;

2. Be at risk of ICF/ID placement, as documented by an interdisciplinary team assessment pursuant to paragraph 83.61(2)“a”; or

3. Be a child whose long-term placement outside the home is necessary because continued stay in the home would be a detriment to the health and welfare of the child or the family, and all service options to keep the child in the home have been reviewed by an interdisciplinary team, as documented in the service file.

*l.* For day habilitation, be 16 years of age or older.

*m.* For the consumer choices option as set forth in 441—subrule 78.41(5), not be living in a residential care facility.

**83.61(2) Need for services.**

*a.* Applicants currently receiving Medicaid case management or services of a department-qualified intellectual disability professional (QIDP) shall have the applicable coordinating staff and other interdisciplinary team members complete Form 470-4694, Case Management Comprehensive Assessment, and identify the applicant’s needs and desires as well as the availability and appropriateness of the services.

*b.* Applicants not receiving services as set forth in paragraph 83.61(2)“a” shall have a department service worker or case manager:

(1) Complete Form 470-4694, Case Management Comprehensive Assessment, for the initial level of care determination;

(2) Establish an initial interdisciplinary team for HCBS intellectual disability waiver services; and

(3) With the initial interdisciplinary team, identify the applicant’s needs and desires as well as the availability and appropriateness of services.

*c.* Applicants meeting other eligibility criteria who do not have a Medicaid case manager shall be referred to a Medicaid case manager.

*d.* Services shall not exceed the number of maximum units established for each service.

*e.* The cost of services shall not exceed unit expense maximums. Requests shall only be reviewed for funding needs exceeding the supported community living service unit cost maximum. Requests require special review by the department and may be denied as not cost-effective.

*f.* The service worker, department QMRP, or Medicaid case manager shall complete Form 470-4694, Case Management Comprehensive Assessment, for the initial level of care determination within 30 days from the date of the HCBS application unless the worker can document difficulty in locating information necessary for completion of Form 470-4694 or other circumstances beyond the worker’s control.

*g.* At initial enrollment, the service worker, department QIDP, case manager or Medicaid case manager shall establish an interdisciplinary team for each applicant and, with the team, identify the applicant’s need for service based on the applicant’s needs and desires as well as the availability and appropriateness of services. The Medicaid case manager shall complete an annual review thereafter. The following criteria shall be used for the initial and ongoing assessments:

(1) The assessment shall be based, in part, on information on the completed Case Management Comprehensive Assessment, Form 470-4694.

(2) Service plans must be developed or reviewed to reflect use of all appropriate nonwaiver Medicaid services so as not to replace or duplicate those services.

(3) Service plans for applicants aged 20 or under which include supported community living services beyond intermittent shall be approved (signed and dated) by the designee of the bureau of long-term care. The service worker, department QIDP, or Medicaid case manager shall attach a written request for a variance from the maximum for intermittent supported community living with a summary of services and service costs. The written request for the variance shall provide a rationale for requesting supported community living beyond intermittent. The rationale shall contain sufficient information for the designee to make a decision regarding the need for supported community living beyond intermittent.

*h.* Interim medical monitoring and treatment services must be needed because all usual caregivers are unavailable to provide care due to one of the following circumstances:

(1) Employment. Interim medical monitoring and treatment services are to be received only during hours of employment.

(2) Academic or vocational training. Interim medical monitoring and treatment services provided while a usual caregiver participates in postsecondary education or vocational training shall be limited to 24 periods of no more than 30 days each per caregiver as documented by the service worker. Time spent in high school completion, adult basic education, GED, or English as a second language does not count toward the limit.

(3) Absence from the home due to hospitalization, treatment for physical or mental illness, or death of the usual caregiver. Interim medical monitoring and treatment services under this subparagraph are limited to a maximum of 30 days.

(4) Search for employment.

1. Care during job search shall be limited to only those hours the usual caregiver is actually looking for employment, including travel time.

2. Interim medical monitoring and treatment services may be provided under this paragraph only during the execution of one job search plan of up to 30 working days in a 12-month period, approved by the department service worker or targeted case manager pursuant to 441—subparagraph 170.2(2) “b”(5).

3. Documentation of job search contacts shall be furnished to the department service worker or targeted case manager.

**83.61(3) HCBS intellectual disability waiver program limit.** The number of persons receiving HCBS intellectual disability waiver services in the state shall be limited to the number of payment slots provided in the HCBS intellectual disability waiver approved by the Centers for Medicare and Medicaid Services (CMS). The department shall make a request to CMS to adjust the program limit as deemed necessary.

a. The payment slots are available on a statewide basis. These slots shall be available based on the prioritized need of an applicant pursuant to subrule 83.61(4).

b. When services are denied because the limit is reached, a notice of decision denying service based on the limit and stating that the person’s name will be put on a waiting list shall be sent to the person by the department.

**83.61(4) Securing a payment slot.** The department shall determine if a payment slot is available for each applicant for the HCBS intellectual disability waiver.

a. A payment slot shall be assigned to the applicant upon confirmation of an available slot.

(1) Once a payment slot is assigned, the department shall give written notice to the applicant.

(2) The department shall hold the payment slot for the applicant as long as reasonable efforts are being made to arrange services and the applicant has not been determined to be ineligible for the program. If services have not been initiated and reasonable efforts are no longer being made to arrange services, the slot shall revert for use by the next person on the waiting list, if applicable. The applicant originally assigned the slot must reapply for a new slot.

b. If no payment slot is available, the applicant shall be placed on a statewide priority waiting list. The department shall assess each applicant to determine the applicant’s priority need. The assessment shall be made for all applicants who are on a waiting list maintained by the state or a county on September 30, 2011, and for all new applications received on or after October 1, 2011.

(1) Emergency need criteria are as follows:

1. The usual caregiver has died or is incapable of providing care, and no other caregivers are available to provide needed supports.

2. The applicant has lost primary residence or will be losing housing within 30 days and has no other housing options available.

3. The applicant is living in a homeless shelter and no alternative housing options are available.

4. There is founded abuse or neglect by a caregiver or others living within the home of the applicant, and the applicant must move from the home.

5. The applicant cannot meet basic health and safety needs without immediate supports.

(2) Urgent need criteria are as follows:

1. The caregiver will need support within 60 days in order for the applicant to remain living in the current situation.

2. The caregiver will be unable to continue to provide care within the next 60 days.
3. The caregiver is 55 years of age or older and has a chronic or long-term physical or psychological condition that limits the ability to provide care.
4. The applicant is living in temporary housing and plans to move within 31 to 120 days.
5. The applicant is losing permanent housing and plans to move within 31 to 120 days.
6. The caregiver will be unable to be employed if services are not available.
7. There is a potential risk of abuse or neglect by a caregiver or others within the home of the applicant.
8. The applicant has behaviors that put the applicant at risk.
9. The applicant has behaviors that put others at risk.
10. The applicant is at risk of facility placement when needs could be met through community-based services.

(3) Applicants who meet an emergency need criterion shall be placed on the priority waiting list based on the total number of criteria in subparagraph 83.61(4) “b”(1) that are met. If applicants meet an equal number of criteria, the position on the waiting list shall be based on the date of application and the age of the applicant. The applicant who has been on the waiting list longer shall be placed higher on the waiting list. If the application date is the same, the older applicant shall be placed higher on the waiting list.

(4) Applicants who meet an urgent need criterion shall be placed on the priority waiting list after applicants who meet emergency need criteria. The position on the waiting list shall be based on the total number of criteria in subparagraph 83.61(4) “b”(2) that are met. If applicants meet an equal number of criteria, the position on the waiting list shall be based on the date of application and the age of the applicant. The applicant who has been on the waiting list longer shall be placed higher on the waiting list. If the application date is the same, the older applicant shall be placed higher on the waiting list.

(5) Applicants who do not meet emergency or urgent need criteria shall be placed lower on the waiting list than the applicants meeting urgent need criteria, based on the date of application. If the application date is the same, the older applicant shall be placed higher on the waiting list.

(6) Applicants shall remain on the waiting list until a payment slot has been assigned to them for use, they withdraw from the list, or they become ineligible for the waiver. If there is a change in an applicant’s need, the applicant may contact the local department office and request that a new assessment be completed. The outcome of the assessment shall determine placement on the waiting list as directed in this subrule.

c. To maintain the approved number of members in the program, persons shall be selected from the waiting list as payment slots become available, based on their priority order on the waiting list.

(1) Once a payment slot is assigned, the department shall give written notice to the person within five working days.

(2) The department shall hold the payment slot for 30 days for the person to file a new application. If an application has not been filed within 30 days, the slot shall revert for use by the next person on the waiting list, if applicable. The person originally assigned the slot must reapply for a new slot.

[ARC 9650B, IAB 8/10/11, effective 10/1/11; ARC 0191C, IAB 7/11/12, effective 7/1/12; ARC 0306C, IAB 9/5/12, effective 11/1/12; ARC 0359C, IAB 10/3/12, effective 12/1/12]

#### **441—83.62(249A) Application.**

**83.62(1)** *Application for HCBS intellectual disability waiver services.* The application process as specified in rules 441—76.1(249A) to 441—76.6(249A) shall be followed.

**83.62(2)** Rescinded IAB 6/5/96, effective 8/1/96.

**83.62(3)** *Approval of application.*

a. Applications for the HCBS intellectual disability waiver program shall be processed in 30 days unless the case manager or worker can document difficulty in locating and arranging services or other circumstance beyond the worker’s control. In these cases a decision shall be made as soon as possible.

b. Decisions shall be mailed or given to the applicant on the date when both service and income maintenance eligibility determinations are completed.

*c.* An applicant shall be given the choice between HCBS waiver services and ICF/ID care. The case manager or worker shall have the consumer or legal representative complete and sign Form 470-4694, Case Management Comprehensive Assessment, indicating the consumer's choice of care.

*d.* HCBS intellectual disability waiver services provided before eligibility for the waiver is approved shall not be reimbursed by the HCBS waiver program.

*e.* Services provided when the person is a consumer of group foster care services or is an inpatient in a medical institution shall not be reimbursed.

*f.* HCBS intellectual disability waiver services are not available in conjunction with other Medicaid waiver services or group foster care services.

*g.* Rescinded IAB 5/6/09, effective 7/1/09.

**83.62(4) Effective date of eligibility.**

*a.* Deeming of parental income and resources ceases the month following the month in which a person requires care in a medical institution.

*b.* The effective date of eligibility for the waiver for persons who are already determined eligible for Medicaid is the date on which the person is determined to meet the criteria set forth in rule 441—83.61(249A).

*c.* The effective date of eligibility for the waiver for persons who qualify for Medicaid due to eligibility for the waiver services is the date on which the person is determined to meet criteria set forth in rule 441—83.61(249A) and when the eligibility factor set forth in 441—subrule 75.1(7) and for married persons, in rule 441—75.5(249A) have been satisfied.

*d.* Eligibility continues until the consumer fails to meet eligibility criteria listed in rule 441—83.61(249A). Consumers who are inpatients in a medical institution for 30 consecutive days shall receive a review by the interdisciplinary team to determine additional inpatient needs for possible termination from the HCBS program. Consumers shall be reviewed for eligibility under other Medicaid coverage groups. The consumer or legal representative shall participate in the review and receive formal notification of that decision through Form 470-0602, Notice of Decision.

If the consumer returns home before the effective date of the notice of decision and the consumer's needs can still be met by the HCBS waiver services, the denial may be rescinded and eligibility may continue.

*e.* Eligibility and service reimbursement are effective through the last day of the month of the previous annual service plan staffing meeting and the corresponding long-term care need determination.

**83.62(5) Attribution of resources.** For the purposes of attributing resources as provided in rule 441—75.5(249A), the date on which the waiver applicant met the level of care criteria in a medical institution as established by the peer review organization shall be used as the date of entry to the medical institution. Only one attribution of resources shall be completed per person. Attributions completed for prior institutionalizations shall be applied to the waiver application.

[ARC 7741B, IAB 5/6/09, effective 7/1/09; ARC 9650B, IAB 8/10/11, effective 10/1/11; ARC 0306C, IAB 9/5/12, effective 11/1/12]

**441—83.63(249A) Client participation.** Persons who are eligible under the 300 percent group must contribute a predetermined client participation amount to the costs of the services.

**83.63(1) Computation of client participation.** Client participation shall be computed by deducting an amount for the maintenance needs of the individual which is 300 percent of the maximum SSI grant for an individual from the client's total income.

**83.63(2) Limitation on payment.** If the sum of the third-party payment and client participation equals or exceeds the reimbursement for the specific HCBS waiver service, Medicaid will make no payments for the HCBS waiver service. However, Medicaid will make payments to other medical vendors.

**441—83.64(249A) Redetermination.** A redetermination of eligibility for HCBS intellectual disability waiver services shall be completed at least once every 12 months.

A redetermination of continuing eligibility factors shall be made when a change in circumstances occurs that affects eligibility in accordance with rule 441—83.61(249A).

[ARC 9650B, IAB 8/10/11, effective 10/1/11]

**441—83.65(249A)** Rescinded IAB 6/5/96, effective 8/1/96.

**441—83.66(249A) Allowable services.** Services allowable under the HCBS intellectual disability waiver are supported community living, respite, personal emergency response system, nursing, home health aide, home and vehicle modification, supported employment, consumer-directed attendant care, interim medical monitoring and treatment, transportation, adult day care, day habilitation, prevocational services, financial management, independent support brokerage, self-directed personal care, self-directed community supports and employment, and individual-directed goods and services as set forth in rule 441—78.41(249A).

[ARC 9650B, IAB 8/10/11, effective 10/1/11]

**441—83.67(249A) Service plan.** A service plan shall be prepared for each HCBS intellectual disability waiver consumer.

**83.67(1) Development.** The service plan shall be developed by the interdisciplinary team, which includes the consumer, and, if appropriate, the legal representative, consumer's family, case manager or service worker, service providers, and others directly involved.

**83.67(2) Retention.** The service plan shall be stored by the case manager for a minimum of three years.

**83.67(3) Interdisciplinary team meeting.** The interdisciplinary team meeting shall be conducted before the current service plan expires.

**83.67(4) Information in plan.** The plan shall be in accordance with 441—subrule 24.4(3) and shall additionally include the following information to assist in evaluating the program:

- a. A listing of all services received by a consumer at the time of waiver program enrollment.
- b. For supported community living:
  - (1) The consumer's living environment at the time of waiver enrollment.
  - (2) The number of hours per day of on-site staff supervision needed by the consumer.
  - (3) The number of other waiver consumers who will live with the consumer in the living unit.
- c. An identification and justification of any restriction of the consumer's rights including, but not limited to:
  - (1) Maintenance of personal funds.
  - (2) Self-administration of medications.
- d. The name of the service provider responsible for providing each service.
- e. The service funding source.
- f. The amount of the service to be received by the consumer.
- g. Whether the consumer has elected the consumer choices option and, if so:
  - (1) The independent support broker selected by the consumer; and
  - (2) The financial management service selected by the consumer.
- h. A plan for emergencies and identification of the supports available to the consumer in an emergency.

**83.67(5) Documentation.** The Medicaid case manager shall ensure that the consumer's case file contains the consumer's service plan and documentation supporting the diagnosis of mental retardation.

**83.67(6) Approval of plan.** The plan shall be approved through the Individualized Services Information System (ISIS). Services shall be entered into ISIS based on the service plan.

- a. Services must be authorized and entered into ISIS before the plan implementation date.
- b. The department has 15 working days after receipt of the summary and service costs in which to approve the services and service cost or request modification of the service plan unless the parties mutually agree to extend that time frame.
- c. If the department and the service worker or case manager are unable to agree on the terms of the services or service cost within 10 days, the department has final authority regarding the services and service cost.

[ARC 9650B, IAB 8/10/11, effective 10/1/11; ARC 0191C, IAB 7/11/12, effective 7/1/12; ARC 0359C, IAB 10/3/12, effective 12/1/12]

**441—83.68(249A) Adverse service actions.**

**83.68(1) Denial.** An application for services shall be denied when it is determined by the department that:

- a. The applicant is not eligible for the services.
- b. Service needs exceed the service unit or reimbursement maximums.
- c. Service needs are not met by the services provided.
- d. Needed services are not available or received from qualifying providers.
- e. No HCBS intellectual disability waiver service is identified in the applicant's service plan.
- f. There is another community resource available to provide the service or a similar service free of charge to the applicant that will meet the applicant's needs.
- g. Completion or receipt of required documents by the department for the HCBS program applicant has not occurred.

**83.68(2) Reduction.** A particular service may be reduced when the department determines that the provisions of 441—subrule 130.5(3), paragraph “a” or “b,” apply.

**83.68(3) Termination.** A particular service may be terminated when the department determines that:

- a. The provisions of 441—subrule 130.5(2), paragraph “d,” “g,” or “h,” apply.
- b. Needed services are not available or received from qualifying providers.
- c. No HCBS intellectual disability waiver service is identified in the member's annual service plan.
- d. Service needs are not met by the services provided.
- e. Services needed exceed the service unit or reimbursement maximums.
- f. Completion or receipt of required documents by the department for the HCBS program consumer has not occurred.
- g. The consumer receives services from other Medicaid waiver programs.
- h. The consumer or legal representative through the interdisciplinary process requests termination from the services.

[ARC 9650B, IAB 8/10/11, effective 10/1/11]

**441—83.69(249A) Appeal rights.** Notice of adverse action and right to appeal shall be given in accordance with 441—Chapter 7 and rule 441—130.5(234).

[ARC 0191C, IAB 7/11/12, effective 7/1/12; ARC 0306C, IAB 9/5/12, effective 11/1/12; ARC 0359C, IAB 10/3/12, effective 12/1/12]

**441—83.70(249A) County reimbursement.** Rescinded ARC 0191C, IAB 7/11/12, effective 7/1/12.

**441—83.71(249A) Conversion to the X-PERT system.** Rescinded IAB 8/7/02, effective 10/1/02.

**441—83.72(249A) Rent subsidy program.** Members in the HCBS intellectual disability waiver program may be eligible for a rent subsidy. See 265—Chapter 24.

[ARC 9650B, IAB 8/10/11, effective 10/1/11]

These rules are intended to implement Iowa Code sections 249A.3 and 249A.4.

**441—83.73 to 83.80** Reserved.

DIVISION V—BRAIN INJURY WAIVER SERVICES

**441—83.81(249A) Definitions.**

“*Adaptive*” means age appropriate skills related to taking care of one's self and the ability to relate to others in daily living situations. These skills include limitations that occur in the areas of communication, self-care, home living, social skills, community use, self-direction, safety, functional academics, leisure and work.

“*Adult*” means a person with a brain injury aged 18 years or over.

“*Appropriate*” means that the services or supports or activities provided or undertaken by the organization are relevant to the consumer's needs, situation, problems, or desires.

*“Assessment”* means the review of the consumer’s current functioning in regard to the consumer’s situation, needs, strengths, abilities, desires and goals.

*“Attorney in fact under a durable power of attorney for health care”* means an individual who is designated by a durable power of attorney for health care, pursuant to Iowa Code chapter 144B, as an agent to make health care decisions on behalf of an individual and who has consented to act in that capacity.

*“Basic individual respite”* means respite provided on a staff-to-consumer ratio of one to one or higher to individuals without specialized needs requiring the care of a licensed registered nurse or licensed practical nurse.

*“Behavior”* means skills related to regulating one’s own behavior including coping with demands from others, making choices, conforming conduct to laws, and displaying appropriate sociosexual behavior.

*“Brain injury”* means clinically evident damage to the brain resulting directly or indirectly from trauma, infection, anoxia, vascular lesions or tumor of the brain, not primarily related to degenerative or aging processes, which temporarily or permanently impairs a person’s physical, cognitive, or behavioral functions. The person must have a diagnosis from the following list:

- Malignant neoplasms of brain, cerebrum.
- Malignant neoplasms of brain, frontal lobe.
- Malignant neoplasms of brain, temporal lobe.
- Malignant neoplasms of brain, parietal lobe.
- Malignant neoplasms of brain, occipital lobe.
- Malignant neoplasms of brain, ventricles.
- Malignant neoplasms of brain, cerebellum.
- Malignant neoplasms of brain, brain stem.
- Malignant neoplasms of brain, other part of brain, includes midbrain, peduncle, and medulla oblongata.
- Malignant neoplasms of brain, cerebral meninges.
- Malignant neoplasms of brain, cranial nerves.
- Secondary malignant neoplasm of brain.
- Secondary malignant neoplasm of other parts of the nervous system, includes cerebral meninges.
- Benign neoplasm of brain and other parts of the nervous system, brain.
- Benign neoplasm of brain and other parts of the nervous system, cranial nerves.
- Benign neoplasm of brain and other parts of the nervous system, cerebral meninges.
- Encephalitis, myelitis and encephalomyelitis.
- Intracranial and intraspinal abscess.
- Anoxic brain damage.
- Subarachnoid hemorrhage.
- Intracerebral hemorrhage.
- Other and unspecified intracranial hemorrhage.
- Occlusion and stenosis of precerebral arteries.
- Occlusion of cerebral arteries.
- Transient cerebral ischemia.
- Acute, but ill-defined, cerebrovascular disease.
- Other and ill-defined cerebrovascular diseases.
- Fracture of vault of skull.
- Fracture of base of skull.
- Other and unqualified skull fractures.
- Multiple fractures involving skull or face with other bones.
- Concussion.
- Cerebral laceration and contusion.
- Subarachnoid, subdural, and extradural hemorrhage following injury.
- Other and unspecified intracranial hemorrhage following injury.

Intracranial injury of other and unspecified nature.

Poisoning by drugs, medicinal and biological substances.

Toxic effects of substances.

Effects of external causes.

Drowning and nonfatal submersion.

Asphyxiation and strangulation.

Child maltreatment syndrome.

Adult maltreatment syndrome.

*"Case management services"* means those services established pursuant to Iowa Code chapter 225C.

*"Child"* means a person with a brain injury aged 17 years or under.

*"Client participation"* means the amount of the consumer's income that the person must contribute to the cost of brain injury waiver services, exclusive of medical vendor payments, before Medicaid will provide additional reimbursement.

*"Deemed status"* means acceptance of certification or licensure of a program or service by another certifying body in place of certification based on review and evaluation.

*"Department"* means the Iowa department of human services.

*"Direct service"* means services involving face-to-face assistance to a consumer such as transporting a consumer or providing therapy.

*"Fiscal accountability"* means the development and maintenance of budgets and independent fiscal review.

*"Group respite"* is respite provided on a staff-to-consumer ratio of less than one to one.

*"Guardian"* means a guardian appointed in probate court.

*"Health"* means skills related to the maintenance of one's health including eating; illness identification, treatment and prevention; basic first aid; physical fitness; regular physical checkups and personal habits.

*"Immediate jeopardy"* means circumstances where the life, health, or safety of a person will be severely jeopardized if the circumstances are not immediately corrected.

*"Intermittent supported community living service"* means supported community living service provided from one to three hours a day for not more than four days a week.

*"Medical assessment"* means a visual and physical inspection of the consumer, noting deviations from the norm, and a statement of the consumer's mental and physical condition that can be amendable to or resolved by appropriate actions of the provider.

*"Medical institution"* means a nursing facility, a skilled nursing facility, intermediate care facility for persons with an intellectual disability, or hospital which has been approved as a Medicaid vendor.

*"Medical intervention"* means consumer care in the areas of hygiene, mental and physical comfort, assistance in feeding and elimination, and control of the consumer's care and treatment to meet the physical and mental needs of the consumer in compliance with the plan of care in areas of health, prevention, restoration, and maintenance.

*"Medical monitoring"* means observation for the purpose of assessing, preventing, maintaining, and treating disease or illness based on the consumer's plan of care.

*"Natural supports"* means services and supports identified as wanted or needed by the consumer and provider by persons not for pay (family, friends, neighbors, coworkers, and others in the community) and organizations or entities that serve the general public.

*"Organization"* means the entity being certified.

*"Organizational outcome"* means a demonstration by the organization of actions taken by the organization to provide for services or supports to consumers.

*"Outcome"* means an action or event that follows as a result or consequence of the provision of a service or support.

*"Procedures"* means the steps to be taken to implement a policy.

*"Process"* means service or support provided by an agency to a consumer that will allow the consumer to achieve an outcome. This can include a written, formal, consistent trackable method or an informal process that is not written but is trackable.

“*Program*” means a set of related resources and services directed to the accomplishment of a fixed set of goals and objectives for the population of a specified geographic area or for special target populations. It can mean an agency, organization, or unit of an agency, organization or institution.

“*Qualified brain injury professional*” means one of the following who meets the educational and licensure or certification requirements for the profession as required in the state of Iowa and who has two years’ experience working with people living with a brain injury: a psychologist; psychiatrist; physician; physician assistant; registered nurse; certified teacher; social worker; mental health counselor; physical, occupational, recreational, or speech therapist; or a person with a bachelor of arts or science degree in psychology, sociology, or public health or rehabilitation services.

“*Service coordination*” means activities designed to help individuals and families locate, access, and coordinate a network of supports and services that will allow them to live a full life in the community.

“*Service plan*” means a written consumer-centered, outcome-based plan of services developed using an interdisciplinary process, which addresses all relevant services and supports being provided. It may involve more than one provider.

“*Specialized respite*” means respite provided on a staff-to-consumer ratio of one to one or higher to individuals with specialized medical needs requiring the care, monitoring or supervision of a licensed registered nurse or licensed practical nurse.

“*Staff*” means a person under the direction of the organization to perform duties and responsibilities of the organization.

“*Third-party payments*” means payments from an individual, institution, corporation, or public or private provider which is liable to pay part or all of the medical costs incurred as a result of injury or disease on behalf of a consumer of medical assistance.

“*Usual caregiver*” means a person or persons who reside with the consumer and are available on a 24-hour-per-day basis to assume responsibility for the care of the consumer.

[ARC 0306C, IAB 9/5/12, effective 11/1/12]

**441—83.82(249A) Eligibility.** To be eligible for brain injury waiver services a consumer must meet eligibility criteria and be determined to need a service allowable under the program.

**83.82(1) Eligibility criteria.** All of the following criteria must be met. The person must:

- a. Have a diagnosis of brain injury.
- b. Be eligible for Medicaid under SSI, SSI-related, FMAP, or FMAP-related coverage groups or be eligible under the special income level (300 percent) coverage group consistent with a level of care in a medical institution.
- c. Be aged 1 month to 64 years.
- d. Be a U.S. citizen and Iowa resident.
- e. Rescinded IAB 7/11/01, effective 7/1/01.
- f. Be determined by the IME medical services unit as in need of intermediate care facility for persons with an intellectual disability (ICF/ID), skilled nursing, or ICF level of care.
- g. Be assessed by the IME medical services unit as able to live in a home- or community-based setting where all medically necessary service needs can be met within the scope of this waiver.
- h. At a minimum, receive a waiver service each quarter in addition to case management.
- i. Choose HCBS.
- j. To be eligible for interim medical monitoring and treatment services the consumer must be:
  - (1) Under the age of 21;
  - (2) Currently receiving home health agency services under rule 441—78.9(249A) and require medical assessment, medical monitoring, and regular medical intervention or intervention in a medical emergency during those services. (The home health aide services for which the consumer is eligible must be maximized before the consumer accesses interim medical monitoring and treatment.);
  - (3) Residing in the consumer’s family home or foster family home; and
  - (4) In need of interim medical monitoring and treatment as ordered by a physician.
- k. Receive services in a community, not an institutional, setting.

*l.* Be assigned a state payment slot within the yearly total approved by the Centers for Medicare and Medicaid Services.

*m.* For the consumer choices option as set forth in rule 441—subrule 78.43(15), not be living in a residential care facility.

**83.82(2) Need for services.**

*a.* The applicant shall have a service plan approved by the department that is developed by the certified case manager for this waiver as identified by the county of residence. This must be completed before services provision and annually thereafter. The case manager shall establish the interdisciplinary team for the applicant and, with the team, identify the applicant's need for service based on the applicant's needs and desires as well as the availability and appropriateness of services using the following criteria:

(1) The assessment shall be based, in part, on information provided to the IME medical services unit.

(2) Service plans must be developed to reflect use of all appropriate nonwaiver Medicaid state services so as not to replace or duplicate those services.

(3) Service plans for applicants aged 20 or under which include supported community living services beyond intermittent shall not be approved until a home health provider has made a request to cover the service through all nonwaiver Medicaid services.

(4) Service plans for applicants aged 20 or under which include supported community living services beyond intermittent must be approved (signed and dated) by the designee of the bureau of long-term care. The Medicaid case manager must request in writing more than intermittent supported community living with a summary of services and service costs, and submit a written justification with the service plan. The rationale must contain sufficient information for the bureau's designee to make a decision regarding the need for supported community living beyond intermittent.

*b.* Interim medical monitoring and treatment services must be needed because all usual caregivers are unavailable to provide care due to one of the following circumstances:

(1) Employment. Interim medical monitoring and treatment services are to be received only during hours of employment.

(2) Academic or vocational training. Interim medical monitoring and treatment services provided while a usual caregiver participates in postsecondary education or vocational training shall be limited to 24 periods of no more than 30 days each per caregiver as documented by the service worker. Time spent in high school completion, adult basic education, GED, or English as a second language does not count toward the limit.

(3) Absence from the home due to hospitalization, treatment for physical or mental illness, or death of the usual caregiver. Interim medical monitoring and treatment services under this subparagraph are limited to a maximum of 30 days.

(4) Search for employment.

1. Care during job search shall be limited to only those hours the usual caregiver is actually looking for employment, including travel time.

2. Interim medical monitoring and treatment services may be provided under this paragraph only during the execution of one job search plan of up to 30 working days in a 12-month period, approved by the department service worker or targeted case manager pursuant to 441—subparagraph 170.2(2) "b"(5).

3. Documentation of job search contacts shall be furnished to the department service worker or targeted case manager.

*c.* The consumer shall access, if a child, all other services for which the person is eligible and which are appropriate to meet the person's needs as a precondition of eligibility for the HCBS BI waiver.

*d.* The total cost of brain injury waiver services shall not exceed \$2,954 per month. If more than \$520 is paid for home and vehicle modification services, the service worker shall encumber up to \$520 per month within the monthly dollar cap allowed for the member until the total amount of the modification is reached within a 12-month period.

**83.82(3) HCBS brain injury (BI) waiver program limit for persons requiring the ICF/MR level of care.** Rescinded IAB 7/11/01, effective 7/1/01.

**83.82(4) Securing a state payment slot.**

*a.* The county department office shall enter all waiver applications into the individualized services information system (ISIS) to determine if a payment slot is available for all new applicants for the HCBS BI waiver program.

(1) For applicants not currently receiving Medicaid, the county department office shall make the entry by the end of the fifth working day after receipt of a completed Form 470-2927 or 470-2927(S), Health Services Application, or within five working days after receipt of disability determination, whichever is later.

(2) For current Medicaid members, the county department office shall make the entry by the end of the fifth working day after receipt of a written request signed and dated by the waiver applicant.

*b.* If no payment slot is available, the department shall enter the applicant on a waiting list according to the following:

(1) Applicants not currently eligible for Medicaid shall be entered on the waiting list on the basis of the date a completed Form 470-2927 or 470-2927(S), Health Services Application, is received by the department or upon receipt of disability determination, whichever is later. Applicants currently eligible for Medicaid shall be added to the waiting list on the basis of the date the applicant requests HCBS BI program services.

(2) In the event that more than one application is received at one time, applicants shall be entered on the waiting list on the basis of the month of birth, January being month one and the lowest number.

*c.* Persons who do not fall within the available slots shall have their applications rejected but their names shall be maintained on the waiting list. As slots become available, persons shall be selected from the waiting list to maintain the number of approved persons on the program based on their order on the waiting list.

[ARC 0191C, IAB 7/11/12, effective 7/1/12; ARC 0306C, IAB 9/5/12, effective 11/1/12; ARC 0359C, IAB 10/3/12, effective 12/1/12; ARC 0548C, IAB 1/9/13, effective 1/1/13; ARC 0665C, IAB 4/3/13, effective 6/1/13; ARC 0842C, IAB 7/24/13, effective 7/1/13; ARC 1056C, IAB 10/2/13, effective 11/6/13]

**441—83.83(249A) Application.**

**83.83(1) Application for financial eligibility.** The application process as specified in rules 441—76.1(249A) to 441—76.6(249A) shall be followed.

**83.83(2) Approval of application for eligibility.**

*a.* Applications for the determination of ability of the consumer to have all medically necessary service needs met within the scope of this waiver shall be initiated on behalf of the consumer and with the consumer's consent or with the consent of the consumer's legal representative by the discharge planner of the medical facility where the consumer resides at the time of application or the case manager. The discharge planner or case manager shall provide to the IME medical services unit all appropriate information needed regarding all the medically necessary service needs of the consumer. After completing the determination of ability to have all medically necessary service needs met within the scope of this waiver, the IME medical services unit shall inform the discharge planner or case manager on behalf of the consumer or the consumer's legal representative and send to the income maintenance worker a copy of the decision as to whether all of the consumer's service needs can be met in a home- or community-based setting.

*b.* Eligibility for the HCBS BI waiver shall be effective as of the date when both the service eligibility and financial eligibility have been completed. Decisions shall be mailed or given to the consumer or the consumer's legal representative on the date when each eligibility determination is completed.

*c.* An applicant shall be given the choice between waiver services and institutional care. The applicant or legal representative shall complete and sign Form 470-4694, Case Management Comprehensive Assessment, indicating that the applicant has elected home- and community-based services. This shall be arranged by the medical facility discharge planner or case manager.

*d.* The medical facility discharge planner, if there is one involved, shall contact the appropriate case manager for the consumer's county of residence to initiate development of the consumer's service plan and initiation of waiver services.

*e.* HCBS BI waiver services provided prior to both approvals of eligibility for the waiver cannot be paid.

*f.* HCBS BI waiver services are not available in conjunction with other HCBS waiver programs or group foster care services.

*g.* The Medicaid case manager shall establish an HCBS BI waiver interdisciplinary team for each consumer and, with the team, identify the consumer's "need for service" based on the consumer's needs and desires as well as the availability and appropriateness of services.

**83.83(3)** *Effective date of eligibility.*

*a.* The effective date of eligibility for the waiver for persons who are already determined eligible for Medicaid is the date on which the person is determined to meet all of the criteria set forth in rule 441—83.82(249A).

*b.* The effective date of eligibility for the waiver for persons who qualify for Medicaid due to eligibility for the waiver services is the date on which the person is determined to meet all of the criteria set forth in rule 441—83.82(249A) and when the eligibility factors set forth in 441—subrule 75.1(7) and for married persons, in rule 441—75.5(249A), have been satisfied.

*c.* Eligibility for the waiver continues until the consumer fails to meet eligibility criteria listed in rule 441—83.82(249A). Consumers who return to inpatient status in a medical institution for more than 30 consecutive days shall be reviewed by the IME medical services unit to determine additional inpatient needs for possible termination from the brain injury waiver. The consumer shall be reviewed for eligibility under other Medicaid coverage groups in accordance with rule 441—76.11(249A). The consumer shall be notified of that decision through Form 470-0602, Notice of Decision.

If the consumer returns home before the effective date of the notice of decision and the consumer's condition has not substantially changed, the denial may be rescinded and eligibility may continue.

**83.83(4)** *Attribution of resources.* For the purposes of attributing resources as provided in rule 441—75.5(249A), the date on which the waiver consumer meets the level of care criteria in a medical institution as established by the peer review organization shall be used as the date of entry to the medical institution. Only one attribution of resources shall be completed per person. Attributions completed for prior institutionalizations shall be applied to the waiver application.

[ARC 0306C, IAB 9/5/12, effective 11/1/12]

**441—83.84(249A) Client participation.** Consumers who are financially eligible under 441—subrule 75.1(7) (the 300 percent group) must contribute a predetermined participation amount to the cost of brain injury waiver services.

**83.84(1)** *Computation of client participation.* Client participation shall be computed by deducting an amount for the maintenance needs of the consumer which is 300 percent of the maximum SSI grant for an individual from the consumer's total income. For a couple, client participation is determined as if each person were an individual.

**83.84(2)** *Limitation on payment.* If the sum of the third-party payment and client participation equals or exceeds the reimbursement for the specific brain injury waiver service, Medicaid shall make no payments for the waiver service. However, Medicaid shall make payments to other medical providers.

**441—83.85(249A) Redetermination.** A complete financial redetermination of eligibility for brain injury waiver shall be completed at least once every 12 months. A redetermination of continuing eligibility factors shall be made when a change in circumstances occurs that affects eligibility in accordance with rule 441—83.82(249A). A redetermination shall contain the components listed in rule 441—83.82(249A).

**441—83.86(249A) Allowable services.** Services allowable under the brain injury waiver are case management, respite, personal emergency response, supported community living, behavioral programming, family counseling and training, home and vehicle modification, specialized medical equipment, prevocational services, transportation, supported employment, adult day care, consumer-directed attendant care, interim medical monitoring and treatment, financial management,

independent support brokerage, self-directed personal care, self-directed community supports and employment, and individual-directed goods and services as set forth in rule 441—78.43(249A).

**441—83.87(249A) Service plan.** A service plan shall be prepared and utilized for each HCBS BI waiver consumer. The service plan shall be developed by an interdisciplinary team, which includes the consumer, and, if appropriate, the legal representative, consumer's family, case manager, providers, and others directly involved. The service plan shall be stored by the case manager for a minimum of three years. The service plan staffing shall be conducted before the current service plan expires.

**83.87(1) Information in plan.** The plan shall be in accordance with 441—subrule 24.4(3) and shall additionally include the following information to assist in evaluating the program:

- a. A listing of all services received by a consumer at the time of waiver program enrollment.
- b. For supported community living:
  - (1) The consumer's living environment at the time of waiver enrollment.
  - (2) The number of hours per day of on-site staff supervision needed by the consumer.
  - (3) The number of other waiver consumers who will live with the consumer in the living unit.
- c. An identification and justification of any restriction of a consumer's rights including, but not limited to:
  - (1) Maintenance of personal funds.
  - (2) Self-administration of medications.
- d. The names of all providers responsible for providing all services.
- e. All service funding sources.
- f. The amount of the service to be received by the consumer.
- g. Whether the consumer has elected the consumer choices option and, if so:
  - (1) The independent support broker selected by the consumer; and
  - (2) The financial management service selected by the consumer.
- h. A plan for emergencies and identification of the supports available to the consumer in an emergency.

**83.87(2) Use of nonwaiver services.** Service plans must be developed to reflect use of all appropriate nonwaiver Medicaid services and so as not to replace or duplicate those services. Service plans for members aged 20 or under which include supported community living services beyond intermittent must be approved (signed and dated) by the designee of the bureau of long-term care. The Medicaid case manager shall attach a written request for a variance from the limitation on supported community living to intermittent.

**83.87(3) Annual assessment.** The IME medical services unit shall assess the member annually and certify the member's need for long-term care services. The IME medical services unit shall be responsible for determining the level of care based on the completed Form 470-4694, Case Management Comprehensive Assessment, and supporting documentation as needed.

**83.87(4) Service file.** The Medicaid case manager must ensure that the consumer service file contains the consumer's service plan.

a. to d. Rescinded IAB 8/7/02, effective 10/1/02.  
 [ARC 0191C, IAB 7/11/12, effective 7/1/12; ARC 0306C, IAB 9/5/12, effective 11/1/12; ARC 0359C, IAB 10/3/12, effective 12/1/12]

**441—83.88(249A) Adverse service actions.**

**83.88(1) Denial.** An application for services shall be denied when it is determined by the department that:

- a. The consumer is not eligible for the services because all of the medically necessary service needs cannot be met in a home- or community-based setting.
- b. Service needs exceed the service unit or reimbursement maximums.
- c. Service needs are not met by the services provided.
- d. Needed services are not available or received from qualifying providers.
- e. The brain injury waiver service is not identified in the consumer's service plan.

*f.* There is another community resource available to provide the service or a similar service free of charge to the consumer that will meet the consumer's needs.

*g.* The consumer receives services from other Medicaid waiver providers.

*h.* The consumer or legal representative through the interdisciplinary process requests termination from the services.

**83.88(2) Reduction.** A particular service may be reduced when the department determines that the provisions of 441—subrule 130.5(3), paragraph “a” or “b,” apply.

**83.88(3) Termination.** A particular service may be terminated when the department determines that:

*a.* The provisions of 441—subrule 130.5(2), paragraph “d,” “g,” or “h,” apply.

*b.* Needed services are not available or received from qualifying providers.

*c.* The brain injury waiver service is not identified in the consumer's annual service plan.

*d.* Service needs are not met by the services provided.

*e.* Services needed exceed the service unit or reimbursement maximums.

*f.* Completion or receipt of required documents by the department or the medical facility discharge planner for the brain injury waiver service consumer has not occurred.

*g.* The consumer receives services from other Medicaid providers.

*h.* The consumer or legal representative through the interdisciplinary process requests termination from the services.

**441—83.89(249A) Appeal rights.** Notice of adverse actions and right to appeal shall be given in accordance with 441—Chapter 7 and rule 441—130.5(234).

[ARC 0191C, IAB 7/11/12, effective 7/1/12; ARC 0306C, IAB 9/5/12, effective 11/1/12; ARC 0359C, IAB 10/3/12, effective 12/1/12]

**441—83.90(249A) County reimbursement.** Rescinded ARC 0191C, IAB 7/11/12, effective 7/1/12.

**441—83.91(249A) Conversion to the X-PERT system.** Rescinded IAB 8/7/02, effective 10/1/02.

These rules are intended to implement Iowa Code sections 249A.3 and 249A.4.

**441—83.92 to 83.100** Reserved.

#### DIVISION VI—PHYSICAL DISABILITY WAIVER SERVICES

**441—83.101(249A) Definitions.**

“*Adaptive*” means age-appropriate skills related to taking care of one's self and the ability to relate to others in daily living situations. These skills include limitations that occur in the areas of communication, self-care, home living, social skills, community use, self-direction, safety, functional academics, leisure and work.

“*Adult*” means a person with a physical disability aged 18 years to 64 years.

“*Appropriate*” means that the services or supports or activities provided or undertaken by the organization are relevant to the consumer's needs, situation, problems, or desires.

“*Assessment*” means the review of the consumer's current functioning in regard to the consumer's situation, needs, strengths, abilities, desires and goals.

“*Attorney in fact under a durable power of attorney for health care*” means an individual who is designated by a durable power of attorney for health care, pursuant to Iowa Code chapter 144B, as an agent to make health care decisions on behalf of an individual and who has consented to act in that capacity.

“*Behavior*” means skills related to regulating one's own behavior including coping with demands from others, making choices, controlling impulses, conforming conduct to laws, and displaying appropriate sociosexual behavior.

“*Client participation*” means the amount of the consumer's income that the person must contribute to the cost of physical disability waiver services, exclusive of medical vendor payments, before Medicaid will provide additional reimbursement.

“*Department*” means the Iowa department of human services.

“*Guardian*” means a guardian appointed in probate court for an adult.

“*Medical institution*” means a nursing facility, a skilled nursing facility, intermediate care facility for persons with an intellectual disability, or hospital which has been approved as a Medicaid vendor.

“*Physical disability*” means a severe, chronic condition that is attributable to a physical impairment that results in substantial limitations of physical functioning in three or more of the following areas of major life activities: self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, and economic self-sufficiency.

“*Service plan*” means a written consumer-centered, outcome-based plan of services developed using an interdisciplinary process which addresses all relevant services and supports being provided. It may involve more than one provider.

“*Third-party payments*” means payments from an individual, institution, corporation, or public or private provider which is liable to pay part or all of the medical costs incurred as a result of injury or disease on behalf of a consumer of medical assistance.

“*Waiver year*” means a 12-month period commencing on April 1 of each year.  
[ARC 0306C, IAB 9/5/12, effective 11/1/12]

**441—83.102(249A) Eligibility.** To be eligible for physical disability waiver services, a consumer must meet eligibility criteria set forth in subrule 83.102(1) and be determined to need a service allowable under the program per subrule 83.102(2).

**83.102(1) Eligibility criteria.** All of the following criteria must be met. The person must:

- a. Have a physical disability.
- b. Be blind or disabled as determined by the receipt of social security disability benefits or by a disability determination made through the department. Disability determinations are made according to supplemental security income guidelines under Title XVI of the Social Security Act or the disability guidelines for the Medicaid employed people with disabilities coverage group.
- c. Be ineligible for the HCBS intellectual disability waiver.
- d. Have the ability to hire, supervise, and fire the provider as determined by the service worker, and be willing to do so, or have a parent or guardian named by probate court, or attorney in fact under a durable power of attorney for health care who will take this responsibility on behalf of the consumer.
- e. Be eligible for Medicaid under 441—Chapter 75.
- f. Be aged 18 years to 64 years.
- g. Rescinded IAB 2/7/01, effective 2/1/01.
- h. Be in need of skilled nursing or intermediate care facility level of care based on information submitted on Form 470-4392, Level of Care Certification for HCBS Waiver Program.

(1) A physician, doctor of osteopathy, registered nurse practitioner, or physician assistant shall complete Form 470-4392 when the person applies for waiver services, upon request to report a change in the person’s condition, and annually for reassessment of the person’s level of care.

(2) Initial decisions on level of care shall be made for the department by the IME medical services unit within two working days of receipt of medical information. The IME medical services unit determines whether the level of care requirement is met based on medical necessity and the appropriateness of the level of care under 441—subrules 79.9(1) and 79.9(2).

(3) Adverse decisions by the IME medical services unit may be appealed to the department pursuant to 441—Chapter 7.

- i. Choose HCBS.
- j. Use a minimum of one unit of service per calendar quarter under this program.
- k. For the consumer choices option as set forth in 441—subrule 78.46(6), not be living in a residential care facility.

**83.102(2) Need for services.**

a. The applicant shall have a service plan which is developed by the applicant and a department service worker. The plan must be completed and approved before service provision.

(1) The service worker shall identify the need for service based on the needs of the applicant, as documented in Form 470-5044, Service Worker Comprehensive Assessment, as well as the availability and appropriateness of services.

(2) The service worker shall have a face-to-face visit with the member at least annually.

*b.* The total cost of physical disability waiver services shall not exceed \$692 per month. If more than \$520 is paid for home and vehicle modification services, the service worker shall encumber up to \$520 per month within the monthly dollar cap allowed for the member until the total amount of the modification is reached within a 12-month period.

**83.102(3) Slots.** The total number of persons receiving HCBS physical disability waiver services in the state shall be limited to the number provided in the waiver approved by the Secretary of the U.S. Department of Health and Human Services. These slots shall be available on a first-come, first-served basis.

**83.102(4) County payment slots for persons requiring the ICF/MR level of care.** Rescinded IAB 10/6/99, effective 10/1/99.

**83.102(5) Securing a slot.**

*a.* The county department office shall enter all waiver applications into the individualized services information system (ISIS) to determine if a slot is available for all new applicants for the HCBS physical disability waiver program.

(1) For applicants not currently receiving Medicaid, the county department office shall make the entry by the end of the fifth working day after receipt of a completed Form 470-2927 or 470-2927(S), Health Services Application, or within five working days after receipt of disability determination, whichever is later.

(2) For current Medicaid members, the county department office shall make the entry by the end of the fifth working day after receipt of a written request signed and dated by the waiver applicant.

*b.* If no slot is available, the department shall enter applicants on the HCBS physical disabilities waiver waiting list according to the following:

(1) Applicants not currently eligible for Medicaid shall be entered on the basis of the date a completed Form 470-2927 or 470-2927(S), Health Services Application, is received by the department or upon receipt of disability determination, whichever is later. Applicants currently eligible for Medicaid shall be added on the basis of the date the applicant requests HCBS physical disability program services. In the event that more than one application is received on the same day, applicants shall be entered on the waiting list on the basis of the day of the month of their birthday, the lowest number being first on the list. Any subsequent tie shall be decided by the month of birth, January being month one and the lowest number.

(2) Persons who do not fall within the available slots shall have their applications rejected but their names shall be maintained on the waiting list. As slots become available, persons shall be selected from the waiting list to maintain the number of approved persons on the program based on their order on the waiting list.

**83.102(6) Securing a county payment slot.** Rescinded IAB 10/6/99, effective 10/1/99.

**83.102(7) HCBS physical disability waiver waiting list.** When services are denied because the limit on the number of slots is reached, a notice of decision denying service based on the limit and stating that the person's name shall be put on a waiting list shall be sent to the person by the department.

[**ARC 9650B**, IAB 8/10/11, effective 10/1/11; **ARC 0306C**, IAB 9/5/12, effective 11/1/12; **ARC 0548C**, IAB 1/9/13, effective 1/1/13; **ARC 0665C**, IAB 4/3/13, effective 6/1/13; **ARC 0842C**, IAB 7/24/13, effective 7/1/13; **ARC 1056C**, IAB 10/2/13, effective 11/6/13]

#### **441—83.103(249A) Application.**

**83.103(1) Application for financial eligibility.** The application process as specified in rules 441—76.1(249A) to 441—76.6(249A) shall be followed. Applications for this program may only be filed on or after April 1, 1999.

**83.103(2)** *Approval of application for eligibility.*

a. Applications for this waiver shall be initiated on behalf of the applicant who is a resident of a medical institution with the applicant's consent or with the consent of the applicant's legal representative by the discharge planner of the medical facility where the applicant resides at the time of application.

(1) The discharge planner shall have the applicant's primary care provider complete Form 470-4392, Level of Care Certification for HCBS Waiver Program, and submit it to the IME medical services unit.

(2) After completing the determination of the level of care needed by the applicant, the IME medical services unit shall inform the income maintenance worker and the discharge planner of the IME medical services unit's decision.

b. Applications for this waiver shall be initiated by the applicant, the applicant's parent or legal guardian, or the applicant's attorney in fact under a durable power of attorney for health care on behalf of the applicant who is residing in the community.

(1) The applicant's primary care provider shall complete Form 470-4392, Level of Care Certification for HCBS Waiver Program, and submit it to the IME medical services unit.

(2) After completing the determination of the level of care needed by the applicant, the IME medical services unit shall inform the income maintenance worker and the applicant, the applicant's parent or legal guardian, or the applicant's attorney in fact under a durable power of attorney for health care.

c. Eligibility for this waiver shall be effective as of the date when both the eligibility criteria in subrule 83.102(1) and need for services in subrule 83.102(2) have been established. Decisions shall be mailed or given to the applicant, the applicant's parent or legal guardian, or the applicant's attorney in fact under a durable power of attorney for health care on the date when each eligibility determination is completed.

d. An applicant shall be given the choice between waiver services and institutional care. The applicant or the applicant's parent, legal guardian, or attorney in fact under a durable power of attorney for health care shall sign Form 470-5044, Service Worker Comprehensive Assessment, indicating that the applicant has elected home- and community-based services.

e. The applicant, the applicant's parent or guardian, or the applicant's attorney in fact under a durable power of attorney for health care shall cooperate with the service worker in the development of the service plan, which must be approved by the department service worker prior to the start of services.

f. HCBS physical disability waiver services provided prior to both approvals of eligibility for the waiver cannot be paid.

g. HCBS physical disability waiver services are not available in conjunction with other HCBS waiver programs. The consumer may also receive in-home health-related care service if eligible for that program.

**83.103(3)** *Effective date of eligibility.*

a. The effective date of eligibility for the waiver for persons who are already determined eligible for Medicaid is the date on which the person is determined to meet all of the criteria set forth in rule 441—83.102(249A).

b. The effective date of eligibility for the waiver for persons who qualify for Medicaid due to eligibility for the waiver services is the date on which the person is determined to meet all of the criteria set forth in rule 441—83.102(249A) and when the eligibility factors set forth in 441—subrule 75.1(7) and, for married persons, in rule 441—75.5(249A), have been satisfied.

c. Eligibility for the waiver continues until the consumer fails to meet eligibility criteria listed in rule 441—83.102(249A). Consumers who return to inpatient status in a medical institution for more than 30 consecutive days shall be reviewed by the IME medical services unit to determine additional inpatient needs for possible termination from the physical disability waiver. The consumer shall be reviewed for eligibility under other Medicaid coverage groups in accordance with rule 441—76.11(249A). The consumer shall be notified of that decision through Form 470-0602, Notice of Decision.

If the consumer returns home before the effective date of the notice of decision and the consumer's condition has not substantially changed, the denial may be rescinded and eligibility may continue.

**83.103(4) Attribution of resources.** For the purposes of attributing resources as provided in rule 441—75.5(249A), the date on which the waiver consumer meets the institutional level of care requirement as determined by the IME medical services unit or an appeal decision shall be used as the date of entry to the medical institution. Only one attribution of resources shall be completed per person. Attributions completed for a prior institutionalization shall be applied to the waiver application. [ARC 0306C, IAB 9/5/12, effective 11/1/12]

**441—83.104(249A) Client participation.** Consumers who are financially eligible under 441—subrule 75.1(7) (the 300 percent group) must contribute a client participation amount to the cost of physical disability waiver services.

**83.104(1) Computation of client participation.** Client participation shall be computed by deducting a maintenance needs allowance equal to 300 percent of the maximum SSI grant for an individual from the consumer's total income. For a couple, client participation is determined as if each person were an individual.

**83.104(2) Limitation on payment.** If the sum of the third-party payment and client participation equals or exceeds the reimbursement for the specific physical disability waiver service, Medicaid shall make no payments for the waiver service. However, Medicaid shall make payments to other medical providers.

**441—83.105(249A) Redetermination.** A complete financial redetermination of eligibility for the physical disability waiver shall be completed at least once every 12 months. A redetermination of continuing eligibility factors shall be made when a change in circumstances occurs that affects eligibility in accordance with rule 441—83.102(249A). A redetermination shall contain the components listed in rule 441—83.102(249A).

**441—83.106(249A) Allowable services.** The services allowable under the physical disability waiver are consumer-directed attendant care, home and vehicle modification, personal emergency response system, transportation, specialized medical equipment, financial management, independent support brokerage, self-directed personal care, self-directed community supports and employment, and individual-directed goods and services as set forth in rule 441—78.46(249A).

**441—83.107(249A) Individual service plan.** An individualized service plan shall be prepared and used for each HCBS physical disability waiver consumer. The service plan shall be developed and approved by the consumer and the DHS service worker prior to services beginning and payment being made to the provider. The plan shall be reviewed by the consumer and the service worker annually, and the current version approved by the service worker.

**83.107(1) Information in plan.** The plan shall be in accordance with 441—subrule 24.4(3) and shall additionally include the following information to assist in evaluating the program:

- a. A listing of all services received by a consumer at the time of waiver program enrollment.
- b. The name of all providers responsible for providing all services.
- c. All service funding sources.
- d. The amount of the service to be received by the consumer.
- e. Whether the consumer has elected the consumer choices option and, if so:
  - (1) The independent support broker selected by the consumer; and
  - (2) The financial management service selected by the consumer.
- f. A plan for emergencies and identification of the supports available to the consumer in an emergency.

**83.107(2) Annual assessment.** The IME medical services unit shall review the member's need for continued care annually and recertify the member's need for long-term care services, pursuant to paragraph 83.102(1) "h" and the appeal process at rule 441—83.109(249A), based on the completed Form 470-4392, Level of Care Certification for HCBS Waiver Program, and supporting documentation as needed.

**83.107(3) Case file.** Rescinded IAB 8/7/02, effective 10/1/02.  
[ARC 0306C, IAB 9/5/12, effective 11/1/12]

**441—83.108(249A) Adverse service actions.**

**83.108(1) Denial.** An application for services shall be denied when it is determined by the department that:

- a. All of the medically necessary service needs cannot be met in a home- or community-based setting.
- b. Service needs exceed the reimbursement maximums.
- c. Service needs are not met by the services provided.
- d. Needed services are not available or received from qualifying providers.
- e. The physical disability waiver service is not identified in the consumer's service plan.
- f. There is another community resource available to provide the service or a similar service free of charge to the consumer that will meet the consumer's needs.
- g. The consumer receives services from other Medicaid waiver providers.
- h. The consumer or legal representative requests termination from the services.

**83.108(2) Reduction.** A particular service may be reduced when the department determines that the provisions of 441—subrule 130.5(3), paragraph "a" or "b," apply.

**83.108(3) Termination.** A particular service may be terminated when the department determines that:

- a. The provisions of 441—subrule 130.5(2), paragraph "d," "g," or "h," apply.
- b. Needed services are not available or received from qualifying providers.
- c. The physical disability waiver service is not identified in the consumer's annual service plan.
- d. Service needs are not met by the services provided.
- e. Services needed exceed the service unit or reimbursement maximums.
- f. Completion or receipt of required documents by the consumer for the physical disability waiver service has not occurred.
- g. The consumer receives services from other Medicaid providers.
- h. The consumer or legal representative requests termination from the services.

**441—83.109(249A) Appeal rights.** Notice of adverse actions and right to appeal shall be given in accordance with 441—Chapter 7 and rule 441—130.5(234).

**83.109(1) Appeal to county.** Rescinded IAB 2/7/01, effective 2/1/01.

**83.109(2) Reconsideration request to IME medical services unit.** Rescinded IAB 9/5/12, effective 11/1/12.  
[ARC 0306C, IAB 9/5/12, effective 11/1/12]

**441—83.110(249A) County reimbursement.** Rescinded IAB 10/6/99, effective 10/1/99.

**441—83.111(249A) Conversion to the X-PERT system.** Rescinded IAB 8/7/02, effective 10/1/02.  
These rules are intended to implement Iowa Code sections 249A.3 and 249A.4.

**441—83.112 to 83.120** Reserved.

DIVISION VII—HCBS CHILDREN'S MENTAL HEALTH WAIVER SERVICES

**441—83.121(249A) Definitions.**

"*Assessment*" means the review of the consumer's current functioning in regard to the consumer's situation, needs, abilities, desires, and goals.

"*Case manager*" means the person designated to provide Medicaid targeted case management services for the consumer.

"*CMS*" means the Centers for Medicare and Medicaid Services, a division of the U.S. Department of Health and Human Services.

“*Consumer*” means an individual up to the age of 18 who is included in a Medicaid coverage group listed in 441—75.1(249A) and is a recipient of children’s mental health waiver services.

“*Deeming*” means considering parental or spousal income or resources as income or resources of a consumer in determining eligibility for a consumer according to Supplemental Security Income program guidelines.

“*Department*” means the Iowa department of human services.

“*Guardian*” means a parent of a consumer or a legal guardian appointed by the court.

“*HCBS*” means home- and community-based services provided under a Medicaid waiver.

“*IME*” means the Iowa Medicaid enterprise.

“*IME medical services unit*” means the contracted entity in the Iowa Medicaid enterprise that determines level of care for consumers initially applying for or continuing to receive children’s mental health waiver services.

“*Interdisciplinary team*” means the consumer, the consumer’s family, and persons of varied professional and nonprofessional backgrounds with knowledge of the consumer’s needs, as designated by the consumer and the consumer’s family, who meet to develop a service plan based on the individualized needs of the consumer.

“*ISIS*” means the department’s individualized services information system.

“*Local office*” means a department of human services office as described in 441—subrule 1.4(2).

“*Medical institution*” means a nursing facility, an intermediate care facility for persons with an intellectual disability, a psychiatric hospital or psychiatric medical institution for children, or a state mental health institute that has been approved as a Medicaid vendor.

“*Mental health professional*” means a person who meets all of the following conditions:

1. Holds at least a master’s degree in a mental health field including, but not limited to, psychology, counseling and guidance, psychiatric nursing and social work; or is a doctor of medicine or osteopathic medicine; and
2. Holds a current Iowa license when required by the Iowa professional licensure laws (such as a psychiatrist, a psychologist, a marital and family therapist, a mental health counselor, an advanced registered nurse practitioner, a psychiatric nurse, or a social worker); and
3. Has at least two years of postdegree experience supervised by a mental health professional in assessing mental health problems, mental illness, and service needs and in providing mental health services.

“*Serious emotional disturbance*” means a diagnosable mental, behavioral, or emotional disorder that (1) is of sufficient duration to meet diagnostic criteria for the disorder specified by the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV-TR), published by the American Psychiatric Association; and (2) has resulted in a functional impairment that substantially interferes with or limits a consumer’s role or functioning in family, school, or community activities. “*Serious emotional disturbance*” shall not include developmental disorders, substance-related disorders, or conditions or problems classified in DSM-IV-TR as “*other conditions that may be a focus of clinical attention*” (V codes), unless these conditions co-occur with another diagnosable serious emotional disturbance.

“*Service plan*” means a written, consumer-centered, outcome-based plan of services developed by the consumer’s interdisciplinary team that addresses all relevant services and supports being provided. The service plan may involve more than one provider.

“*Skill development*” means that the service provided is habilitative and is intended to impart an ability or capacity to the consumer. Supervision without habilitation is not skill development.

“*Targeted case management*” means Medicaid case management services accredited under 441—Chapter 24 and provided according to 441—Chapter 90 for consumers eligible for the children’s mental health waiver.

“*Waiver year*” for the children’s mental health waiver means a 12-month period commencing on July 1 of each year.

[ARC 0306C, IAB 9/5/12, effective 11/1/12]

**441—83.122(249A) Eligibility.** To be eligible for children’s mental health waiver services, a consumer must meet all of the following requirements:

**83.122(1) Age.** The consumer must be under 18 years of age.

**83.122(2) Diagnosis.** The consumer must be diagnosed with a serious emotional disturbance.

*a. Initial certification.* For initial application to the HCBS children’s mental health waiver program, psychological documentation that substantiates a mental health diagnosis of serious emotional disturbance as determined by a mental health professional must be current within the 12-month period before the application date.

*b. Ongoing certification.* A mental health professional must complete an annual evaluation that substantiates a mental health diagnosis of serious emotional disturbance.

**83.122(3) Level of care.** The applicant must be certified as being in need of a level of care that, but for the waiver, would be provided in a psychiatric hospital serving children under the age of 21. The IME medical services unit shall certify the applicant’s level of care annually based on Form 470-4694, Case Management Comprehensive Assessment.

**83.122(4) Financial eligibility.** The consumer must be eligible for Medicaid as follows:

*a.* Be eligible for Medicaid under an SSI, SSI-related, FMAP, or FMAP-related coverage group; or

*b.* Be eligible under the special income level (300 percent) coverage group; or

*c.* Become eligible through application of the institutional deeming rules; or

*d.* Would be eligible for Medicaid if in a medical institution. For this purpose, deeming of parental or spousal income or resources ceases in the month after the month of application.

**83.122(5) Choice of program.** The applicant must choose HCBS children’s mental health waiver services over institutional care, as indicated by the signature of the applicant’s parent or legal guardian on Form 470-4694, Case Management Comprehensive Assessment.

**83.122(6) Need for service.** The consumer must have service needs that can be met under the children’s mental health waiver program, as documented in the service plan developed in accordance with rule 441—83.12(249A).

*a.* The consumer must be a recipient of targeted case management services or be identified to receive targeted case management services immediately following program enrollment.

*b.* The total cost of children’s mental health waiver services needed to meet the member’s needs may not exceed \$1,967 per month.

*c.* At a minimum, each consumer must receive one billable unit of a children’s mental health waiver service per calendar quarter.

*d.* A consumer may not receive children’s mental health waiver services and foster family care services under 441—Chapter 202 at the same time.

*e.* A consumer may be enrolled in only one HCBS waiver program at a time.

[ARC 7741B, IAB 5/6/09, effective 7/1/09; ARC 0306C, IAB 9/5/12, effective 11/1/12; ARC 0548C, IAB 1/9/13, effective 1/1/13; ARC 0665C, IAB 4/3/13, effective 6/1/13; ARC 0842C, IAB 7/24/13, effective 7/1/13; ARC 1056C, IAB 10/2/13, effective 11/6/13]

**441—83.123(249A) Application.** The Medicaid application process as specified in rules 441—76.1(249A) to 441—76.6(249A) shall be followed for an application for HCBS children’s mental health waiver services.

**83.123(1) Program limit.** The number of persons who may be approved for the HCBS children’s mental health waiver shall be subject to the number of consumers to be served as set forth in the federally approved HCBS children’s mental health waiver. When the number of applicants exceeds the number of consumers specified in the approved waiver, the consumer’s application shall be rejected and the consumer’s name shall be placed on a waiting list.

*a.* The local office shall determine if a payment slot is available by the end of the fifth working day after receipt of:

(1) A completed Form 470-2297, Health Services Application, from a consumer who is not currently a Medicaid member;

(2) Form 470-4694, Case Management Comprehensive Assessment, with HCBS waiver choice indicated by signature of a Medicaid member's parent or legal guardian; or

(3) A written request signed and dated by a Medicaid member's parent or legal guardian.

*b.* When a payment slot is available, the local office shall enter the application into ISIS to begin the waiver approval process.

(1) The department shall hold the payment slot for the consumer as long as reasonable efforts are being made to arrange services and the consumer has not been determined to be ineligible for the program.

(2) If services have not been initiated and reasonable efforts are no longer being made to arrange services, the slot shall revert for use by the next consumer on the waiting list, if applicable. The consumer must reapply for a new slot.

*c.* If no payment slot is available, the department shall enter the names of persons on a waiting list according to the following:

(1) The names of applicants not currently eligible for Medicaid shall be entered on the waiting list on the basis of the date a completed Form 470-2927 or 470-2927(S), Health Services Application, is received by the department;

(2) The names of Medicaid members shall be added to the waiting list on the date as specified in paragraph 83.123(1) "a."

(3) In the event that more than one application is received at one time, the names of consumers shall be entered on the waiting list on the basis of the month of birth, January being month one and the lowest number.

*d.* Consumers whose names are on the waiting list shall be contacted to reapply as slots become available, based on the order of the waiting list, so that the number of approved consumers on the program is maintained.

(1) Once a payment slot is assigned, the department shall give written notice to the consumer within five working days.

(2) The department shall hold the payment slot for 30 days for the consumer to file a new application.

(3) If an application has not been filed within 30 days, the slot shall revert for use by the next consumer on the waiting list, if applicable. The consumer originally assigned the slot must reapply for a new slot.

**83.123(2) Approval of waiver eligibility.**

*a. Time limit.* Applications for the HCBS children's mental health waiver program shall be processed within 30 days unless one or more of the following conditions exist:

(1) An application has been filed and is pending for federal Supplemental Security Income (SSI) benefits.

(2) The application is pending because the department has not received information for a reason that is beyond the control of the consumer or the department.

(3) The application is pending because the assessment or the service plan has not been completed. When a determination is not completed 90 days after the date of application due to the lack of a service plan, the application shall be denied.

*b. Notice of decisions.* The department shall mail or give decisions to the applicant on the dates when eligibility and level-of-care determinations and the consumer's service plan are completed.

**83.123(3) Effective date of eligibility.** The effective date of a consumer's eligibility for children's mental health waiver services shall be the first date that all of the following conditions exist:

*a.* All eligibility requirements are met;

*b.* Eligibility and level-of-care determinations have been made; and

*c.* The service plan has been completed.

[ARC 0306C, IAB 9/5/12, effective 11/1/12]

**441—83.124(249A) Financial participation.** A consumer must contribute to the cost of children's mental health waiver services to the extent of the consumer's total income less 300 percent of the

maximum monthly payment for one person under the federal Supplemental Security Income (SSI) program.

**441—83.125(249A) Redetermination.** The department shall redetermine a consumer's eligibility for the children's mental health waiver at least once every 12 months or when there is significant change in the consumer's situation or condition.

**83.125(1) Eligibility review.** Every 12 months, the local office shall review a consumer's eligibility in accordance with procedures in rule 441—76.7(249A). The review shall verify:

- a. Continuing eligibility factors as specified in rule 441—83.122(249A).
- b. The existence of a current service plan meeting the requirements listed in rule 441—83.125(249A).

**83.125(2) Continuation of eligibility.** A consumer's waiver eligibility shall continue until one of the following conditions occurs.

- a. The consumer fails to meet eligibility criteria listed in rule 441—83.122(249A).
- b. The consumer is an inpatient of a medical institution for 30 or more consecutive days.
  - (1) After the consumer has spent 30 consecutive days in a medical institution, the local office shall terminate the consumer's waiver eligibility and review the consumer for eligibility under other Medicaid coverage groups. The local office shall notify the consumer and the consumer's parents or legal guardian through Form 470-0602, Notice of Decision.
  - (2) If the consumer returns home after 30 consecutive days but no more than 60 days, the consumer must reapply for children's mental health waiver services, and the IME medical services unit must redetermine the consumer's level of care.

- c. The consumer does not reside at the consumer's natural home for a period of 60 consecutive days. After the consumer has resided outside the home for 60 consecutive days, the local office shall terminate the consumer's waiver eligibility and review the consumer for eligibility under other Medicaid coverage groups. The local office shall notify the consumer and the consumer's parents or legal guardian through Form 470-0602, Notice of Decision.

**83.125(3) Payment slot.** When a consumer loses waiver eligibility, the consumer's assigned payment slot shall revert for use to the next consumer on the waiting list.

**441—83.126(249A) Allowable services.** Services allowable under the children's mental health waiver shall be provided as set forth in rule 441—78.52(249A) and shall include:

1. Environmental modifications, adaptive devices and therapeutic resources;
2. Family and community support services;
3. In-home family therapy; and
4. Respite care.

**441—83.127(249A) Service plan.** The consumer's case manager shall prepare an individualized service plan for each consumer that meets the requirements set for case plans in rule 441—130.7(234).

**83.127(1)** The service plan shall be developed through an interdisciplinary team process.

**83.127(2)** The service plan shall be developed annually or when there is significant change in the consumer's situation or condition.

**83.127(3)** The service plan shall be based on information in Form 470-4694, Case Management Comprehensive Assessment.

**83.127(4)** The service plan shall specify the type and frequency of the waiver services and the providers that will deliver the services.

**83.127(5)** The service plan shall identify and justify any restriction of the consumer's rights.  
[ARC 0306C, IAB 9/5/12, effective 11/1/12]

**441—83.128(249A) Adverse service actions.**

**83.128(1) Denial.** An application for children's mental health waiver services shall be denied when the department determines that:

- a. The consumer is not eligible for or in need of waiver services.

- b. Needed services are not available or received from qualified providers.
- c. Service needs exceed the limit on aggregate monthly costs established in 83.122(6) “c” or are not met by the services provided.

**83.128(2) Termination.** A consumer’s participation in the children’s mental health waiver program may be terminated when the department determines that:

- a. The provisions of 441—paragraph 130.5(2) “a,” “b,” “c,” “g,” or “h” apply.
- b. The costs of the children’s mental health waiver services for the consumer exceed the aggregate monthly costs established in 83.122(6) “c.”
- c. The consumer receives care in a hospital, nursing facility, psychiatric hospital serving children under the age of 21, or psychiatric medical institution for children for 30 days in any one stay.
- d. The physical or mental condition of the consumer requires more care than can be provided in the consumer’s own home, as determined by the consumer’s case manager.
- e. Service providers are not available.

**83.128(3) Reduction.** Reduction of services shall apply as specified in 441—paragraphs 130.5(3) “a” and “b.”

**441—83.129(249A) Appeal rights.** Notice of adverse action and right to appeal shall be given in accordance with 441—Chapter 7 and rule 441—130.5(234).

[ARC 0306C, IAB 9/5/12, effective 11/1/12]

These rules are intended to implement Iowa Code section 249A.4 and 2005 Iowa Acts, chapter 167, section 13, and chapter 117, section 3.

[Filed emergency 8/31/84—published 9/26/84, effective 10/1/84]

[Filed 1/22/86, Notice 12/4/85—published 2/12/86, effective 4/1/86]

[Filed emergency 1/15/87—published 2/11/87, effective 1/15/87]

[Filed emergency 5/13/88 after Notice 3/23/88—published 6/1/88, effective 6/1/88]

[Filed 7/14/89, Notice 4/19/89—published 8/9/89, effective 10/1/89]

[Filed 3/16/90, Notice 2/7/90—published 4/4/90, effective 6/1/90]

[Filed 4/13/90, Notice 11/29/89—published 5/2/90, effective 8/1/90]

[Filed emergency 6/13/90—published 7/11/90, effective 6/14/90]

[Filed 10/12/90, Notice 8/8/90—published 10/31/90, 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 5/17/91 after Notice of 4/3/91—published 6/12/91, effective 7/1/91]

[Filed 10/10/91, Notice 9/4/91—published 10/30/91, effective 1/1/92]

[Filed emergency 1/16/92, Notice 11/27/91—published 2/5/92, effective 3/1/92]

[Filed 2/13/92, Notice 1/8/92—published 3/4/92, effective 5/1/92]

[Filed emergency 6/12/92—published 7/8/92, effective 7/1/92]

[Filed 7/17/92, Notice 5/13/92—published 8/5/92, effective 10/1/92]

[Filed 8/14/92, Notice 7/8/92—published 9/2/92, effective 11/1/92]

[Filed 9/11/92, Notice 7/8/92—published 9/30/92, effective 12/1/92]

[Filed emergency 7/13/93 after Notice 5/12/93—published 8/4/93, effective 8/1/93]

[Filed 8/12/93, Notice 4/28/93—published 9/1/93 effective 11/1/93]

[Filed 10/14/93, Notice 8/18/93—published 11/10/93, effective 1/1/94]

[Filed emergency 12/16/93 after Notice 10/27/93—published 1/5/94, effective 1/1/94]

[Filed emergency 2/10/94 after Notice 1/5/94—published 3/2/94, effective 3/1/94]

[Filed emergency 7/15/94 after Notice 6/8/94—published 8/3/94, effective 8/1/94]

[Filed 11/9/94, Notice 9/14/94—published 12/7/94, effective 2/1/95]

[Filed 12/15/94, Notice 11/9/94—published 1/4/95, effective 3/1/95]

[Filed 2/16/95, Notice 11/23/94—published 3/15/95, effective 5/1/95]

[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, 9/13/95, 9/27/95—published 12/6/95, effective 2/1/96]

- [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 6/19/96—published 9/11/96, effective 11/1/96]
- [Filed emergency 10/9/96 after Notice 8/14/96—published 11/6/96, effective 11/1/96]
- [Filed 1/15/97, Notice 11/20/96—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 emergency 5/14/97 after Notice 3/12/97—published 6/4/97, effective 7/1/97]
- [Filed 6/12/97, Notice 4/23/97—published 7/2/97, effective 10/1/97]
- [Filed 11/12/97, Notice 9/10/97—published 12/3/97, effective 2/1/98]
- [Filed 12/10/97, Notice 11/5/97—published 12/31/97, effective 4/1/98]
- [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 6/10/98, Notice 5/6/98—published 7/1/98, effective 10/1/98]
- [Filed 8/12/98, Notices 6/17/98, 7/1/98—published 9/9/98, effective 11/1/98]
- [Filed 12/9/98, Notice 10/7/98—published 12/30/98, effective 4/1/99]
- [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 emergency 6/10/99—published 6/30/99, effective 7/1/99]
- [Filed 8/11/99, Notice 6/30/99—published 9/8/99, effective 11/1/99]
- [Filed emergency 9/13/99—published 10/6/99, effective 10/1/99]
- [Filed 11/10/99, Notice 10/6/99—published 12/1/99, effective 2/1/00]
- [Filed emergency 6/8/00—published 6/28/00, effective 7/1/00]
- [Filed 9/12/00, Notice 6/14/00—published 10/4/00, effective 12/1/00]
- [Filed emergency 1/10/01 after Notice 11/29/00—published 2/7/01, effective 2/1/01]
- [Filed 2/14/01, Notice 12/13/00—published 3/7/01, effective 5/1/01]
- [Filed emergency 6/13/01 after Notice 4/18/01—published 7/11/01, effective 7/1/01]
- [Filed emergency 6/13/01—published 7/11/01, effective 7/1/01]
- [Filed 9/11/01, Notice 7/11/01—published 10/3/01, effective 12/1/01]
- [Filed 7/15/02, Notice 5/1/02—published 8/7/02, effective 10/1/02]
- [Filed 10/10/02, Notice 8/21/02—published 10/30/02, effective 1/1/03]
- [Filed emergency 6/12/03 after Notice 4/30/03—published 7/9/03, effective 6/15/03]
- [Filed emergency 6/12/03—published 7/9/03, effective 7/1/03]
- [Filed 9/22/03, Notice 7/9/03—published 10/15/03, effective 12/1/03]
- [Filed emergency 6/14/04 after Notice 4/28/04—published 7/7/04, effective 7/1/04]
- [Filed 8/12/04, Notice 6/23/04—published 9/1/04, effective 11/1/04]
- [Filed emergency 9/23/04—published 10/13/04, effective 10/1/04]
- [Filed 12/14/04, Notice 10/13/04—published 1/5/05, effective 2/9/05]
- [Filed without Notice 5/4/05—published 5/25/05, effective 7/1/05]
- [Filed emergency 9/21/05—published 10/12/05, effective 10/1/05]
- [Filed emergency 11/16/05—published 12/7/05, effective 12/1/05]
- [Filed 3/10/06, Notice 10/12/05—published 3/29/06, effective 5/3/06]
- [Filed emergency 8/10/06 after Notice 3/15/06—published 8/30/06, effective 10/1/06]
- [Filed emergency 9/14/06—published 10/11/06, effective 10/1/06]
- [Filed emergency 11/8/06—published 12/6/06, effective 12/1/06]
- [Filed 1/12/07, Notice 12/6/06—published 2/14/07, effective 3/21/07]
- [Filed 3/14/07, Notice 10/11/06—published 4/11/07, effective 5/16/07]
- [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 ARC 7741B (Notice ARC 7526B, IAB 1/28/09), IAB 5/6/09, 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]

[Filed ARC 9650B (Notice ARC 9497B, IAB 5/4/11), IAB 8/10/11, effective 10/1/11]  
[Filed Emergency ARC 0191C, IAB 7/11/12, effective 7/1/12]  
[Filed ARC 0306C (Notice ARC 0143C, IAB 5/30/12), IAB 9/5/12, effective 11/1/12]  
[Filed ARC 0359C (Notice ARC 0193C, IAB 7/11/12), IAB 10/3/12, effective 12/1/12]  
[Filed Emergency ARC 0548C, IAB 1/9/13, effective 1/1/13]  
[Filed ARC 0665C (Notice ARC 0547C, IAB 1/9/13), IAB 4/3/13, effective 6/1/13]  
[Filed ARC 0757C (Notice ARC 0615C, IAB 2/20/13), IAB 5/29/13, effective 8/1/13]  
[Filed Emergency ARC 0842C, IAB 7/24/13, effective 7/1/13]  
[Filed ARC 1056C (Notice ARC 0841C, IAB 7/24/13), IAB 10/2/13, effective 11/6/13]



CHAPTER 88  
MANAGED HEALTH CARE PROVIDERS  
[Prior to 2/11/87, Human Services[498]]

PREAMBLE

This chapter contains rules governing the delivery of managed health care under the Medicaid program. These rules make provision for the following managed health care options: health maintenance organizations (HMOs), prepaid health plans (PHPs), patient management, known as Medicaid Patient Access to Service System (MediPASS), the managed care plan for the delivery of mental health and substance abuse services (Iowa Plan for Behavioral Health), and programs of all-inclusive care for the elderly (PACE). The rules cover eligibility of a provider to participate, reimbursement methodologies, record-keeping requirements, grievance procedures, and member enrollment and disenrollment procedures. Services covered or requiring authorization and member access to services are specified.

DIVISION I  
HEALTH MAINTENANCE ORGANIZATION

**441—88.1(249A) Definitions.**

“*Capitation rate*” shall mean the fee the department pays monthly to an HMO for each enrolled recipient for the provision of covered medical and health services whether or not the enrolled recipient received services during the month for which the fee is intended.

“*Contract*” shall mean a contract between the department and an HMO for the provision of medical and health services to Medicaid recipients in which the HMO assumes a risk as defined in the contract. These contracts shall meet the requirements of the Code of Federal Regulations, Title 42, Part 434 as amended to December 31, 1996.

“*Covered services*” shall mean all or a part of those medical and health services set forth in 441—Chapter 78 and covered in the contract between the department and an HMO.

“*Department*” shall mean the Iowa department of human services.

“*Emergency care*” shall mean those medical services rendered for an emergent medical condition or protection of the public health.

“*Emergent medical condition*” shall mean a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect it to result in:

1. Placing the health of the person (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,
2. Serious impairment to bodily functions, or
3. Serious dysfunction of any bodily organ or part.

The determination of whether an emergent medical condition exists shall be decided by a medical professional and shall be based on the patient’s medical condition, including presenting symptoms and medical history (as related to severe pain) prior to treatment.

In cases where the above criteria are satisfied, no prior authorization procedures are allowed.

“*Enrolled recipient*” shall mean a Medicaid recipient who is eligible for HMO enrollment as defined at subrule 88.2(4) and has been enrolled with an HMO as defined at subrule 88.3(2) or 88.3(7).

“*Enrollment area*” shall mean the county or counties or region or regions in which an HMO is licensed to operate by the state of Iowa and in which service capability exists as defined by the department and set forth in the contract. An enrollment area shall not be less than an entire county but may be less than a region. Regions shall be established by the department and outlined in the contract with the HMO.

“*Extended-participation program*” shall mean a mandatory six-month enrollment period with a managed care entity.

“*Federally qualified HMO*” shall mean an HMO qualified under Section 1315(a) of the Public Health Service Act as determined by the U.S. Public Health Service.

“*Grievance*” shall mean an incident, complaint, or concern which cannot be resolved in a manner satisfactory to enrolled recipients by the immediate response, verbal or otherwise, of the HMO staff member receiving the complaint or any complaint received in writing.

“*Health maintenance organization (HMO)*” shall mean a public or private organization which is licensed as an HMO under commerce department rules 191—Chapter 40.

“*Managed care entity*” shall mean either a managed care organization licensed by the department of insurance (e.g., HMO or PHP) or a primary care case management program (i.e., MediPASS).

“*Managed health care*” shall mean any one of the alternative deliveries of regular fee-for-service Medicaid such as defined in subrules dealing with health maintenance organizations (HMOs), prepaid health plans (PHPs), or Medicaid Patient Access to Service System (MediPASS).

“*Managed health care review committee*” shall mean a committee composed of representatives from the department. The committee shall review and render a decision on all requests for disenrollment which are not automatically approvable.

“*Mandatory enrollment*” shall mean mandatory participation in managed health care as specified in subrule 88.3(3).

“*Mandatory project county*” shall mean a county where the department has contracts with more than one managed care entity, one of which may be primary care case management (MediPASS) in cases where the number of MediPASS providers willing to serve as patient managers is sufficient to meet the needs and makeup of the recipient population in the county, or where the department has implemented the MediPASS program alone in the county.

“*Noncovered services*” shall mean services covered under Medicaid which are not included in the HMO’s contract with the department. Payment for these services will be made under regular Medicaid procedures.

“*Participating providers*” shall mean the providers of covered medical and health services who subcontract with or who are employed by an HMO.

“*Recipient*” shall mean any person determined by the department to be eligible for Medicaid and for HMO enrollment. See subrule 88.2(4) for a list of Medicaid eligibles who are not eligible for HMO enrollment.

“*Region*” shall mean an area consisting of two or more contiguous counties, as established by the department and specified in contracts with health maintenance organizations.

“*Routine care*” shall mean medical care which is not urgent or emergent in nature and can wait for a regularly scheduled physician appointment without risk of permanent damage to the patient’s life or health status. The condition requiring routine care is not likely to substantially worsen without immediate clinical intervention.

“*Urgent care*” shall mean those medical services rendered for an urgent medical condition or protection of the public health.

“*Urgent medical condition*” shall mean a medical condition manifesting itself by acute symptoms that are of lesser severity (including severe pain) than that recognized for an emergent medical condition, such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the illness or injury to result in:

1. Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in jeopardy.
2. Impairment to bodily functions, or
3. Dysfunction of any bodily organ or part.

#### **441—88.2(249A) Participation.**

**88.2(1) Contracts with HMOs.** The department shall enter into contracts for the scope of services specified in 441—Chapter 78, or a part thereof, with an HMO licensed under the provisions of commerce department rules 191—Chapter 40.

- a. The department must determine that the HMO meets the following additional requirements:

(1) It shall make the services it provides to its Medicaid enrollees at least as accessible to them (in terms of timeliness, duration and scope) as those services are accessible to nonenrolled Medicaid recipients in the area served by the HMO.

(2) It shall provide satisfaction to the department against the risk of insolvency and assure that Medicaid recipients shall not be responsible for its debts if it does become insolvent. Compliance shall exist with commerce department rules regarding deposit requirements at 191—40.12(514B) and reporting requirements at 191—40.14(514B).

(3) For any contract executed or extended to be in effect on or after July 1, 2002, an HMO must have accreditation by the National Committee on Quality Assurance (NCQA) or the Joint Commission on Accreditation of Healthcare Organizations (JCAHO).

*b.* The contract shall meet the following minimum requirements. The contract shall:

(1) Be in writing.

(2) Be renewable by mutual consent for a period of up to three years.

(3) List the services covered.

(4) Describe information access and disclosure.

(5) List conditions for nonrenewal, termination, suspension, and modification.

(6) Specify the method and rate of reimbursement.

(7) Provide for disclosure of ownership and subcontractor relationship.

(8) Be made with the licensee by the department.

(9) Specify the enrollment area which shall be at least a county and effective July 1, 1998, a region of two or more contiguous counties.

*c.* Any protests to the award of contracts shall be in writing and submitted to the director of the department. Prior to termination or suspension of a contract, the department shall send a notice to cure to the HMO, specifying the number of days the HMO has to correct the problems. Failure to correct the problems in the time given shall then result in termination or suspension. The HMO may appeal the decision of the department in writing to the director of the department or to the federal Department of Health and Human Services, Centers for Medicare and Medicaid Services, if the appeal documents state violations of federal law or regulation.

**88.2(2) Method of selection of HMO.** In those counties served by a single HMO, the department shall attempt to negotiate a contract. In those counties served by two or more HMOs, the department shall initiate communication and attempt to negotiate as many contracts as are cost-effective and administratively feasible. The department reserves the right to contract with more than one HMO serving any enrollment area.

*a.* *Request for proposal.* Rescinded IAB 11/10/93, effective 11/1/93.

*b.* *Minimum contract requirements.* Rescinded IAB 11/10/93, effective 11/1/93.

**88.2(3) Termination of contract.** The department and an HMO may by mutual consent terminate a contract by either party giving 60 days' written notice to the other party. The department may terminate or suspend a contract if the contract is determined by the department to be inconsistent with the overall goals and objectives of the Medicaid program. The determination shall be based on factors including, but not limited to, the following:

*a.* The HMO's delivery system does not ensure Medicaid recipients adequate access to medical services.

*b.* The HMO's delivery system does not ensure the availability of all services covered under the contract.

*c.* There are not proper assurances of financial solvency on the part of the HMO.

*d.* There is not substantial compliance with all provisions of the contract.

*e.* The HMO has discriminated against persons eligible to be covered under the contract on the basis of age, race, sex, religion, national origin, creed, color, physical or mental disability, political belief, health status, or the need for health services.

**88.2(4) Recipients eligible to enroll.** Any Medicaid-eligible recipient is eligible to enroll in a contracting HMO except for the following:

*a.* Recipients who are medically needy as defined at 441—subrule 75.1(35).

- b.* Recipients over the age of 65 and under the age of 21 in psychiatric institutions as defined at 441—Chapter 85.
- c.* Recipients who are supplemental security income-related case members.
- d.* Rescinded IAB 10/3/01, effective 12/1/01.
- e.* Recipients whose eligibility is in the process of automatic redetermination as defined at rule 441—76.11(249A).
- f.* Recipients who are foster care and subsidized adoption-related case members.
- g.* Recipients who are Medicare beneficiaries.
- h.* Recipients who are pregnant women and who are deemed to be presumptively eligible as defined at 441—subrule 75.1(30).
- i.* Recipients who are Native American Indians or Alaskan natives.
- j.* Recipients who are receiving services from a Title V provider.

#### **441—88.3(249A) Enrollment.**

**88.3(1) *Enrollment area.*** Counties in an HMO enrollment area shall be designated as either voluntary or mandatory. In voluntary counties enrollment is not required but eligible recipients may choose to join the HMO. See subrule 88.3(2) for information about voluntary enrollment. In mandatory counties enrollment is required for eligible recipients. See subrule 88.3(3) for information about mandatory enrollment.

**88.3(2) *Voluntary enrollment.*** When only one HMO in any county has a contract with the department, and the county is not a mandatory project county for Medicaid Patient Management (MediPASS) under subrule 88.43(1), enrollment by Medicaid recipients in the HMO is voluntary. The state encourages recipients to enroll in an HMO. Applicants and recipients eligible for HMO enrollment as set forth in subrule 88.2(4) are offered the option of HMO enrollment. Persons who enroll with the HMO shall have the right to request disenrollment at any time as defined at subrule 88.4(3).

Applicants or recipients can designate their choices on a form designated by the managed health care contractor or in writing to or with a verbal request to the Medicaid managed health care contractor. The form shall be available through the county office, provider offices, the HMO office, the managed health care contractor, or other locations at the department's discretion. If the HMO (or any entity listed above other than the managed health care contractor) receives the form, it shall be forwarded to the managed health care contractor within three working days.

Recipients shall be accepted by the HMO in the order in which they enroll without restrictions.

Recipients who choose not to enroll in an HMO shall be covered under regular Medicaid.

**88.3(3) *Mandatory enrollment.*** Participation in managed health care, if available, is required as specified in this subrule for covered eligibles who reside in a mandatory project county. The department shall require, whenever administratively feasible, that all eligible recipients enroll with a managed care entity. Administrative feasibility is determined by whether a freedom-of-choice waiver or state plan amendment has been approved by the Centers for Medicare and Medicaid Services and whether the managed care entities demonstrate sufficient access to and quality of services.

**88.3(4) *Effective date.*** The effective date of enrollment shall be no later than the first day of the second month subsequent to the date on which the managed health care contractor receives the designated managed health care choice form or written or verbal request except as defined at 88.4(4) "b." The recipients shall be entitled to regular Medicaid until the effective date of HMO enrollment which shall always be the first day of the month. The effective date shall be earlier than the second subsequent month where computer cutoff allows.

**88.3(5) *Identification card.*** The HMO may issue an appropriate identification card to the enrollee or request the department to do it on its behalf. The identification card shall be issued so the recipient receives it prior to the effective date of enrollment.

**88.3(6) *Limitations on enrollment.*** Contracting managed care entities may specify in a contract a limit to the number of recipients who can be assigned under subrule 88.3(7). If a limit is specified, the contracting entity must still provide services to all enrolled recipients who voluntarily select enrollment

in that option. If a specified limitation is reached, the remaining assignment needs in that county shall be met by the other managed care entities who are contracting with the department in that county.

**88.3(7) Enrollment procedures.** In mandatory enrollment counties, recipients shall be required to choose their managed care entity. When no choice is made by the recipient, the recipient shall be assigned to a contracting health maintenance organization (HMO) serving the recipient's county of residence when an HMO is available or to a MediPASS patient manager on a rotating basis to ensure an equitable distribution between the HMO and MediPASS programs based on the number of managed health care options (MediPASS and HMOs) available in the county. In the event there is no contracting HMO serving the recipient's county of residence in a mandatory enrollment county, the recipient shall be assigned to a MediPASS patient manager.

Within the MediPASS option, recipients shall be assigned according to age appropriateness. Whenever possible, family units shall be assigned to the same provider that an enrolled family member has selected, if that provider is appropriate according to age parameters. If not, the household shall be assigned to another physician. MediPASS patient managers shall not be assigned more recipients than their self-imposed maximum or the maximum described in subrule 88.46(5), whichever is lower.

Recipients who are assigned a managed care entity as described in this subrule shall have at least ten days in which to request enrollment in a different available entity. The change is subject to provisions in subrule 88.4(2) dealing with the effective date.

*a. Timely notice.* Recipients shall be sent timely notice of the managed care entity assignment. The recipient shall have a minimum of ten days in which a change to the assigned managed care entity can be made. The notice shall include the name of the managed care entity to whom the recipient shall be assigned if the recipient does not make a different selection by the date specified in the notice. If the covered eligible does not make a selection before the due date, the recipient shall be enrolled with the managed care entity listed on the notice.

*b. Enrollment.* Enrollment in managed health care shall be discussed during the face-to-face interview with all applicants for Medicaid under covered categories of assistance in mandatory or voluntary enrollment areas. The applicant shall be shown an informational videotape and encouraged to make a selection of a managed care entity. Applicants in mandatory enrollment areas shall be informed that should the applicant become eligible for a managed health care selection, one shall be assigned. Covered eligibles who are not enrolled shall be sent a notice of their managed health care assignment when the recipient:

- (1) Attains initial eligibility for a covered category of service in a mandatory project county.
- (2) Changes from an excluded category of assistance to a covered category of assistance in a mandatory project county.
- (3) Is receiving a covered category of assistance and moves from a county where no managed health care is available or from a voluntary project county to a mandatory project county.
- (4) Reattains eligibility.
- (5) Has a new member of the household receiving a covered category of assistance.

*c. Selection of a managed health care provider.* A list of health care providers participating in managed care entities serving the county shall be available to recipients for use in selecting a provider. If the recipient wishes to request an exception to the list of available managed health care providers, the managed health care review committee shall make a determination on the exception request. While the determination is being made, the recipient's enrollment shall be placed in a pending status.

*d. Request to change enrollment.* An enrolled recipient may, within 90 days from timely notice, request to change enrollment from one managed health care provider to another or one managed care entity to another. The request may be made on a choice form designated by the department, in writing, or by telephone call to the toll-free recipient managed health care telephone line maintained by the department. Changes are subject to the provisions of subrule 88.4(2) dealing with effective date.

*e. Managed care entity extended-participation program (EPP).* After the initial 90 days from timely notice, recipients will remain enrolled with the chosen entity for the following six months, with three exceptions:

- (1) A request for disenrollment by recipient for good cause pursuant to paragraph 88.4(3) "a."

- (2) A request for disenrollment by provider for good cause pursuant to paragraph 88.4(3) “b.”
- (3) Availability of a new, previously unavailable, managed care entity. In this instance recipients will be allowed to select that entity for the remainder of the current EPP period.

*f. Enrollment cycle.* Prior to the end of any EPP period, recipients shall be notified of their ability to enroll with a different managed care option. A change in enrollment or failure to change enrollment will begin a new EPP enrollment period at the end of the current EPP.

#### **441—88.4(249A) Disenrollment.**

**88.4(1)** *Disenrollment request.* Rescinded IAB 5/6/98, effective 7/1/98.

**88.4(2)** *Effective date.* Disenrollment will be effective no later than the first day of the second calendar month after the month in which the department receives a request for disenrollment. The recipient will remain enrolled in the HMO and the HMO will be responsible for services covered under the contract until the effective date of disenrollment which will always be the first day of a month.

**88.4(3)** *Disenrollment process.* The recipient may complete the form designated by the managed health care contractor which can be obtained through the locations described in subrule 88.3(2). The recipient may also make a verbal or written request through the managed health care contractor. If the HMO or any other entity described in subrule 88.3(2) receives a request to disenroll from the recipient, the request shall be forwarded to the Medicaid managed health care contractor office within three working days. If the recipient must show good cause for disenrollment or if the HMO is requesting disenrollment, the determination as to whether disenrollment shall occur shall be made by the managed health care review committee within 30 days. If the recipient or HMO disagrees with the decision of the review committee, an appeal may be filed under the provisions of 441—Chapter 7. The HMO may request disenrollment of a recipient by showing good cause and completing Form 470-2169, Managed Health Care Provider Request for Disenrollment. If the county office receives a completed Form 470-2169 from the managed health care provider, the county office shall forward the form to the managed health care review committee within three days.

*a. Request for disenrollment by the recipient.* The enrolled recipient may request disenrollment by completing a choice form designated by the managed health care contractor, in writing or by telephone call to the toll-free recipient managed health care telephone line maintained by the department at any time prior to enrollment with a managed health care entity and within the 90 days from timely notice date. After this time period, a recipient may be disenrolled for good cause when the recipient can demonstrate that services were untimely, inaccessible, of insufficient quality or inadequately provided. In a mandatory county, a disenrollment request must be accompanied by a choice for another managed health care provider.

*b. Request for disenrollment by the HMO.* With prior approval of the DHS/HMO Review Committee a recipient may be disenrolled when:

(1) There is evidence of fraud or forgery in the use of HMO services or in the application for HMO coverage.

(2) There is evidence of unauthorized use of the HMO identification card.

(3) Upon documentation that the HMO has been unable after reasonable efforts to establish or maintain a satisfactory physician-patient relationship with the recipient. Examples include, but are not limited to, repeated failure to follow a prescribed treatment plan, disruptive or abusive behavior with office or clinic staff, documented pattern of missed appointments or “drop-in” requests for service without making appointments.

**88.4(4)** *Disenrollments by the department.* Disenrollments will occur when:

*a.* The contract between the department and the HMO is terminated.

*b.* The recipient becomes ineligible for Medicaid. If the recipient becomes ineligible and is later reinstated to Medicaid, enrollment in the HMO will also be reinstated.

*c.* The recipient permanently moves outside the HMO’s enrollment area.

*d.* The recipient transfers to an eligibility group excluded from HMO enrollment. See definition of recipient in rule 441—88.1(249A).

*e.* The department has determined that participation in the HIPP (Health Insurance Premium Payment) program as described in rule 441—75.21(249A) is more cost-effective than enrollment in managed health care.

*f.* The department has determined that the recipient's enrollment in the recipient lock-in program, as defined in rule 441—76.9(249A), would be more cost-effective for the department.

**88.4(5)** *No disenrollment for health reasons.* No recipient will be disenrolled from an HMO because of an adverse change in health status.

**441—88.5(249A) Covered services.**

**88.5(1)** *Amount, duration, and scope of services.* Except as provided for in the contract, HMOs shall cover as a minimum all services covered by the Medicaid program as set forth in 441—Chapter 78.

*a.* The recipient shall be issued Form 470-1911, Medical Assistance Eligibility Card, and information about those services not covered by the HMO.

*b.* To the maximum extent possible, the HMO shall make enrolled recipients aware of alternate providers for services not covered by the HMO.

**88.5(2)** *Required services.*

*a.* The HMO shall cover as a minimum the following services:

- (1) Inpatient hospital services.
- (2) Outpatient hospital services.
- (3) Physician services.
- (4) Family planning services.
- (5) Home health agency services.
- (6) Early periodic screening, diagnosis and treatment for individuals under the age of 21.
- (7) Laboratory and X-ray services.
- (8) Rural health clinic services (where available).
- (9) Advanced registered nurse practitioners.
- (10) Optometric and ophthalmology services.
- (11) Clinic services.
- (12) Ambulance services.
- (13) Rescinded IAB 11/5/97, effective 1/1/98.
- (14) Other practitioner services (e.g., speech therapy, audiology, physical therapy, and occupational therapy).
- (15) Rehabilitation agencies.

*b.* HMOs shall attempt to subcontract with all local family planning clinics funded by Title X moneys and maternal and child health centers funded by Title V moneys. The attempt to contract by the HMO is expected to be a reasonable and good faith effort. The determination of whether or not a good faith effort was made shall be completed by the department.

**88.5(3)** *Excluded services.* Unless specifically included in the contract, HMOs will not be required to cover:

- a.* Long-term care (skilled nursing facilities, intermediate care facilities, residential care facilities, state hospital schools, or intermediate care facilities for the mentally retarded).
- b.* Inpatient psychiatric care provided at state-administered mental health institutes.
- c.* Services provided by the area education agencies.
- d.* Services provided at psychiatric medical institutions for children.
- e.* Dental services.
- f.* Hospice services.
- g.* Mental health services as defined in rule 441—88.65(249A).
- h.* Rescinded IAB 8/1/07, effective 9/5/07.
- i.* Psychiatric services.
- j.* Infant and toddler program services.
- k.* Local education agency services.

Reimbursement to recipients for nonemergency medical transportation as described at rule 441—78.13(249A) will not be covered by the HMO. The department will continue to reimburse as it currently does for this service.

**88.5(4) *Restrictions and limitations.*** If the HMO covers a type of service which is also covered under Medicaid, the HMO shall offer the same scope of procedures available under regular Medicaid as described in the provisions at 441—Chapter 78. The HMO may not impose limitations on days of service or length of stay not pertinent to regular Medicaid. The HMO may, however, require the use of certain providers, as defined in subrule 88.5(5); require preauthorization for services other than those meeting the definition of emergency, as defined in rule 441—88.1(249A); direct enrollees to the appropriate level of care for receipt of covered services; and deny payment if these enrollment requirements are not met by the enrollee. The HMO may at its discretion offer services to recipients beyond the scope of Medicaid as defined in 441—Chapter 78.

**88.5(5) *Recipient use of HMO services.*** A recipient enrolled in an HMO must use HMO providers of service, unless the HMO has authorized a referral to a provider outside the HMO for provision of a service or treatment plan. Payment shall be denied by the HMO on claims for services provided by non-HMO providers if the same service is covered by the HMO under its contract with the department except as provided in rule 441—88.6(249A), as allowed for by a referral to a non-HMO provider, or as an additional service permitted by subrule 88.5(4).

#### **441—88.6(249A) Emergency and urgent care services.**

**88.6(1) *Availability of services.*** The HMO shall ensure that emergency services are available on an emergency basis 24 hours a day, seven days a week, either through the HMO's own providers or through arrangements with other providers. In addition the HMO must provide payment to nonparticipating providers within 60 days of receipt of the bill for all contracted services furnished by providers which do not have arrangements with the HMO to provide services but were provided because they were needed immediately as defined at rule 441—88.1(249A) and in which cases the medical emergency does not permit a choice of provider.

**88.6(2) *HMO payment liability.*** HMO payment liability on account of injury or emergency illness is limited to emergency care as defined in rule 441—88.1(249A). If an ambulance is medically necessary to transport the recipient to follow-up treatment the HMO shall be financially liable. The HMO may require that follow-up treatment to an emergency be provided by HMO-participating providers.

If a recipient is injured or becomes ill and receives emergency services while temporarily outside the HMO's enrollment area, the HMO shall pay the facility or person who rendered the emergency care for emergency medical services and medical services, for inpatient hospital services in a general hospital as a result of the emergency, and for emergency ambulance service.

**88.6(3) *Notification and claim filing time spans.*** The HMO may set notification and claim filing time limitations in the event of the provision of care by nonparticipating providers. However, failure to give notice or file claims within those time limitations will not invalidate any claim if it can be shown not to have been reasonably possible to give such notice and that notice was in fact given as soon as was reasonably possible.

**88.6(4) *Provision of urgent care.*** If the recipient is assigned to a patient manager by the HMO, the patient manager shall arrange for urgent care within 24 hours by either providing it or referring to and authorizing another appropriate provider to provide care.

#### **441—88.7(249A) Access to service.**

**88.7(1) *Choice of provider.*** Recipients will have the opportunity to choose their health care professionals to the extent possible and medically appropriate from any of the HMO providers participating in the Medicaid project.

**88.7(2) *Medical service delivery sites.*** Medical service delivery sites must have the following specific characteristics:

- a. Be located within 30 miles of and accessible from the personal residences of enrolled recipients.

- b. Have sufficient staff resources to adequately provide the medical services contracted for by the site including physicians with privileges at one or more participating acute care hospitals.
- c. Have arrangements for services to be provided by other providers where in-house capability to serve specific medical needs does not exist.
- d. Meet the applicable standards for participating in the Medicaid program.
- e. Be in compliance with all applicable local, state, and federal standards related to the service provided as well as those for fire and safety.

**88.7(3) Adequate appointment system.** The HMO shall have procedures for the scheduling of patient appointments which are appropriate to the reason for the visit as follows:

- a. Patients with urgent symptoms shall be seen within one day of contacting their HMO provider at an HMO medical service delivery site.
- b. Patients with persistent symptoms shall be seen within 48 hours of reporting of the onset of the persistent symptoms.
- c. Patient routine visits shall be scheduled within four to six weeks of the date the patient requests the appointment.
- d. Scheduling of appointments shall be by specific time intervals and not on a block basis.

**88.7(4) Adequate after hours call-in coverage.** The HMO must have in effect the following arrangements which provide for adequate after hours call-in coverage.

- a. Twenty-four-hour-a-day phone coverage shall exist.
- b. If a physician does not respond to the initial telephone call there must be a written protocol specifying when a physician must be consulted. Calls requiring a medical decision shall be forwarded to the on-call physician and a response to each call which requires a medical decision must be provided by the physician within 30 minutes.
- c. Notations shall be made in the patient's medical record of relevant information related to an after-hours call.

**88.7(5) Adequate referral system.** The HMO must effect the following arrangements which provide for an adequate referral system:

- a. A network of referral sources for all services which are covered in the contract and not provided by the HMO directly.
- b. Procedures for the return of relevant medical information from referral sources including review of information by the referring physician, entry of information into the patient's medical record, and arrangements for periodic reports from ongoing referral arrangements.
- c. A notation for hospitalized patients in the medical record indicating the reason, date, and duration of hospitalization and entry of pertinent reports from the hospitalization and discharge planning in the medical record.

#### **441—88.8(249A) Grievance procedures.**

**88.8(1) Written procedure.** The HMO must have a written procedure by which enrolled recipients may express grievances, complaints, concerns, or recommendations, either individually or as a class and which:

- a. Is approved by the department prior to use.
- b. Acknowledges receipt of a grievance to the grievant.
- c. Sets time frames for resolution including emergency procedures which are appropriate to the nature of the grievance and which require that all grievances shall be resolved within 30 days.
- d. Ensures the participation of persons with authority to require corrective action.
- e. Includes at least one level of appeal.
- f. Ensures the confidentiality of the grievant.
- g. Ensures issuance of a departmentally approved notice of decision for each adverse action and for each decision on requests for HMO reconsideration. These notices shall contain the enrollee's appeal rights with the department and shall contain an adequate explanation of the action taken and the reason for the decision.

**88.8(2) *Written record.*** All grievances, including informal or verbal complaints, which must be referred or researched for resolution must be recorded in writing. A log of the grievances must be maintained and made available at the time of audit and must include progress notes and resolutions.

**88.8(3) *Information concerning grievance procedures.*** The HMO's written grievance procedure must be provided to each newly covered recipient not later than the effective date of coverage.

**88.8(4) *Appeals to the department.*** A recipient shall exhaust the established grievance procedure of the HMO before appealing the issue to the department under the provisions of 441—Chapter 7. The HMO appeal process shall not be more stringent in requirements and time frames than the department's appeal process. The HMO shall issue a written notice stating the outcome of all appeals.

**88.8(5) *Periodic report to the department.*** The HMO must make quarterly reports to the department summarizing grievances and resolutions as specified in the contract.

**88.8(6) *Consent for state fair hearing.*** Network providers which are contracted and in good standing with a medical managed care organization (MCO) 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. The network 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 network provider submits a document providing such member's approval of the request for a state fair hearing. 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 member's 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.

[ARC 0583C, IAB 2/6/13, effective 4/1/13]

#### **441—88.9(249A) Records and reports.**

**88.9(1) *Medical records system.*** The HMO shall comply with the provisions of rule 441—79.3(249A) regarding maintenance and retention of clinical and fiscal records and shall file a letter with the commissioner of insurance as described in Iowa Code section 228.7. In addition the HMO must maintain a medical records system which:

- a. Identifies each medical record by state identification number.
- b. Identifies the location of every medical record.
- c. Places medical records in a given order and location.
- d. Provides a specific medical record on demand.
- e. Maintains the confidentiality of medical records information and releases the information only in accordance with established policy pursuant to subrule 88.9(3).
- f. Maintains inactive medical records in a specific place.
- g. Permits effective professional review in medical audit processes.
- h. Facilitates an adequate system for follow-up treatment including monitoring and follow-up of off-site referrals and inpatient stays.
- i. Meets state and federal reporting requirements applicable to HMOs.

**88.9(2) *Content of individual medical record.*** The HMO must have in effect arrangements which provide for an adequate medical record-keeping system which includes a complete medical record for each enrolled recipient in accordance with provisions set forth in the contract.

**88.9(3) *Confidentiality of records.*** HMOs must maintain the confidentiality of medical record information and release the information only in the following manner:

- a. All medical records of enrolled recipients shall be confidential and shall not be released without the written consent of the enrolled recipients or responsible party.
- b. Written consent is not required for the transmission of medical record information to physicians, other practitioners, or facilities who are providing services to enrolled recipients under a subcontract with the HMO. This provision also applies to specialty providers who are retained by the HMO to provide

services which are infrequently used, provide a support system service to the operation of the HMO, or are of an unusual nature. This provision is also intended to waive the need for written consent for department staff assisting in the administration of the program, reviewers from the peer review organization (PRO), monitoring authorities from the Centers for Medicare and Medicaid Services (CMS), the HMO itself, and other subcontractors which require information as described under paragraph “e” of this subrule.

c. Written consent is not required for the transmission of medical record information to physicians or facilities providing emergency care pursuant to rule 441—88.6(249A).

d. Written consent is required for the transmission of the medical record information of a former enrolled recipient to any physician not connected with the HMO.

e. The extent of medical record information to be released in each instance shall be based upon tests of medical necessity and a “need to know” on the part of the practitioner or a facility requesting the information.

f. Medical records maintained by subcontractors must meet the requirements of this rule.

**88.9(4) Reports to the department.** Each HMO shall submit reports to the department as follows:

a. Annual audited financial statements no later than 120 days after the close of the HMO’s fiscal year or other additional terms as specified by the contract.

b. Periodic financial, utilization, and statistical reports as required by the department under the contract.

c. Time-specific reports required by the contract which define activity for child health care, grievances, and other designated activities which may, at the department’s discretion, vary among HMOs, depending on the services covered and other contractual differences.

**88.9(5) Audits.** The department or its designee and the U.S. Department of Health and Human Services (HHS) may evaluate through inspections or other means the quality, appropriateness, and timeliness of services performed by the HMO. The department or HHS may audit and inspect any records of an HMO, or the subcontractor of the HMO that pertain to services performed and the determination of amounts paid under the contract. These records will be made available at times, places, and in a manner as authorized representatives of the department, its designee or HHS may request.

#### **441—88.10(249A) Marketing.**

**88.10(1) General requirements.** An HMO may not distribute directly or through any agent or independent contractor any marketing materials, without the prior approval of the department, and may not distribute marketing materials that contain false or materially misleading information.

a. *Service market.* An HMO shall distribute any marketing materials to its entire service area or region.

b. *Prohibition of tie-ins.* An HMO, or any agency of the entity, may not seek to influence an individual’s enrollment with the HMO in conjunction with the sale of any other insurance.

c. *Prohibiting marketing fraud.* Each HMO shall comply with the procedures and conditions the department prescribes in the contract in order to ensure that, before an individual is enrolled with the HMO, the individual is provided accurate oral and written information sufficient to make an informed decision whether or not to enroll.

d. *Prohibition of “cold-call” marketing.* HMOs shall not, directly or indirectly, conduct door-to-door, telephonic, or other “cold-call” marketing of enrollment.

**88.10(2) Marketing representatives.** Marketing representatives utilized to market Medicaid recipients must be sufficiently trained and capable of performing marketing activities within the requirements of the contract. The HMO’s marketing representatives must represent the HMO in an honest and straightforward manner. In its marketing presentations the HMO must include information which ensures that the marketing representative is not mistaken for a state or county employee.

**88.10(3) Marketing presentations.** The HMO may make marketing presentations in the local offices of the department or otherwise include the department in their marketing efforts at the discretion of the department.

**88.10(4) *Marketing materials.*** Written material must include a marketing brochure or a member handbook that fully explains the services available, how and when to obtain them, and special factors applicable to Medicaid recipients as specified in the contract.

**441—88.11(249A) Patient education.**

**88.11(1) *Health education procedures.*** The HMO will have written procedures for health education designed to prepare patients for participation in and reaction to specific medical procedures and to instruct patients in self-management of medical problems and in disease prevention. This service may be provided by any health practitioner or by any other person approved by the HMO.

**88.11(2) *Use of services.*** The HMO will have procedures in effect to orient covered persons in the use of all services provided. This includes but is not limited to written instructions regarding appropriate use of the referral system, grievance procedure, after hours call-in system, and provisions for emergency treatment.

**88.11(3) *Patient rights and responsibilities.*** The HMO shall have in effect a written statement of patient rights and responsibilities which is available to patients upon request and which is sent to all new enrolled recipients. The rights of the recipient to request disenrollment shall be included.

**441—88.12(249A) Reimbursement.**

**88.12(1) *Capitation rate.*** In consideration for all services rendered by an HMO under a contract with the department, the HMO will receive a payment each month for each enrolled recipient. This capitation rate represents the total obligation of the department with respect to the costs of medical care and services provided to enrolled recipients under the contract.

A portion of any increase in capitation payments may be reserved for an incentive payment to be paid based on the percentage of counties in a region included in an HMO's enrollment area. Incentive payments shall be made retroactively to the beginning of a state fiscal year if an HMO increases the percentage of counties in a region included in its enrollment area.

**88.12(2) *Determination of rate.*** The capitation rate is actuarially determined for the beginning of each new fiscal year using statistics and data about Medicaid fee-for-service expenses for HMO-covered services to a similar population during a base fiscal year. The capitation rate shall not exceed the cost to the department of providing the same services on a fee-for-service basis to an actuarially equivalent nonenrolled population group. HMOs electing to share risk with the department shall have their payment rates reduced by an amount reflecting the department's experience for high cost fee-for-service recipients.

**88.12(3) *Amounts not included in rate.*** The capitation rate does not include any amounts for the recoupment of losses suffered by the HMO for risks assumed under the contract or any previous risk contract. Any savings realized by the HMO due to the expenditure for necessary health services by the enrolled population being less than the capitation rate paid by the department will be wholly retained by the HMO.

**88.12(4) *Third-party liability.*** If an enrolled recipient has health insurance coverage or a responsible party other than the Medicaid program available for payment of medical expenses it is the right and responsibility of the HMO to investigate these third-party resources and attempt to obtain payment. The HMO will retain all funds collected for third-party resources. A complete record of all income from these sources must be maintained and made available to the department on request.

**441—88.13(249A) Quality assurance.** The HMO shall have in effect an internal quality assurance system that meets the requirements of 42 CFR 434.44 as amended to December 31, 1996, and a system of periodic medical audits meeting the requirements of 42 CFR 434.53 as amended to December 13, 1990.

**441—88.14(249A) Contracts with federally qualified health centers (FQHCs) and rural health clinics (RHCs).** In the case of services provided pursuant to a contract between an FQHC or RHC and a managed care organization, the organization shall provide payment to the FQHC or RHC that is not less than the amount of payment that it would make for the services if furnished by a provider other

than an FQHC or RHC. The payment from the managed care organization to the FQHC or RHC shall be supplemented by a direct payment from the department to the FQHC or RHC to provide reimbursement at 100 percent of reasonable cost as determined by Medicare cost reimbursement principles. FQHCs and RHCs shall be required to submit Form 470-3495, Managed Care Wraparound Payment Request Form, to the Iowa Medicaid enterprise provider audits and rate setting unit to document Medicaid encounters and differences between payments by the managed care organization and 100 percent of reasonable cost as determined by Medicare cost reimbursement principles.

**441—88.15 to 88.20** Reserved.

DIVISION II  
PREPAID HEALTH PLANS

**441—88.21(249A) Definitions.**

*“Capitation rate”* shall mean the fee the department pays monthly to a PHP for each enrolled recipient for the provision of covered medical services whether or not the enrolled recipient received services during the month for which the fee is intended.

*“Contract”* shall mean a contract between the department and a PHP for the provision of medical services to enrolled Medicaid recipients for whom the PHP assumes a risk as defined in the contract. These contracts shall meet the requirements of the Code of Federal Regulations, Title 42, Part 434 as amended to December 31, 1996.

*“Department”* shall mean the Iowa department of human services.

*“Emergency service”* shall mean those medical services rendered under unforeseen conditions which require hospitalization for the treatment of accidental injury and relief of acute pain, which, if not immediately diagnosed and treated, would result in risk of permanent danger to the patient’s health.

*“Enrollment area”* shall mean the county or counties which the PHP has capability to serve and is defined in the contract with the department. An enrollment area shall not be less than an entire county.

*“Grievance”* shall mean an incident, complaint, or concern which cannot be resolved in a manner satisfactory to enrolled recipients by the immediate response, verbal or otherwise, of the PHP staff member receiving the complaint or any complaint received in writing.

*“Managed health care”* shall mean any one of the alternative deliveries of regular, fee-for-service Medicaid such as defined in subrules dealing with health maintenance organizations (HMOs), or prepaid health plans (PHPs), or Medicaid Patient Access to Service System (MediPASS).

*“Managed health care review committee”* shall mean a committee composed of representatives from the department. The committee shall review and render a decision on all requests for disenrollment which are not automatically approvable.

*“Managed services”* shall mean all or part of those medical services set forth in 441—Chapter 78 and covered in the contract between the department and a PHP.

*“Nonmanaged services”* shall mean medical services covered under regular Medicaid, but which are not covered in the PHP’s contract with the department. Payment for nonmanaged services incurred by an enrolled recipient shall be made under regular Medicaid procedures.

*“Participating providers”* shall mean the providers of covered medical services who subcontract with or who are employed by the PHP.

*“Prepaid health plan (PHP)”* shall mean an entity defined in Section 1903(m)(2)(B)(iii) of the Social Security Act and considered to be a PHP by the department based upon criteria set forth in the Code of Federal Regulations at Title 42, Part 434.20(a)(3) as amended to March 31, 1991.

*“Recipient”* shall mean any person determined by the department to be eligible for Medicaid and for PHP enrollment. See subrule 88.22(4) for a list of Medicaid eligibles who are not eligible for PHP enrollment.

*“Routine care”* shall mean medical care which is not urgent or emergent in nature and can wait for a regularly scheduled physician appointment without risk of permanent damage to the patient’s life or

health status. The condition requiring routine care is not likely to substantially worsen without immediate clinical intervention.

“*Urgent, nonemergency need*” shall mean the existence of conditions due to an illness or injury which are not life threatening but which require expeditious treatment because of the prospect of the condition worsening without immediate clinical intervention.

**441—88.22(249A) Participation.**

**88.22(1) *Contracts with PHPs.*** The department shall enter into contracts for the scope of services specified in 441—Chapter 78, or a part thereof, with a PHP which has verified to the department that the criteria set forth in the Social Security Act have been met. This verification shall be reviewed by Centers for Medicare and Medicaid Services (CMS) staff to ensure that the status of PHP is rightfully conferred.

*a.* The department shall also determine that the PHP meets the following additional requirements:

(1) The PHP shall make the services it provides to enrolled recipients at least as accessible (in terms of timeliness, duration, and scope) to them as those services are accessible to recipients in the enrollment area who are not enrolled.

(2) The PHP shall provide satisfaction to the department that insolvency is not likely to occur and that enrolled Medicaid recipients shall not be responsible for its debts if the PHP should become insolvent.

*b.* The contract shall meet the following minimum requirements. The contract shall:

(1) Be in writing.

(2) Be renewable by mutual consent for a period of up to three years.

(3) List the services covered.

(4) Describe information access and disclosure.

(5) List conditions for nonrenewal, termination, suspension, and modification.

(6) Specify the method and rate of reimbursement.

(7) Provide for disclosure of ownership and subcontractor relationship.

(8) Be made with the licensee by the department.

*c.* Any protests to the award of contracts shall be in writing and submitted to the director of the department. Prior to termination or suspension of a contract, the department shall send a notice to cure to the PHP, specifying the number of days the PHP has to correct the problems. Failure to correct the problems in the time given shall then result in termination or suspension. The PHP may appeal the decision of the department in writing to the director of the department or to the federal Department of Health and Human Services, Centers for Medicare and Medicaid Services, if the appeal documents state violations of federal law or regulation.

**88.22(2) *Method of selection of PHP.*** In counties served by a single prospective PHP, the department shall attempt to negotiate directly with the PHP. In counties where two or more prospective PHPs exist, the department shall initiate communication and attempt to negotiate as many contracts as are administratively feasible.

**88.22(3) *Termination of contract.*** Either party may, by mutual consent, terminate a contract. Either party may give 60 days written notice to the other party. The effective date of termination must be the first day of a month. The department may terminate or suspend a contract if the contract is determined by the department to be inconsistent with the overall goals and objectives of the Medicaid program. The determination shall be based upon, but not limited to, the following:

*a.* The PHP’s delivery system does not ensure enrolled recipients adequate access to medical services.

*b.* The PHP’s delivery system does not ensure the availability of all services covered under the contract.

*c.* There are not proper assurances of solvency on the part of the PHP.

*d.* There is not substantial compliance with all provisions of the contract.

*e.* The PHP has discriminated against persons eligible to be covered under the contract on the basis of age, race, sex, religion, national origin, creed, color, physical or mental disability, political belief, health status, or the need for health services.

**88.22(4) Recipients eligible to enroll.** Any Medicaid-eligible recipient is eligible to enroll in a contracting PHP except for the following:

- a. Recipients who are medically needy as defined at 441—subrule 75.1(35).
- b. Recipients over the age of 65 and under the age of 21 in psychiatric institutions as defined at 441—Chapter 85.
- c. Recipients who are supplemental security income-related case members.
- d. Rescinded IAB 10/3/01, effective 12/1/01.
- e. Recipients whose eligibility is in the process of automatic redetermination as defined at rule 441—76.11(249A).
- f. Recipients who are foster care and subsidized adoption-related case members.
- g. Recipients who are Medicare beneficiaries.
- h. Recipients who are pregnant women and who are deemed to be presumptively eligible as defined at 441—subrule 75.1(30).
- i. Recipients who are Native American Indians or Alaskan natives.
- j. Recipients who are receiving services from a Title V provider.

**441—88.23(249A) Enrollment.**

**88.23(1) Enrollment area.** Counties in a PHP enrollment area shall be designated as voluntary or mandatory. In voluntary counties, enrollment is not required but eligible recipients may choose to join the PHP. Recipients not excluded in rule 441—88.21(249A) may volunteer to enroll in the PHP. In mandatory counties, enrollment in managed health care is required for eligible recipients.

**88.23(2) Voluntary enrollment.** When only one managed health care option is providing service in a county, enrollment by recipients is voluntary. The department encourages recipients to enroll in a managed health care option. Applicants and recipients are offered the option of managed health care enrollment or regular Medicaid coverage. Applicants and recipients who do not choose one option or the other shall be assigned to a managed health care provider as defined in subrule 88.23(6). These persons shall have the right to request disenrollment at any time as defined in subrule 88.24(3).

Applicants or recipients may designate their choices of providers on a form designated by the managed health care contractor or in writing to or through a verbal request to the managed health care contractor. The form shall be available through the county office, the PHP office, provider offices, the managed health care contractor, or other locations at the department's discretion. If the PHP (or any entity listed above other than the managed health care contractor) receives the form, it shall be forwarded to the managed health care contractor within three working days.

Recipients shall be accepted by the PHP as they are enrolled by the department unless a maximum limit has been specified in the contract.

Recipients who choose not to enroll in a PHP shall be covered under regular Medicaid.

**88.23(3) Mandatory enrollment.** In a county where the department has a contract with more than one PHP, HMO, or other managed health care provider, the department shall require whenever it is administratively feasible that all eligible recipients enroll with a managed health care provider of their own choosing. Administrative feasibility is determined by whether the managed health care providers have the capacity to adequately serve all potential enrolled recipients. Recipients may enroll by completing the choice form designated by the managed health care contractor, in writing to or through verbal request to the managed health care offices. Recipients may also contact the managed health care contractor by the publicized toll-free telephone number for enrollment assistance.

**88.23(4) Effective date.** The effective date of enrollment shall be no later than the first day of the second month subsequent to the date on which the managed health care contractor receives the form designated by the managed health care contractor.

**88.23(5) Identification card.** The PHP may issue an appropriate identification card to the enrolled recipient or request the department to do so on its behalf. The identification card shall be issued so that the recipient receives it prior to the effective date of enrollment.

**88.23(6) Assignment methodology.** When no choice is made, the recipient shall be systematically assigned to, between, or among the contracting managed health care providers.

*a. Notification.* Recipients who are assigned to a managed health care provider shall receive notification of the assignment and the name of the provider in a timely fashion prior to the effective date of enrollment.

*b. Limitations.* Contracting providers may specify in the contract a limit to the number of recipients who can be assigned under this subrule. If a specified limitation is attained, the remaining assignment needs in that county shall be met by the other managed health care providers who are contracting with the department in that county.

*c. Household member enrollment.* Inasmuch as persons within a household are allowed to make individual decisions about choosing enrollment in managed health care, it is possible that a case may exist where some household members have made a choice and some have not (so that assignment is required). In these instances, a systematic search of household member choices regarding managed health care option shall be completed. Assignment of those who have made no choice shall be made whenever possible to the managed health care provider with whom the first household member is already enrolled.

*d. Assigned recipients who desire another choice.* Recipients who are assigned to a managed health care provider as described in this subrule shall have at least 30 days in which to request enrollment in a different available managed health care plan. The change of plan is subject to provisions in subrules 88.23(4) and 88.24(2) dealing with effective date.

#### **441—88.24(249A) Disenrollment.**

**88.24(1) *Disenrollment request.*** An enrolled recipient may request disenrollment at any time. In voluntary counties, this request shall be approved and acted upon within ten days of receipt without requiring the recipient to demonstrate good cause. In mandatory counties as defined at subrule 88.23(3), the disenrollment shall not be acted upon by the health care contractor unless the request includes an alternate choice of managed health care.

**88.24(2) *Effective date.*** Disenrollment will be effective no later than the first day of the second calendar month after the month in which the department receives a request for disenrollment. The recipient will remain enrolled in the PHP and the PHP will be responsible for services covered under the contract until the effective date of disenrollment which will always be the first day of a month.

**88.24(3) *Disenrollment process.*** If the recipient is requesting disenrollment, the recipient shall complete the choice form designated by the managed health care contractor which can be obtained through the PHP, the county office, or the managed health care contractor. If the PHP receives a request from the recipient, the PHP shall forward the form to the managed health care contractor within three working days. If the recipient must show good cause for disenrollment, the determination as to whether disenrollment shall occur shall be made by the managed health care review committee within 30 days. If the recipient or the PHP disagrees with the decision of the review committee, an appeal may be filed under the provisions of 441—Chapter 7. If the PHP is requesting disenrollment, the PHP shall complete Form 470-2169, Managed Health Care Provider Request for Disenrollment. If the county office receives a completed Form 470-2169 from the managed health care provider, the county office shall forward the form to the managed health care review committee within three working days.

*a. Request for disenrollment by the recipient.* In voluntary counties, the request shall be approved and acted upon within ten days of receipt by the managed health care contractor. In mandatory counties, a request for disenrollment shall be denied unless a choice of another managed health care provider is requested simultaneously or good cause can be demonstrated to the review committee. Examples of good cause include services received which were untimely, inaccessible, of insufficient quality, or inadequately provided by all of the contracting managed health care providers in the recipient's county of residence. If the recipient has not experienced the above conditions in all the other available managed health care programs, enrollment in one of the alternative managed health care programs shall be a condition of approving disenrollment.

*b. Request for disenrollment by the PHP.* With prior approval of the managed health care review committee, a request for disenrollment of an enrolled recipient may be approved when:

- (1) There is evidence of fraud or forgery in the use of PHP services or in the choice for PHP services.
- (2) There is evidence of unauthorized use of the PHP identification card.

(3) Upon documentation, the PHP has been unable after reasonable efforts to establish or maintain a satisfactory physician-patient relationship with the recipient.

**88.24(4) *Disenrollments by the department.*** Disenrollments will occur when:

- a. The contract between the department and the PHP is terminated.
- b. The recipient becomes ineligible for Medicaid. If the recipient becomes ineligible and is later reinstated to Medicaid, enrollment in the PHP will also be reinstated.
- c. The recipient permanently moves outside the PHP's enrollment area.
- d. The recipient transfers to an eligibility group excluded from PHP enrollment. See definition of recipient in rule 441—88.21(249A).
- e. The department has determined that participation in the HIPP (Health Insurance Premium Payment) program as described in rule 441—75.21(249A) is more cost-effective than enrollment in managed health care.

**88.24(5) *No disenrollment for health reasons.*** No recipient shall be disenrolled from a PHP because of an adverse change in health status.

**441—88.25(249A) Covered services.**

**88.25(1) *Amount, duration, and scope of services.*** Except as provided for in the contract, PHPs shall cover as a minimum all services covered by the Medicaid program as set forth in 441—Chapter 78.

**88.25(2) *Mandatory services.***

a. Although the contract may specify additional services covered (with the exception of those defined in 88.25(3)), the PHP shall cover as a minimum the following services:

- (1) Inpatient hospital services.
- (2) Outpatient hospital services.
- (3) Physician services.
- (4) Family planning services.
- (5) Home health agency services.
- (6) Laboratory and X-ray services.
- (7) Early periodic screening, diagnosis and treatment for persons under age 21.
- (8) Rural health clinic services (where available).
- (9) Advanced registered nurse practitioners.

b. PHPs shall attempt to subcontract with all local family planning clinics funded by Title X moneys and all maternal and child health centers funded by Title V moneys.

c. According to the Consolidated Omnibus Budget Reconciliation Act of 1985, Public Law 99-272, recipients enrolled in managed health care options (including PHPs) may seek family planning services anywhere without referral, even if they are minors. The PHP must pay any claims submitted by a provider of family planning services when the service has been provided to a recipient in a month for which a capitation rate has been paid on the recipient's behalf to the PHP by the department.

**88.25(3) *Excluded services.*** Unless specifically included in the contract, PHPs will not be required to cover long-term care (skilled nursing facilities, intermediate care facilities, residential care facilities, state resource centers, or intermediate care facilities for the mentally retarded), inpatient psychiatric care provided at the state-administered mental health institutes, services provided by the area education agencies, services provided at specialized adolescent psychiatric facilities, day treatment and partial hospitalization services for persons aged 20 or under, or the enhanced services provided to certain eligible recipients. Reimbursement to recipients for nonemergency medical transportation as described at rule 441—78.13(249A) will not be covered by the PHP; the department will continue to reimburse through its fee-for-service methodology for this service.

**88.25(4) *Restrictions and limitations.*** If the PHP covers a type of service which is also covered under Medicaid, the PHP may not impose any restrictions or limitations on that service more stringent than those applicable in Medicaid according to the provisions at 441—Chapter 78. The PHP may, at its discretion, offer services to its enrolled recipients beyond the scope of Medicaid as defined at 441—Chapter 78.

**88.25(5) Recipient use of PHP services.** An enrolled recipient must utilize PHP participating providers of service. No payment by the PHP will be made for services provided by non-PHP providers if the same type of service is available through the PHP under its contract with the department except as provided in subrule 88.25(2) “c,” and rule 441—88.26(249A).

**441—88.26(249A) Emergency services.**

**88.26(1) Availability of services.** The PHP will ensure that the services of a primary care physician are available on an emergency basis 24 hours a day, seven days a week, either through the PHP’s own providers or through arrangements with other providers. In addition, the PHP must provide payment to nonparticipating providers within 60 days of receipt of the bill for all contracted services furnished by providers which do not have contractual arrangements with the PHP to provide services but which were needed immediately because of an injury or illness and in which case the illness or injury did not permit a choice of provider.

**88.26(2) PHP payment liability.** PHP payment liability on account of injury or emergency illness is limited to emergency care required before the recipient can, without medically harmful consequences, return to the enrollment area or to the care of a provider with whom the PHP has arrangements to provide services. If an ambulance is necessary to transport the recipient to follow-up treatment, the PHP shall be financially liable. Benefits for continuing the follow-up treatment are provided only in the PHP’s enrollment area.

If an enrolled recipient is injured or becomes ill and receives emergency services outside the PHP’s enrollment area, the PHP shall pay the facility or person who provided the emergency care for emergency medical services and medical services, for inpatient hospital services in a general hospital as a result of the emergency, and for emergency ambulance service.

**88.26(3) Notification and claim filing time span.** The PHP may set notification and claim filing time limitations in the event of the provision of care by nonparticipating providers. However, failure to give notice or to file claims within those time limitations will not invalidate any claim if it can be shown that it was not reasonably possible to give the notice and that notice was, in fact, given as soon as was reasonably possible.

**441—88.27(249A) Access to service.**

**88.27(1) Choice of provider.** Recipients will have the opportunity to choose their health care professionals to the extent possible and medically appropriate from any of the PHP providers participating in the Medicaid contract.

**88.27(2) Medical service delivery sites.** Medical service delivery sites shall have the following specific characteristics:

- a. Be located within 30 miles of and be accessible from the personal residences of enrolled recipients.
- b. Have sufficient staff resources to adequately provide the medical services for which the contract is in effect including physicians with privileges at one or more acute care hospitals.
- c. Have arrangements for services to be provided by other providers where in-house capability to serve specific medical needs does not exist.
- d. Meet the applicable standards for participating in the Medicaid program.
- e. Be in compliance with all applicable local, state, and federal standards related to the service provided as well as those for fire and safety.

**88.27(3) Adequate appointment system.** The PHP shall have procedures for the scheduling of patient appointments which are appropriate to the reason for the visit as follows:

- a. Patients with urgent nonemergency needs shall be seen within one hour of presentation at a PHP medical service delivery site.
- b. Patients with persistent symptoms shall be seen within 48 hours of reporting of the onset of the persistent symptoms.
- c. Patient routine visits shall be scheduled within four to six weeks of the date the patient requests the appointment.

d. Scheduling of appointments shall be by specific time intervals and not on a block basis.

**88.27(4) Adequate after hours call-in coverage.** The PHP must have in effect the following arrangements which provide for adequate after hours call-in coverage:

a. Twenty-four-hour-a-day telephone coverage shall exist.

b. If a physician does not respond to the initial telephone call, there must be a written protocol specifying when a physician must be consulted. Calls requiring a medical decision shall be forwarded to the on-call physician and a response to each call which requires a medical decision must be provided within 30 minutes.

c. Notations shall be made in the patient's medical record of relevant information related to an after-hours call.

**88.27(5) Adequate referral system.** The PHP must effect the following arrangements which provide for an adequate referral system:

a. A network of referral sources for all services which are covered in the contract, but not directly provided by the PHP.

b. Procedures for the return of relevant medical information from referral sources including review of information by the referring physicians, entry of information into the patient's medical record, and arrangements for periodic reports from ongoing referral arrangements.

c. A notation in the medical record for hospitals' patients indicating the reason, date, and duration of hospitalization and entry of pertinent reports from the hospitalization and discharge planning in the medical record.

#### **441—88.28(249A) Grievance procedures.**

**88.28(1) Written procedure.** The PHP must have a written procedure by which enrolled recipients may express grievances, complaints, or recommendations, either individually or as a class and which:

a. Is approved by the department prior to use.

b. Acknowledges receipt of a grievance to the grievant.

c. Sets time frames for resolution including emergency procedures which are appropriate to the nature of the grievance and which require that all grievances shall be resolved within 30 days.

d. Ensures the participation of persons with authority to require corrective action.

e. Includes at least one level of appeal.

f. Ensures the confidentiality of the grievant.

**88.28(2) Written record.** All grievances, including all informal or verbal complaints, which must be referred or researched for resolution must be recorded in writing. A log of the grievances must be retained and made available at the time of audit and must include progress notes and method of resolution.

**88.28(3) Information concerning grievance procedures.** The PHP's written grievance procedure must be provided to each newly enrolled recipient not later than the effective date of coverage.

**88.28(4) Appeals to the department.** A recipient who has exhausted the grievance procedure of the PHP may appeal the issue to the department under the provisions of 441—Chapter 7. Instances where the substance of the grievance relates to department policy shall be appealed directly to the department.

**88.28(5) Periodic report to the department.** The PHP shall make quarterly reports to the department summarizing grievances and resolutions as specified in the contract.

#### **441—88.29(249A) Records and reports.**

**88.29(1) Medical records system.** The PHP shall comply with the provisions of rule 441—79.3(249A) regarding maintenance and retention of clinical and fiscal records and, in addition, the PHP must maintain a medical record system which:

a. Identifies each medical record by the departmentally assigned state identification number.

b. Identifies the location of every medical record.

c. Places medical records in a given order and location.

d. Provides a specific medical record on demand.

e. Maintains the confidentiality of medical records information and releases the information only in accordance with established policy pursuant to subrule 88.29(3).

- f.* Maintains inactive medical records in a specific place.
- g.* Permits effective professional review in medical audit processes.
- h.* Facilitates an adequate system for follow-up treatment including monitoring and follow-up of off-site referrals and inpatient stays.
- i.* Meets state and federal reporting requirements applicable to PHPs.

**88.29(2) *Content of individual medical record.*** The PHP must have in effect arrangements which provide for an adequate medical record-keeping system which includes a complete medical record for each enrolled recipient in accordance with provisions set forth in the contract.

**88.29(3) *Confidentiality of records.*** PHPs must maintain the confidentiality of medical record information and release the information only in the following manner:

*a.* All medical records of enrolled recipients shall be confidential and shall not be released without the written consent of the enrolled recipients or the responsible party acting on behalf of the enrolled recipient.

*b.* Written consent is not required for the transmission of medical record information to physicians, other practitioners, or facilities which are providing services to enrolled recipients under a subcontract with the PHP. This provision also applies to specialty providers who are retained by the PHP to provide services which are infrequently used or are of an unusual nature.

*c.* Written consent is not required for the transmission of medical record information to physicians or facilities providing emergency care pursuant to rule 441—89.26(249A).

*d.* Written consent is required for the transmission of medical record information of a former enrolled recipient to any medical provider not connected with the PHP.

*e.* The extent of medical record information to be released in each instance shall be based upon tests of medical necessity and a “need to know” on the part of the practitioner or facility requesting the information.

*f.* Medical records maintained by subcontracting providers must meet the requirements of this rule.

**88.29(4) *Reports to the department.*** Each PHP shall submit reports to the department as follows:

*a.* Annual audited financial statements no later than 120 days after the close of the PHP’s fiscal year.

*b.* Periodic financial, utilization, and statistical reports as required by the department under the contract.

**88.29(5) *Audits.*** The department or its designee and the U.S. Department of Health and Human Services (HHS) may evaluate through inspections or other means, the quality, appropriateness, and timeliness of services performed by the PHP. The department or HHS may audit and inspect any records of a PHP, or the subcontractors of a PHP, which pertain to services performed and the determination of amounts paid under the contract. These records will be made available at times, places, and in a manner as authorized representatives of the department, its designee, or HHS may request.

#### **441—88.30(249A) Marketing.**

**88.30(1) *Marketing procedures.*** All marketing plans, procedures, and materials used by the PHP must be approved in writing by the department prior to use. Random door-to-door marketing of low-income families or the offering of financial incentives will not be approved.

**88.30(2) *Marketing representatives.*** Marketing representatives utilized to market Medicaid recipients must be sufficiently trained and capable of performing marketing activities within the requirements of the contract. The PHP’s marketing representatives must represent the PHP in an honest and straightforward manner. In its marketing presentations, the PHP must include information which ensures that the representative is not mistaken for a department employee. Marketing presentations which intentionally belittle or maliciously downplay the benefit package, services, or providers of another participating managed health care option will not be approved.

**88.30(3) *Marketing presentations.*** The PHP may make marketing presentations in the local office(s) of the department or otherwise include the department in marketing efforts at the discretion of the department.

**88.30(4) *Marketing materials.*** Written material must include a marketing brochure or a member handbook which fully explains the services available, how and when to obtain them, and special factors applicable to enrolled recipients as specified in the contract.

**441—88.31(249A) Patient education.**

**88.31(1) *Use of services.*** The PHP shall have procedures in effect to orient enrolled recipients in the use of services the PHP is contracting to provide. This includes what to do if the recipient requires medical care while out of the enrollment area, a 24-hour-a-day telephone number, appropriate use of the referral system, grievance procedures, and how emergency treatment is to be provided.

**88.31(2) *Patient rights and responsibilities.*** The PHP shall have in effect a written statement of patient rights and responsibilities which is available upon request as well as issued to all new enrolled recipients. This statement may be part of an informational brochure provided to all new enrollees. The right of the enrolled recipient to request disenrollment must be included.

**441—88.32(249A) Payment to the PHP.**

**88.32(1) *Capitation rate.*** In consideration for all services rendered by a PHP under a contract with the department, the PHP will receive a payment each month for each enrolled recipient. This capitation rate represents the total obligation of the department with respect to the costs of medical care and services provided to enrolled recipients under the contract.

**88.32(2) *Determination of rate.*** The capitation rate is actuarially determined by the department for the beginning of the new fiscal year using statistics and data about Medicaid fee-for-service expenses for PHP-covered services to a similar population during the preceding fiscal year. (For example, fiscal year 1990 rates are predicted with fiscal year 1988 dates of service for Medicaid fee-for-service expenditures.) The capitation rate may not exceed the cost to the department of providing the same services on a fee-for-service basis to an actuarially equivalent nonenrolled population group. A 1 percent incentive will be available to PHPs who contract to cover all services except those specified in subrule 88.25(3). PHPs electing to share risk with the department will have their payment rates reduced by an amount reflecting the department's experience for high cost fee-for-service recipients.

**88.32(3) *Amounts not included in rate.*** The capitation rate does not include any amounts for the recoupment of losses suffered by the PHP for risks assumed under the current or any previous contract. The PHP accepts the rate as payment in full for the contracted services. Any savings realized by the PHP due to lower utilization from a less frequent incidence of health problems among the enrolled population shall be wholly retained by the PHP.

**88.32(4) *Third-party liability.*** If an enrolled recipient has health coverage or a responsible party other than the Medicaid program available for purposes of payment for medical expenses, it is the right and responsibility of the PHP to investigate these third-party resources and attempt to obtain payment. The PHP shall retain all funds collected through third-party sources. A complete record of all income from these sources must be maintained and made available to the department.

**441—88.33(249A) Quality assurance.** The PHP shall have in effect an internal quality assurance system that meets the requirements of 42 CFR 434.44 as amended to December 31, 1996, and a system of periodic medical audits meeting the requirements of 42 CFR 434.53 as amended to December 13, 1990.

**441—88.34 to 88.40** Reserved.

DIVISION III  
MEDICAID PATIENT MANAGEMENT

**441—88.41(249A) Definitions.**

*“Contract”* shall mean a contract between the department and a Medicaid-participating provider or clinic as specified in rule 441—88.44(249A) and subrule 88.45(1) for the purpose of providing patient management to enrolled recipients.

“*Covered eligibles*” shall mean those groups of Medicaid-eligible recipients specified in subrule 88.42(1) who are eligible to receive services under patient management.

“*Department*” shall mean the Iowa department of human services.

“*Designee*” shall mean an organization designated by the department of human services to act on behalf of the department in the administration of Medicaid managed health care.

“*Eligible providers*” shall mean those providers specified in rule 441—88.44(249A) and subrule 88.45(1) with whom the department may contract to be patient managers.

“*Emergency care*” shall mean those medical services rendered for an emergent medical condition or protection of the public health.

“*Emergent medical condition*” shall mean a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect it to result in:

1. Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,
2. Serious impairment to bodily functions, or
3. Serious dysfunction of any bodily organ or part.

The determination of whether an emergent medical condition exists shall be decided by a medical professional and shall be based on the patient’s medical condition including presenting symptoms and medical history (as related to severe pain) prior to treatment.

In cases where the above criteria are satisfied, no prior authorization procedures are allowed.

“*Enrolled recipient*” shall mean a covered eligible who has been enrolled with a patient manager according to procedures set forth in rule 441—88.46(249A).

“*Extended-participation program*” shall mean mandatory six-month enrollment period with a managed care entity.

“*Grievance*” shall mean a complaint expressed verbally or in writing by an enrolled recipient or provider relative to services under patient management. A grievance at the informal level is one which can be resolved by short-term intervention on the part of the department or its designee via the toll-free managed health care telephone line or through informational correspondence. A formal grievance is one which must be taken to another level for quality of care or policy determination.

“*Managed care entity*” shall mean either a managed care organization licensed by the department of insurance (e.g., HMO or PHP) or a primary care case management program (i.e., MediPASS).

“*Managed health care*” shall mean any of the options for alternative delivery of Medicaid services that provides coordinated delivery of health care. The current options offered by the department are Medicaid patient management, known as MediPASS, health maintenance organization (HMO) enrollment and prepaid health plan (PHP) enrollment.

“*Managed health care review committee*” shall mean a committee composed of representatives from the department and its designee. The committee shall review and render decisions on all requests for disenrollment from managed health care that are not automatically approvable, all requests for exception to eligible provider provisions, and other exceptions to managed health care procedures.

“*Mandatory enrollment*” shall mean a mandatory participation in managed health care as specified in subrule 88.46(1).

“*Mandatory project county*” shall mean a county where the department has contracts with more than one managed care entity, one of which may be primary care case management (MediPASS) in cases where the number of MediPASS providers willing to serve as patient managers is sufficient to meet the needs and makeup of the recipient population in the county, or where the department has implemented the MediPASS program alone in the county.

“*Managed services*” shall mean services as specified in subrule 88.48(1) that require preauthorization from the patient manager in order to be payable by Medicaid.

“*Medical service area*” means a geographic area within which recipients must reside in order to enroll in the managed health care MediPASS option.

“*MediPASS*” shall mean Medicaid patient access to service system and shall be the acronym used to identify the Medicaid patient management program.

“*Nonmanaged services*” shall mean services as specified in subrule 88.48(2) that do not require authorization by the patient manager in order to be payable by Medicaid.

“*Patient management*” shall mean the provision of services to enrolled recipients by a patient manager in accordance with the contract.

“*Patient manager*” shall mean an eligible provider who has signed a contract with the department to perform patient management for enrolled recipients.

“*Urgent care*” shall mean those medical services rendered for an urgent medical condition or protection of the public health.

“*Urgent medical condition*” shall mean a medical condition manifesting itself by acute symptoms that are of lesser severity (including severe pain) than that recognized for an emergent medical condition, such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the illness or injury to result in:

1. Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in jeopardy,
2. Impairment to bodily functions, or
3. Dysfunction of any bodily organ or part.

If the recipient is assigned to a patient manager (e.g., MediPASS or HMO), the patient manager shall arrange for necessary care within 24 hours by either providing it or referring and authorizing another appropriate provider to provide care.

#### **441—88.42(249A) Eligible recipients.**

**88.42(1) *Included categories of assistance.*** All categories of Medicaid-eligible recipients except those specified as excluded in subrule 88.42(2) are required to participate in Medicaid managed health care if they reside in a mandatory project county as described in subrule 88.43(1). Recipients who reside in a voluntary project county as described in subrule 88.43(2) may participate if they so choose.

A choice to enroll in any other form of Medicaid managed health care available in the recipient’s county of residence shall fulfill the requirements to participate in mandatory project counties.

**88.42(2) *Excluded categories of assistance.*** The following categories of Medicaid-eligible recipients shall not be allowed to participate in Medicaid patient management in either mandatory or voluntary project counties:

- a. Medically needy recipients as defined in 441—subrule 75.1(35).
- b. Recipients over age 65 and under age 21 in psychiatric institutions as defined in 441—Chapter 85.
- c. Recipients who are supplemental security income-related case members.
- d. Rescinded IAB 10/3/01, effective 12/1/01.
- e. Automatic redetermination recipients as defined in rule 441—76.11(249A).
- f. Recipients who are foster care and subsidized adoption-related case members.
- g. Recipients who are Medicare beneficiaries.
- h. Pregnant women who are determined presumptively eligible in accordance with provisions in 441—subrule 75.1(30).
- i. Recipients who are Native American Indians or Alaskan natives.
- j. Recipients who are receiving services from a Title V provider.

#### **441—88.43(249A) Project area.**

**88.43(1) *Designation as a mandatory project county.*** The department shall designate mandatory enrollment counties included in the project. In order for a county to be considered a mandatory project county, the number of MediPASS providers willing to serve as patient managers shall be sufficient to meet the needs of the size and makeup of the recipient population in the county, and the county shall be included in the department’s freedom of choice waiver from the Centers for Medicare and Medicaid Services.

**88.43(2) *Voluntary project counties.*** The department shall designate voluntary enrollment counties included in the project. A county may be voluntary where provider participation is not sufficient to be designated mandatory but providers may choose to participate on a voluntary enrollment basis.

**88.43(3) *Expansion to other counties.*** Rescinded IAB 11/10/93, effective 11/1/93.

**441—88.44(249A) Eligible providers.**

**88.44(1) *Specialties allowed.*** Providers shall be allowed to contract with the department to provide patient management to enrolled recipients as long as the provider:

*a.* Is a licensed doctor of medicine or osteopathy or an advanced registered nurse practitioner licensed pursuant to Iowa Code chapter 152 and possessing evidence of certification pursuant to board of nursing rules under 655—Chapter 7 in a specialty area listed in paragraph 88.44(1)“*d.*”

*b.* Is otherwise eligible to enroll as an Iowa Medicaid provider.

*c.* Is a provider in good standing with the Medicaid agency as defined in subrule 88.45(1).

*d.* Is practicing in one of the following specialties in the medical services area:

(1) Family practice.

(2) General practice.

(3) Pediatrics.

(4) Internal medicine.

(5) Obstetrics and gynecology.

**88.44(2) *Clinic or group practice participation.*** A provider may participate as an individual practitioner or as a partner or employee of a clinic or group practice. The clinic or group shall be the contractor. Federally qualified health centers and rural health clinics that employ providers in the specialties specified in subrule 88.44(1) may contract. However, each provider participating within the clinic, group, federally qualified health center, or rural health clinic shall sign and be bound by the terms of the clinic or group contract as if the provider was in individual practice.

**88.44(3) *Exceptions.*** Other providers licensed as doctors of medicine or osteopathy or as advanced registered nurse practitioners may request exception to subrule 88.44(1) for specific individual patients in accordance with the procedures set forth in this subrule.

*a.* If the request is being made in order to allow a different type of specialist to be a patient manager, or to allow a provider practicing outside the recipient’s medical service area to serve the recipient, the provider shall make a written request to the department.

(1) The request shall identify the provider by name, address, telephone number, specialty, and Medicaid provider number, indicating the practice location, or date of application to be a Medicaid provider. The request shall specify the members in question and state agreement to provide primary care and patient management as specified in subrule 88.45(2) to those members.

(2) If the request comes initially from the recipients as specified in paragraph 88.46(2)“*c.*” the department shall contact the provider in question to offer the provider the opportunity to request the exception.

*b.* Rescinded IAB 11/10/93, effective 11/1/93.

*c.* Rescinded IAB 11/10/93, effective 11/1/93.

*d.* The managed health care review committee shall consider the request and respond within ten working days of receipt of the request. If the request is approved, a contract will be forwarded to the physician and procedures for contracting with a physician as specified in rule 441—88.45(249A) shall be followed.

*e.* The following factors shall be taken into account when considering the physician’s request:

(1) Mutual agreement between physician and patient regarding the arrangement.

(2) Existence of an already established physician-patient relationship.

(3) Transportation barriers, if requesting a patient manager outside the medical service area.

(4) Customary practice by the specialist to provide primary care.

(5) A new medical condition which necessitates the proposed physician-patient relationship.

**441—88.45(249A) Contracting for the provision of patient management.**

**88.45(1) Eligibility to contract.** Only Medicaid-participating providers and clinics in good standing shall be eligible to contract with the department to provide patient management.

**88.45(2) Contract provisions.** The department shall enter into a contract arrangement with all providers who are eligible as specified in rule 441—88.44(249A) and who wish to provide patient management. Form 470-2615, Agreement for Participation as a Primary Care Physician Patient Manager in the Medicaid Patient Access to Service System, shall be the form designated as the contract. At a minimum, the contract shall include provisions as follows:

*a.* The patient manager shall provide managed health care to enrolled recipients by providing primary health care and providing or referring the patient appropriately and authorizing payment for all other care covered under the program as specified in subrule 88.48(1). The patient manager is also responsible for monitoring and coordinating all covered care.

*b.* The patient manager shall provide or arrange for 24-hour-per-day, seven-day-per-week provider availability to enrolled recipients.

*c.* The patient manager shall maintain records that at a minimum:

(1) Identify the patient as a patient management recipient.

(2) Document all authorizations for medical services provided by other providers and the extent of those authorizations.

(3) Contain the name, state identification number, age, sex and address of the patient.

(4) Document services provided and where and by whom they are provided.

(5) Contain medical diagnosis, treatment, therapy and drugs prescribed or administered.

(6) Contain the name of the person making the entry and the date of the contact.

*d.* The patient manager shall review and take action upon periodic utilization review reports, according to instructions that the department will provide each patient manager.

*e.* The department shall specify the fees and method of payment to patient managers.

*f.* The department shall specify the manner in which providers shall be notified of the recipients enrolled with them.

**88.45(3) Contract compliance.** The department shall put into place procedures for the monitoring of contract compliance on the part of patient managers to ensure appropriate access to adequate quality care. Those procedures may include, but are not limited to, on-site review of medical records by appropriate professional medical personnel and review of utilization patterns of participating patient managers. The procedures shall also include establishment of a grievance procedure defined in rule 441—88.49(249A).

**88.45(4) Corrective action and sanctions.** The department shall establish procedures for corrective action and sanctions when monitoring activities reveal possible contract noncompliance.

**88.45(5) Termination of contract.** The contract may be terminated in any of the following ways:

*a.* The patient manager may terminate the contract or a clinic may remove a provider from a clinic contract by providing the department with written notice of the desire to terminate the contract 60 days in advance of the desired date of termination in order to allow the department or its designee time to disenroll and reenroll the MediPASS patients with other patient managers.

(1) In no situation shall the provider stop providing patient management or primary care to the patient until the patient can be reenrolled with another provider except as specified in subrule 88.48(4).

(2) Failure to provide the specified period of notice or failure to continue providing patient management or primary care before the reenrollment shall result in forfeiture of all remaining patient management fees that would otherwise have been due the patient manager.

*b.* The department may terminate the contract with the patient manager with 60 days' advance notice for any of the following reasons:

(1) The department has imposed any sanction described at 441—subrule 79.2(3).

(2) Recommendations of contract termination made in accordance with the procedures described in rule 441—88.51(249A), after opportunity for corrective action has been unsuccessful or rejected by the patient manager in question.

Sixty days' advance notice is not required for situations described in subrule 88.48(4).

c. Any patient manager who has had a contract terminated by the department shall have the right to appeal the termination as provided in 441—Chapter 7.

**441—88.46(249A) Enrollment and changes in enrollment.**

**88.46(1) *Mandatory enrollment.*** Participation in managed health care, if available, is required for covered eligibles as specified in subrule 88.42(1) who reside in a mandatory project county. The department shall require, whenever administratively feasible, that all eligible recipients enroll with a managed care entity. Administrative feasibility is determined by whether a freedom-of-choice waiver or state plan amendment has been approved by the Centers for Medicare and Medicaid Services and whether the managed care entities demonstrate sufficient access to and quality of services.

**88.46(2) *Enrollment procedures.*** In mandatory enrollment counties, recipients shall be required to choose their managed health care provider. When no choice is made by the recipient, the recipient will be assigned to a contracting health maintenance organization (HMO) serving the recipient's county of residence when an HMO is available or to a MediPASS patient manager on a rotating basis to ensure an equitable distribution between the HMO and MediPASS programs based on the number of managed health care options (MediPASS and HMOs) available in the county. In the event there is no contracting HMO serving the recipient's county of residence in a mandatory enrollment county, the recipient shall be assigned to a MediPASS patient manager.

Within the MediPASS option, recipients shall be assigned according to age appropriateness. Whenever possible, family units shall be assigned to the same provider that an enrolled family member has selected, if that provider is appropriate according to age parameters. MediPass patient managers shall not be assigned more recipients than their self-imposed maximum or the maximum described in subrule 88.46(5), whichever is lower.

Recipients who are assigned a managed care entity as described in this subrule shall have at least ten days in which to request enrollment in a different available entity. The change is subject to provisions in subrule 88.46(4) dealing with the effective date.

a. *Timely notice.* Recipients shall be sent timely notice of the managed health care assignment. The recipient shall have a minimum of ten days in which a change to the assigned managed care entity can be made. The notice shall include the name of the managed care entity to whom the recipient shall be assigned if the recipient does not make a different selection by the date specified in the notice. If the covered eligible does not make a selection before the due date, the recipient shall be enrolled with the managed care entity listed on the notice.

b. *Enrollment.* Enrollment in managed health care shall be discussed during the face-to-face interview with all applicants for Medicaid under covered categories of assistance in mandatory or voluntary enrollment areas. The applicant shall be shown an informational videotape and encouraged to make a selection of a managed care entity. Applicants in mandatory enrollment areas shall be informed that should the applicant become eligible for a managed health care selection, one shall be assigned. Covered eligibles who are not enrolled shall be sent a notice of their managed health care assignment when the recipient:

- (1) Attains initial eligibility for a covered category of service in a mandatory project county.
- (2) Changes from an excluded category of assistance to a covered category of assistance in a mandatory project county.
- (3) Is receiving a covered category of assistance and moves from a county where no managed health care is available or voluntary project county to a mandatory project county.
- (4) Reattains eligibility.
- (5) Has a new member of the household receiving a covered category of assistance.

If the covered eligible in a mandatory project county does not make another selection before the due date specified in the notice, the covered eligible shall be enrolled with the managed health care provider listed on the notice.

c. *Selection of a managed health care provider.* A list of managed health care providers participating in managed care entities serving the county shall be available to recipients for use in selecting a provider. If the recipient wishes to request an exception to the list of available managed

health care providers as described in subrule 88.44(3), the managed health care review committee shall make a determination on the exception request. While the determination is being made, the recipient's enrollment shall be placed in a pending status.

*d. Rescinded IAB 5/7/97, effective 7/1/97.*

*e. Request to change enrollment.* An enrolled recipient may, within 90 days from timely notice, request to change enrollment from one managed health care provider to another or one managed care entity to another. The request shall be made on a choice form designated by the department, in writing, or by telephone call to the toll-free recipient managed health care telephone line maintained by the department. Changes are subject to the provisions of subrule 88.46(3) dealing with effective date.

*f. Managed care entity extended-participation program (EPP).* After the initial 90 days from timely notice, recipients will remain enrolled with the chosen provider for the following six months, with three exceptions:

- (1) A request for disenrollment by recipient for good cause pursuant to paragraph 88.4(3) "a."
- (2) A request for disenrollment by provider for good cause pursuant to paragraph 88.4(3) "b."
- (3) Availability of a new, previously unavailable, managed care entity. In this instance recipients will be allowed to select that entity for the remainder of the current EPP period.

*g. Enrollment cycle.* Prior to the end of any extended-participation program (EPP) period, recipients will be notified of their ability to enroll with a different managed care option. A change in enrollment or failure to change enrollment will begin a new EPP enrollment period at the end of the current EPP.

**88.46(3) Voluntary enrollment procedures.** Voluntary enrollment procedures shall be the same guidelines as mandatory enrollment procedures except:

- a.* Recipients shall not be informed at the face-to-face interview that enrollment is required.
- b.* Notice to recipient shall not include assignment language.
- c.* Recipients shall not be assigned if no selection is made voluntarily.
- d.* A managed health care provider must be available for enrollment.

**88.46(4) Effective date.** Enrollment or changes in enrollment shall always be effective on the first day of a month. The effective date of enrollment shall be no later than the first day of the second month subsequent to the date the department or its designee receives a choice as specified in subrules 88.46(1) and 88.46(2) or the deadline given a recipient to indicate the recipient's managed health care choice, whichever is applicable. The effective date shall be earlier where computer cutoff allows.

**88.46(5) Identification card.** The department shall issue Form 470-1911, Medical Assistance Eligibility Card, to all enrolled recipients.

Providers of medical services shall access the department's eligibility verification system (ELVS) via telephone or access the department's secure Web site at the time of service in order to establish that the patient is Medicaid-eligible and whether the services being provided require the authorization of the patient manager.

**88.46(6) Enrollment limits.**

*a.* Unless one or more of the following special situations exist, enrollment shall be limited to 1500 enrollees per full-time patient manager with an additional 300 enrollees allowed for each full-time nurse practitioner or physician's assistant employed by the MediPASS provider or clinic:

- (1) The provider treats a disproportionate share of Medicaid patients in the provider's current practice.
- (2) A special group practice arrangement exists with a demonstrated ability to manage a large number of enrollees.
- (3) Other exceptional situations may be considered as special demonstration projects on a case-by-case basis.

*b.* Patient managers wishing to receive consideration for one of these special situations must make a request for consideration in writing to the department and provide sufficient documentation that they fit one or more of the special situations.

c. Providers or clinics may set a lower self-imposed maximum number of enrollees at the time they sign the initial contract and may revise that number by notifying the department or its designee in writing.

(1) If the patient manager decreases the patient manager's own maximum to a number below which the patient manager currently has enrolled, the patient manager must continue to serve those recipients until normal disenrollments put the provider below the provider's new maximum.

(2) No minimum number of enrollees shall be required.

**88.46(7) Reinstatement of patient management status.** When an enrolled recipient loses Medicaid eligibility and is subsequently reinstated before the effective date of cancellation, the enrollment in patient management will also be reinstated.

**441—88.47(249A) Disenrollment.**

**88.47(1) Disenrollment request.** An enrolled recipient may be disenrolled from a patient manager in one of three ways:

a. The enrolled recipient may request disenrollment by completing a choice form designated by the department, in writing, or by telephone call to the toll-free recipient managed health care telephone line maintained by the department at any time prior to enrollment with a managed health care entity and within the 90 days from the date of the enrollment notice. After this time period, a recipient may be disenrolled for good cause when the recipient can demonstrate that services were untimely, inaccessible, of insufficient quality, or inadequately provided. If the recipient is a covered eligible specified in subrule 88.42(1) as a mandatory participant, the recipient's disenrollment request shall not be approved until another patient manager or managed health care option is chosen.

b. The patient manager may request that an enrolled recipient be disenrolled by completing Form 470-2169, Managed Health Care Provider Request for Recipient Disenrollment.

(1) Disenrollment may be approved for good cause, such as but not limited to inability after reasonable effort to establish or maintain a satisfactory provider-patient relationship with the recipient. Documentation of the reason for disenrollment shall be included with or attached to the disenrollment request.

(2) The department shall respond within 30 days as to whether the disenrollment request is approved.

(3) If the request is approved, the patient manager shall continue to serve a mandatory recipient until the recipient can be enrolled with another patient manager or another managed health care option. In no case shall that time exceed 60 days from the date of receipt of the form.

c. The department may disenroll an enrolled recipient in the following situations:

(1) The contract with the patient manager is terminated.

(2) The patient manager dies, retires or leaves the medical service area.

(3) The recipient loses Medicaid eligibility. If the recipient regains eligibility as specified in subrule 88.46(7), the enrollment to patient management will be automatically reinstated.

(4) The recipient moves to a nonproject county.

(5) The recipient's eligibility changes to a category of assistance as specified in subrule 88.42(2) that is excluded from participation in patient management.

(6) The department has determined that participation in the HIPP (Health Insurance Premium Payment) program as described in rule 441—75.21(249A) is more cost-effective than enrollment in managed health care.

(7) The department has determined that the recipient's enrollment in the recipient lock-in program, as defined in 441—Chapter 76, would be more cost-effective for the department.

The department shall request that recipients whose participation is mandatory as specified in subrule 88.42(1) select a new patient manager or other managed health care option if disenrollment is for reasons listed in 88.47(1) "c" (1) or (2). If the recipient does not make the selection the recipient will be assigned a new patient manager by the department.

**88.47(2) Effective date.** Disenrollment shall always be effective on the first day of a month. The effective date of disenrollment shall be no later than the first day of the second month subsequent to the

date the department or its designee receives an enrollment change request as specified in subrule 88.47(1) or the date the department approves a disenrollment request from a physician or the date the department becomes aware of an event which causes the department to disenroll an enrolled recipient, whichever is applicable. The effective date shall be earlier whenever possible.

**441—88.48(249A) Services.**

**88.48(1) *Managed services.*** Provision of the following services by any provider other than the patient manager requires authorization from the patient manager in order to be payable by Medicaid except that mental health and substance abuse services for all managed health care recipients are provided under the Iowa Plan program and do not require authorization (see rule 441—88.61(249A)):

- a. Inpatient hospital.
- b. Outpatient hospital.
- c. Home health.
- d. Physician (except services provided by an ophthalmologist).
- e. Clinic (rural health clinic, federally qualified health center, maternal health center, ambulatory surgical center, birthing center).
- f. Laboratory, X-ray.
- g. Medical supplies.
- h. Physical therapy, audiology, rehabilitation agency, advanced registered nurse practitioner.
- i. Rescinded IAB 11/5/97, effective 1/1/98.
- j. Podiatric.

These services require authorization even if the need for the service is considered urgent. However, in case of urgent medical conditions, the patient manager shall arrange for necessary care within 24 hours by either providing it or referring to and authorizing another appropriate provider to provide care.

**88.48(2) *Nonmanaged services.*** Provision of any services not listed in subrule 88.48(1) does not require authorization from the patient manager in order to be payable by Medicaid.

**88.48(3) *Authorizing managed services.*** The patient manager may make referrals to another provider for specialty care or for primary care during the patient manager's absence or nonavailability.

a. No special authorization or referral form is required, and referrals should occur in accordance with accepted practice in the medical community. To ensure that payment is made for properly authorized services, the patient manager shall provide the specialist or other provider with the patient manager's Medicaid provider number (the national provider identifier number or Iowa-specific provider identifier number), which must be entered on the billing form to signify that the service has been authorized.

b. After the patient manager's initial referral of a patient to a specialist for ongoing treatment, the specialist shall not be required to receive further specific authorizations for the duration of the illness, or at the discretion of the patient manager, for a period of time specified by the patient manager.

c. The referral shall include necessary services rendered by the specialist and referrals for related services made by the specialist. With the patient manager's approval, the patient manager's number may be relayed by the referred specialist to other providers considered necessary for proper treatment of the patient. All authorizations and referrals shall be documented by both the patient manager and the referred-to provider in the patient's medical record.

d. Emergency services are excluded from the authorization requirement, even though these services may be ones customarily requiring authorization under patient management. Urgent care requires authorization in order for Medicaid services to be paid. The unauthorized use of a patient manager's authorization number shall be considered to be a false or fraudulent claim submission and may subject the provider to recoupment or to sanctions described at 441—subrule 79.2(3).

**88.48(4) *Special authorizations.*** Special authorization for the provision of managed services shall be given to providers by the department in situations such as, but not limited to, the death of the enrolled recipient's patient manager, the patient manager has left medical practice, moved from the medical service area or has been removed as a Medicaid provider and the department has not yet been able to establish a new patient manager or other managed health care option for the recipient. The procedure for obtaining this special authorization shall be specified in the provider handbook. The

special authorization procedures shall only be used until the department is able to enroll the recipient with another patient manager or managed health care option. Additionally, special authorizations may be given when contracting patient managers fail to comply with contract provisions such as, but not limited to, failure to maintain 24-hour access as specified in subrule 88.45(2), paragraph “b.”

**441—88.49(249A) Grievance procedure.** The department shall establish a procedure whereby enrolled recipients or providers may express complaints or concerns either verbally or in writing specific to managed health care services.

**88.49(1) *Written record.*** The department or its designee shall maintain a written record of all grievances. A log shall be maintained that includes the date of the grievance, member name and state identification number, provider name and national provider identifier number or Iowa-specific provider identifier number, nature of complaint, resolution and date of resolution.

**88.49(2) *Formal grievance resolution and response.*** The department or its designee shall record the facts involved in all grievances. Pertinent facts shall be obtained, as necessary and appropriate, from interviews with involved parties, on-site visits and consultation with professional medical consultants or an education and review committee. The department or its designee shall respond to all grievances within 15 working days of receipt. The response shall be in writing and copies shall be provided to the recipient, the provider and to the department’s patient manager file. Appeal rights shall be included in the response.

**88.49(3) *Repeated grievances.*** Providers or recipients who file repeated grievances, or providers or recipients against whom repeated grievances are filed, will be reviewed in-depth and a possible on-site visit will be made to resolve any misunderstandings as to patient management policies and procedures.

**88.49(4) *Quality of care grievances.*** In grievances involving quality of care, the case shall be referred to appropriate persons or agencies, including the board of medicine, for investigation.

**88.49(5) *Information concerning grievance procedures.*** The department grievance procedure shall be published on appropriate forms and brochures for the information of recipients and in provider handbooks for the information of patient managers and other providers.

**88.49(6) *Appeals to the department.*** A recipient who has exhausted the formal grievance procedure may appeal the issue to the department under the provisions of 441—Chapter 7.

**441—88.50(249A) Payment.**

**88.50(1) *Fee.*** Patient managers shall be paid a monthly fee of \$2 per enrolled recipient for the provision of patient management, including referrals. Payment for other services rendered shall be reimbursed in accordance with rules governing Medicaid payment. Providers such as federally qualified health centers who are reimbursed on a 100 percent of cost basis are not eligible to receive patient management fees separate from other reimbursement.

**88.50(2) *Basis for payment.*** Payment shall be based on the number of recipients enrolled with the patient manager as of automated benefit calculation system cutoff day in the month for which payment is being calculated.

**88.50(3) *Mode of payment.*** The provider shall be paid individually unless a clinic or group practice elects to receive payment for all providers participating under the clinic or group contract. The same mode of payment must be used for both patient management and regular Medicaid claims.

**88.50(4) *Payment limit.*** Payment shall be limited to \$3000 per month per patient manager no matter how many recipients are enrolled with the patient manager.

**441—88.51(249A) Utilization review and quality assessment.** Patient managers shall be monitored to ensure that recipients are able to access quality care and that utilization patterns and costs fall within acceptable standards. If overutilization or underutilization is apparent or quality of management service is inadequate, efforts shall be made to determine the reason and resolve problems, as necessary.

**88.51(1) *Measured services.*** Cost and units of service data will be reviewed for selected categories of service. This data shall be used to monitor overall utilization patterns and compare peer utilization patterns.

**88.51(2) Reports to patient managers.** Utilization information shall be provided on a periodic basis to patient managers to enable them to review their own utilization patterns and to review utilization by their enrollees. Patient managers will be responsible for reporting any discrepancies detected in this information to the department. The patient manager will be responsible for attempting to correct utilization behavior of recipients who appear from utilization reports to be inappropriate utilizers of medical services.

**88.51(3) Managed health care advisory committee.** Participating managed health care providers will be invited to assist the department or its agent in establishing and assessing goals of the state's Medicaid managed health care program. The department shall form a managed health care advisory committee made up of persons deemed appropriate by the department to review, advise and plan managed care goals with the department. Members may include representatives of MediPASS providers, HMO providers, FQHC providers, RHC providers, association representatives, and other public agencies as deemed appropriate by the department. The committee's functions may include, but are not limited to, the following:

*a.* Assist the department in developing procedures and parameters for utilization review and conduct further review of the utilization of patient managers whose pattern of utilization falls outside established parameters.

*b.* Assist the department in establishing options for managed health care quality assessment.

*c.* Assist the department in reviewing and making recommendations for action on quality of service-related grievances under the grievance procedure outlined in rule 441—88.49(249A).

*d.* Assist the department in developing corrective action steps and recommendations for managed health care providers who have identifiable utilization or quality of management service deficiencies.

*e.* Assist the department in developing standards and procedures for managed health care providers to use in performing review functions.

*f.* Prepare or provide educational or informative articles to be used for patient education and health promotion.

**441—88.52(249A) Marketing.** A MediPASS provider may not distribute directly or through any agent or independent contractor marketing materials without the prior approval of the department, and may not distribute marketing materials that contain false or materially misleading information.

**88.52(1) Service market.** A MediPASS provider shall distribute any marketing materials to the entire service area or region.

**88.52(2) Prohibition of "cold-call" marketing.** MediPASS providers shall not, directly or indirectly, conduct door-to-door, telephonic, or other "cold-call" marketing of enrollment.

**441—88.53 to 88.60** Reserved.

DIVISION IV  
IOWA PLAN FOR BEHAVIORAL HEALTH

**441—88.61(249A) Definitions.**

*"Accredited"* shall mean an entity approved by the division of mental health and disability services of the department to provide mental health services.

*"Appeal"* shall mean the process defined in 441—Chapter 7 by which a Medicaid member, or the member's designee, may request review of a certain decision made by the department or the contractor.

*"ASAM-PPC-2R"* shall mean the American Society of Addiction Medicine Patient Placement Criteria for the Treatment of Substance Related Disorders, Second Edition Revised, published by the American Society of Addiction Medicine in 2001.

*"Assertive community treatment (ACT) program"* shall mean a program of comprehensive outpatient services provided in the community directed toward the amelioration of symptoms and the rehabilitation of behavioral, functional, and social deficits of persons with severe and persistent mental disorders and persons with complex symptomatology who require multiple mental health and supportive services to live in the community.

“*Capitation rate*” shall mean the fee the department pays monthly to the contractor for each enrolled Medicaid member for the provision of covered, required, and optional services, whether or not the enrollee received services during the month for which the fee is paid.

“*Certification*” shall mean the process of determining that a facility, equipment or an individual meets the requirements of federal or state law.

“*Clinical decision review*” shall mean the process by which enrollees and participating and nonparticipating providers may request a review by the contractor of a decision made by an employee of the contractor regarding the prior authorization, denial, or payment for services.

“*Contract*” shall mean the contract between the department and the entity or entities selected by the department to implement the Iowa Plan. Contract sections related to Medicaid-funded services shall be interpreted to meet the requirements of the Code of Federal Regulations, Title 42, Part 434 as amended to December 31, 1996. The department of public health also shall be party to the contracts in relationship to the provision of substance abuse services to non-Medicaid persons served through the Iowa Plan.

“*Contractor*” shall mean each entity with whom the department contracts to provide covered, required and optional services for those members enrolled in the Iowa Plan.

“*Coverage group*” shall mean a category of members who meet certain common eligibility requirements.

“*Covered services*” shall mean mental health and substance abuse treatment services reimbursable based on provisions of the Medicaid state plan and paid through the fee-for-service payment system administered by the Iowa Medicaid enterprise.

“*Department*” shall mean the Iowa department of human services acting in cooperation with the department of public health for governance of the contract.

“*Designee*” shall mean an organization, person, or group of persons designated by the director to act on behalf of the department in the review or evaluation of services provided through the Iowa Plan.

“*Director*” shall mean the director of the Iowa department of human services.

“*Disenrollment*” shall mean the removal of an enrollee from the contractor’s enrollment list either through loss of eligibility or some other cause.

“*Emergency services*” shall mean those services required to meet the needs of an enrollee who is experiencing an acute crisis of a level of severity requiring immediate treatment where a failure to treat could result in death, injury, or lasting harm to the enrollee or serious danger to others.

“*Encounter data*” shall mean information reflecting a face-to-face meeting or other billable service furnished by a provider to a person served through the Iowa Plan. Medicaid encounter data must be submitted by the contractor to the department in an electronic format specified by the department.

“*Enrollee*” shall mean any Medicaid member who is enrolled in the Iowa Plan in accordance with the provisions of the contract.

“*Enrollment*” shall mean the inclusion of a Medicaid member on a contractor’s Medicaid enrollment file.

“*Enrollment area*” shall mean the geographical area in which the enrollees that are assigned by the department to the contractor reside.

“*Fee-for-service*” shall mean the method of making payment for Medicaid services reimbursable under the Medicaid state plan in which reimbursement is based on fees set by the department for defined services. Payment of the fee is based upon delivery of the defined services and is done through the Iowa Medicaid enterprise.

“*Grievance*” shall mean a nonclinical incident, nonclinical complaint, or nonclinical concern which is received verbally and which cannot be resolved in a manner satisfactory to enrollees or participating or nonparticipating providers by the immediate response of the contractor’s staff member or a nonclinical incident, nonclinical complaint, or nonclinical concern which is received in writing.

“*Insolvency*” shall mean a financial condition that exists when an entity is unable to pay its debts as they become due in the usual course of business, or when the liabilities of the entity exceed its assets.

“*Integrated mental health services and supports*” shall mean individualized mental health services and supports planned jointly by the contractor, the enrollee, and others significant to the enrollee as appropriate, which are not regularly defined services otherwise offered by the contractor.

*“Iowa Plan”* shall mean the Iowa Plan for Behavioral Health, established by this division as the managed care plan to provide mental health and substance abuse treatment.

*“Licensed”* shall mean a facility, equipment, individual or entity that has formally met state requirements for licensure and has been granted a license.

*“Member”* shall mean a person determined eligible for Medicaid.

*“Mental health services”* shall mean those clinical, rehabilitative, or supportive services provided by an individual, agency, or other entity that is licensed, accredited, certified, or otherwise approved as required by law to treat any mental disorder listed in the International Classification of Diseases—Ninth Edition (ICD-9). At a minimum, covered disorders include the following ranges of the ICD-9: 290-302.9; 306-309.9; and 311-314.9. Additional code ranges may be included in the contract. Mental health services shall include, but not be limited to, those services listed at subrule 88.65(3).

*“MHI”* shall mean a state mental health institute operated by the department.

*“Open panel”* shall mean that the contractor shall subcontract with all providers who are appropriately licensed, certified, or accredited to provide covered, required, or optional services, and who meet the credentialing criteria, agree to the standard contract terms, and wish to participate.

*“Participating providers”* shall mean the providers of mental health and substance abuse services who subcontract with the contractor.

*“Prepaid health plan (PHP)”* shall mean an entity defined at Section 1903(m)(2)(B)(iii) of the Social Security Act and determined to be a PHP by the department based upon criteria set forth in the Code of Federal Regulations at Title 42, Part 434.20(a)(3), as amended to March 13, 1991.

*“Prior authorization”* shall mean the process by which an enrollee or a provider obtains approval prior to the initiation or continuation of a service as to the appropriateness of a service. The contractor may require prior authorization as a condition of payment. Prior authorization of a mental health service shall be based on psychosocial necessity. Prior authorization of a substance abuse service shall be based on service necessity.

*“Psychosocial necessity”* shall mean that clinical, rehabilitative, or supportive mental health services meet all of the following conditions. The services shall be:

1. Appropriate and necessary to the symptoms, diagnoses or treatment of a covered mental health diagnosis.
2. Provided for the diagnosis or direct care and treatment of a mental disorder.
3. Within standards of good practice for mental health treatment.
4. Required to meet the mental health needs of the enrollee and not primarily for the convenience of the enrollee, the provider, or the contractor.
5. The most appropriate type of service which would reasonably meet the needs of the enrollee in the least costly manner.

The determination of psychosocial necessity shall be made after consideration of the enrollee’s clinical history, including the impact of previous treatment and service interventions; services being provided concurrently by other delivery systems; the potential for services and supports to avert the need for more intensive treatment; the potential for services and supports to allow the enrollee to maintain functioning improvement attained through previous treatment; unique circumstances which may impact the accessibility or appropriateness of particular services for an individual enrollee (e.g., availability of transportation, lack of natural supports including a place to live); and the enrollee’s choice of provider or treatment location.

*“Required services”* shall mean mental health and substance abuse treatment services and supports which are not reimbursable through the Iowa Medicaid fee-for-service program but which are the contractual responsibility of the contractor.

*“Retroactive eligibility”* shall mean the period of time consisting of the three months preceding the month in which an application for Medicaid is filed, during which the person may be eligible for Medicaid coverage as determined by the department.

*“Routine care”* shall mean those clinical, rehabilitative, or supportive mental health or substance abuse services which are typically arranged through regular, scheduled appointments with a provider.

Conditions requiring routine care are not likely to substantially worsen or cause damage or disruption to the recipient's life without immediate intervention.

"*Service necessity*" shall mean that substance abuse services for the treatment of conditions related to substance abuse meet the following requirements according to the criteria of the ASAM-PPC-2R. The services shall be:

1. Appropriate and necessary to the symptoms, diagnoses or treatment of a covered substance abuse diagnosis.
2. Provided for the diagnosis or direct care and treatment of a substance abuse disorder.
3. Within standards of good practice for substance abuse treatment.
4. Required to meet the substance abuse treatment needs of the enrollee and not primarily for the convenience of the enrollee, the provider, or the contractor.
5. The most appropriate type of service which would reasonably meet the needs of the enrollee in the least costly manner.

"*Substance abuse licensed PMIC*" shall mean a psychiatric medical institution for children (PMIC) which also is licensed in accordance with Iowa Code chapter 125 to provide substance abuse treatment services.

"*Substance abuse services*" shall mean those clinical, rehabilitative, supportive and other services provided in response to and to alleviate the symptoms of any substance abuse disorder listed in the International Classification of Diseases—Ninth Edition (ICD-9), disorders 303 through 305.9, provided by an individual, agency, or other entity that is licensed, accredited, certified, or otherwise approved as required by law to treat any of these substance abuse disorders. Services include, but are not limited to, services listed at subrule 88.65(4).

"*Targeted case management services*" shall mean MR/CMI/DD case management services targeted to adults with a primary diagnosis of chronic mental illness as defined at rule 441—90.1(249A), with standards set forth in 441—Chapter 24 and Medicaid requirements set forth in 441—Chapter 90.

"*Third party*" shall mean an individual, entity, or program, excluding Medicaid, that is, may be, could be, should be, or has been liable for all or part of the cost of mental health and substance abuse services related to any medical assistance covered by Medicaid.

"*Urgent, nonemergency care*" shall mean those clinical, rehabilitative, or supportive services provided for conditions which, although they do not present immediate risk of death, injury, or lasting harm, may risk significant damage or disruption to the recipient's life or require expeditious treatment to alleviate the prospect that the condition will substantially worsen without immediate intervention.

#### **441—88.62(249A) Participation.**

**88.62(1) Contract.** The department may enter into a contract for the provision of mental health and substance abuse services specified in 441—Chapter 78, or any portion thereof, with a prepaid health plan.

*a.* The department shall also determine that the contractor meet the following additional requirements:

- (1) The contractor shall make the services it provides to enrollees at least as accessible as those services were to members prior to the implementation of the Iowa Plan.
- (2) The contractor shall comply with insolvency requirements established by the department in the contract and shall ensure that neither Medicaid enrollees nor the state shall be responsible for its debts if the contractor should become insolvent.
- (3) The contractor shall be licensed by the department of commerce, division of insurance, as a limited service organization.

*b.* The contract shall meet the following minimum requirements. The contract shall:

- (1) Be in writing.
- (2) Specify the duration of the contract period.
- (3) List the services which must and may be covered.
- (4) Describe information access and disclosure.
- (5) List conditions for nonrenewal, termination, suspension, and modification.

- (6) Specify the method and rate of reimbursement.
- (7) Provide for disclosure of ownership and subcontractor relationships.
- (8) Specify that all subcontracts shall be in writing, shall comply with the provisions of the contract between the department and the contractor, and shall include any general requirements of the contract that are appropriate to the service or activity covered by the subcontract.

**88.62(2) *Assessment of penalties.*** Penalties shall be assessed according to terms of the contract for failure to perform in either of the following areas:

- a. Substantial failure to provide necessary covered and required services included in this contract when the failure has seriously and adversely affected an enrollee.
- b. Failure to comply with any provision of the contract.

**441—88.63(249A) Enrollment.**

**88.63(1) *Enrollment area.*** The enrollment area shall be set forth in the contract between the department and the contractor. The department has determined that all counties of the state will be covered by the Iowa Plan, whether by a single statewide contractor or by multiple regional contractors.

**88.63(2) *Members subject to enrollment.*** All Medicaid members shall be subject to mandatory enrollment in the Iowa Plan.

a. Members who are enrolled in the Iowa Plan are notified of enrollment and the effective date of the enrollment.

b. When a coverage group is included in or excluded from Iowa Plan enrollment, the department and the contractor shall jointly notify members and participating and nonparticipating Medicaid providers before implementation of the change. The department shall implement a transition plan to ensure continuity of services to members.

**88.63(3) *Others to be served.*** The department may include other recipients of mental health and substance abuse services in the Iowa Plan. The department shall specify in the contract the services, persons to be served, and reimbursement methodology when other recipients are included.

**88.63(4) *Voluntary enrollment.*** There will be no voluntary enrollment in the Iowa Plan.

**88.63(5) *Effective date.*** For new members, the effective date of enrollment with the contractor shall be the first day of the month the Medicaid application was filed in the county office. Members under the age of 21 served at an MHI and members served at a substance abuse licensed PMIC will be enrolled for months of retroactive eligibility for Medicaid when the member resided in a substance abuse licensed PMIC or MHI during those months.

For current members who are no longer in an eligibility group excluded from the Iowa Plan, the effective date of enrollment shall be the first day of the month following the month they leave the excluded group.

**88.63(6) *Medical card.*** The department shall issue Form 470-1911, Medical Assistance Eligibility Card, to each member. Before delivering mental health or substance abuse services, the provider shall access the department's eligibility verification system (ELVS) to verify the member's enrollment in the Iowa Plan.

**441—88.64(249A) Disenrollment.**

**88.64(1) *Disenrollments by the department.*** Disenrollments shall occur when:

a. The enrollee becomes ineligible for Medicaid. If the enrollee becomes ineligible and is later reinstated to Medicaid, enrollment in the Iowa Plan shall also be reinstated.

b. The enrollee is transferred to a coverage group excluded from the Iowa Plan.

c. The enrollee dies.

**88.64(2) *Effective date.*** Disenrollment shall be effective the first day of the month following the month of disenrollment.

**88.64(3) *No disenrollment for health reasons.*** No enrollee shall be disenrolled from the Iowa Plan because of an adverse change in health status, including mental health and substance abuse status.

**441—88.65(249A) Covered services.**

**88.65(1) Amount, duration, and scope of services.** The contractor may not impose limitations on the amount, duration, or scope of services provided which are not allowable under the Medicaid state plan. The contractor may, however, require the use of participating providers, require prior authorization for services other than emergency services as set forth in rule 441—88.66(249A), and direct enrollees to the appropriate level of care for receipt of those services which are the responsibility of the contractor.

**88.65(2) Enrollee use of Iowa Plan services.** Enrollees shall receive all Medicaid-funded covered, required, and optional mental health and substance abuse services only through the Iowa Plan. An enrollee shall use only participating providers of service unless the contractor has authorized a referral to a nonparticipating provider for provision of a service or treatment plan. Payment shall be denied under Medicaid fee-for-service on claims for covered, required, and optional mental health and substance abuse services provided to enrollees. The contractor shall implement policies to ensure that no participating or nonparticipating provider bills an enrollee for all or any part of the cost of a covered, required, or optional service.

**88.65(3) Covered, required and optional mental health services.**

*a.* The contractor shall ensure, arrange, monitor and reimburse, at a minimum, the following covered mental health services:

- (1) Ambulance services for psychiatric conditions.
- (2) Emergency room services for psychiatric conditions available 24 hours per day, 365 days per year.
- (3) Inpatient hospital care for psychiatric conditions.
- (4) Outpatient hospital care for psychiatric conditions including intensive outpatient services.
- (5) Partial hospitalization.
- (6) Day treatment.
- (7) Psychiatric physician services including consultations requested for enrollees receiving treatment for other medical conditions.
- (8) Services of a licensed psychologist for testing, evaluation and treatment of mental illness.
- (9) Services in state MHIs for enrollees under the age of 21 or through the age of 22 if the enrollee is hospitalized on the enrollee's twenty-first birthday.
- (10) Services provided through a community mental health center.
- (11) Targeted case management services to persons with chronic mental illness.
- (12) Medication management.
- (13) Psychiatric nursing services by a home health agency.
- (14) Psychiatric or psychological screenings required subsequent to evaluations for persons applying for admission to nursing homes.
- (15) Mental health services determined necessary subsequent to an EPSDT screening meeting the Omnibus Budget Reconciliation Act of 1989, Public Law 101-239, requirements.
- (16) Behavioral health intervention as set forth in rule 441—78.12(249A).
- (17) Inpatient psychiatric services in psychiatric medical institutions for children as set forth in 441—Chapter 85, Division II.
- (18) Home- and community-based habilitation services as described at rule 441—78.27(249A).

*b.* The contractor shall ensure, arrange, monitor and reimburse the following required mental health services which are not reimbursable by Medicaid fee-for-service:

- (1) Concurrent substance abuse and mental health services for those diagnosed with both chronic substance abuse and chronic mental illness.
- (2) Services of a licensed social worker for treatment of mental illness.
- (3) Mobile crisis services.
- (4) Mobile counseling services.
- (5) Integrated mental health services and supports.
- (6) Psychiatric rehabilitation services.
- (7) Peer support services for persons with chronic mental illness.
- (8) Community support services.

(9) Periodic assessment of the level of functioning for each enrollee who meets the criteria of either a child with a serious emotional disability or a person with serious and persistent mental illness. The assessment is to be conducted by appropriately credentialed participating providers.

(10) Programs of assertive community treatment.

c. The contractor may develop optional services and supports to address the mental health needs of enrollees. These optional services and supports shall be implemented only after approval by the department. Optional services and supports shall be provided by or under the supervision of qualified mental health professionals or appropriately accredited agencies.

d. The department may require the coverage of other mental health services and supports under the terms of the contract.

**88.65(4) Covered and required substance abuse services.** The contractor shall ensure, arrange, monitor and reimburse the following services for the treatment of substance abuse:

a. Outpatient services (all Level I services according to the ASAM-PPC-2R).

b. Intensive outpatient and partial hospitalization services (all Level II services according to the ASAM-PPC-2R).

c. Residential or inpatient services (all Level III services according to the ASAM-PPC-2R).

d. Medically managed intensive inpatient services (all Level IV services according to the ASAM-PPC-2R).

e. Detoxification.

f. PMIC substance abuse treatment services.

g. Emergency room services for substance abuse conditions available 24 hours a day, 365 days a year.

h. Ambulance services for substance abuse conditions.

i. Substance abuse treatment services determined necessary subsequent to an EPSDT screening meeting the Omnibus Budget Reconciliation Act of 1989, Public Law 101-239, requirements.

j. Intake, assessment, evaluation and diagnostic services, including testing for alcohol and drugs, to determine a substance abuse diagnosis.

**88.65(5) Covered diagnoses.** Services for a covered diagnosis cannot be denied solely on the basis of an individual's also having a noncovered diagnosis. Mental health services, including inpatient care, cannot be denied solely on the basis of an individual's having no Axis I diagnosis. The contractor will be responsible for ensuring, arranging, monitoring, and reimbursing services necessary for the behavioral care and treatment of the covered diagnoses for Iowa Plan enrollees who are diagnosed with a covered diagnosis and a noncovered diagnosis.

The services defined at subrules 88.65(3) and 88.65(4) shall be provided to all Iowa Plan enrollees who meet the diagnostic criteria for the following disorders listed in the International Classification of Diseases—Ninth Edition (ICD-9):

1. Mental health: 290-302.9; 306-309.9; 311-314.9.

2. Substance abuse: 303-305.9.

**88.65(6) Excluded services.** Unless the service is specifically included in the contract, the contractor shall not be required to provide long-term care (e.g., residential care facilities, nursing facilities, state resource centers, or intermediate care facilities for persons with mental retardation) services.

[ARC 9487B, IAB 5/4/11, effective 7/1/11; ARC 0191C, IAB 7/11/12, effective 7/1/12; ARC 0359C, IAB 10/3/12, effective 12/1/12; ARC 0848C, IAB 7/24/13, effective 7/1/13; ARC 1051C, IAB 10/2/13, effective 11/6/13]

#### **441—88.66(249A) Emergency services.**

**88.66(1) Availability of services.** The contractor shall ensure that emergency services for covered diagnoses are available 24 hours a day, seven days a week, either through participating providers or through arrangements with other providers.

**88.66(2) Payment for emergency room services.** Emergency room services for covered diagnoses shall be reimbursed for enrollees regardless of whether authorized in advance or whether the provider of service is a participating provider.

*a.* For emergency room services provided to an Iowa Plan enrollee by a participating or a nonparticipating provider when covered diagnoses are the primary condition, the contractor may:

(1) Establish policies requiring notification of the provision of emergency room service within a stated time frame which shall be no less than 48 hours.

(2) Require authorization of any services beyond those provided in the emergency room.

*b.* For emergency room services provided to an Iowa Plan enrollee by a participating or a nonparticipating provider when covered diagnoses are the primary condition, the contractor shall:

(1) Provide a minimum triage fee to the emergency room, regardless of whether the facility notifies the contractor. The triage fee shall be no less than is paid under payment mechanisms established for the Medicaid fee-for-service program.

(2) Reimburse the emergency room for emergency room services provided, contingent upon the facility's compliance with notification policies. Reimbursement to nonparticipating providers shall be no less than the average payment which would be made to a participating provider.

**88.66(3) Contractor payment liability.** The contractor's payment liability for the provision of emergency mental health and substance abuse services by nonparticipating providers is limited to emergency mental health and substance abuse services provided before the enrollee can, without danger or harmful consequences to the enrollee or others, return to the care of a participating provider. If transportation is necessary to transport the enrollee from a nonparticipating provider to a participating provider, the contractor shall be financially liable for the transportation. In reimbursing nonparticipating providers, the contractor's liability is limited to the average reimbursement which the contractor would pay to a participating provider for the same services.

**88.66(4) Notification and claim filing time spans.** The contractor may set notification and claim filing time limitations in the event of the provision of care by nonparticipating providers and shall notify enrollees of these provisions. However, failure to give notice or to file claims within those time limitations shall not invalidate any claim if it can be shown that it was not reasonably possible to give the notice and that notice was, in fact, given as soon as was reasonably possible. In addition, the contractor shall provide payment for emergency services to nonparticipating providers within 60 days of receipt of a bill which complies with all billing requirements established by the contractor's policies.

#### **441—88.67(249A) Access to service.**

**88.67(1) Choice of provider.** Enrollees shall have the opportunity to choose their mental health care and substance abuse treatment professionals and service providers from any of the participating providers to the extent clinically appropriate.

**88.67(2) Open panel requirement.** The contractor shall establish and implement policies to ensure an open panel approach to the recruitment of participating providers.

**88.67(3) Requirements for participating provider panel.** The contractor shall develop and maintain a panel of participating providers which meets the following requirements. The panel shall:

*a.* Have sufficient staff resources to adequately provide mental health and substance abuse services to meet the needs of enrollees or have arrangements for services to be provided by other providers where capability of participating providers to serve specific mental health and substance abuse needs does not exist.

*b.* Maintain treatment sites in compliance with all applicable local, state, and federal standards related to the services provided as well as those for fire and safety.

**88.67(4) Adequate appointment system.** The contractor shall require that participating providers have procedures for the scheduling of enrollee appointments, which are appropriate to the reason for the service, as follows:

*a.* Enrollees with emergency needs shall be seen within 15 minutes of presentation at a service delivery site.

*b.* Persons with urgent nonemergency needs shall be seen within 1 hour of presentation at a service delivery site or within 24 hours of telephone contact with provider or contractor.

*c.* Persons with persistent symptoms shall be seen within 48 hours of reporting symptoms.

d. Persons with need for routine services shall be seen within three weeks of the request for appointment.

**88.67(5) Adequate after-hours call-in coverage.** The contractor shall ensure crisis counseling and referral are available 24 hours a day, 365 days per year via a toll-free telephone line, the number for which is regularly made available to all enrollees.

**88.67(6) Adequate referral system.** The contractor shall have in effect arrangements which provide for an adequate referral system for any specialty mental health and substance abuse treatment services not available through participating providers.

**88.67(7) Discharge planning.** The contractor shall implement policies to ensure that no enrollee who has been receiving services in a 24-hour setting funded by the contractor is discharged from that setting until a discharge plan has been developed which provides appropriate follow-up care and treatment which is accessible to that enrollee.

**88.67(8) Lack of discharge plan.** When a discharge plan as described in subrule 88.67(7) has not been developed or cannot be implemented, the following shall apply:

a. If the contractor is not required to pay for services at the 24-hour level of care as set forth in subrule 88.73(2) because the services do not meet the criteria of psychosocial necessity or service necessity, the contractor is required (keep kids safe policy) to authorize up to 14 calendar days of additional funding on an administrative basis for enrollees under the age of 18 if a safe and appropriate living arrangement is not available because:

(1) A court order is in effect that must be modified to allow the placement of the child into that living arrangement;

(2) A court order is required to allow placement of the child into the appropriate living arrangement;

(3) A bed is not available in the level of care which has been determined as clinically appropriate for the child; or

(4) Services and support must be arranged to assist the natural family, foster family, or other living arrangement to become ready to assist the enrollee after the enrollee's return to that environment.

b. If 24-hour services provided through the Iowa Plan are being decertified, payment is limited in accordance with subrule 88.73(2) except as provided in paragraph 88.67(8) "a."

#### **441—88.68(249A) Review of contractor decisions and actions.**

**88.68(1) Clinical decision review.** The contractor shall have written procedures by which enrollees and participating and nonparticipating providers may request a clinical decision review. The clinical decision review, when requested, shall be conducted by staff other than the person or persons who made the original clinical care decision. All policies related to clinical decision review shall be approved by the department prior to implementation. The contractor's clinical decision review policies shall further:

a. Require acknowledgment of the receipt of a request for a clinical decision review to the enrollee and to the provider if applicable within three working days.

b. Allow for participation by the enrollee and the provider.

c. Set time frames for resolution including emergency procedures which are appropriate to the nature of the clinical decision under review.

d. Require that 95 percent of all clinical decision reviews be resolved within 14 days of receipt of all required documentation and that 100 percent of all clinical decision reviews be resolved within 90 days of the receipt of all required documentation.

e. Ensure the participation of contractor staff with authority to require corrective action.

f. Include at least one level of internal review.

g. Ensure the confidentiality of the enrollee.

**88.68(2) Appeal to department.** Enrollees may appeal clinical care decisions in accordance with the appeal process available to all persons receiving Medicaid-funded services as set forth in 441—Chapter 7 if the enrollee is not satisfied with the final decision rendered by the contractor through the contractor's clinical decision review process.

**88.68(3) Review of nonclinical decisions.** The contractor shall have available to all enrollees and other persons who do business with the contractor a process for the review of any complaints or

grievances concerning nonclinical matters. All policies related to the review of nonclinical decisions shall be approved by the department prior to implementation. Policies regarding the process for the review of nonclinical decisions shall incorporate the following:

- a. Allow initiation both verbally and in writing.
- b. Require a review conducted by someone other than the person who made the original decision.
- c. Require written notice acknowledging the receipt of a complaint or grievance.
- d. Require resolution of 95 percent of all complaints or grievances within 14 days of the receipt of all required documentation and resolution of 100 percent within 90 days of the receipt of all required documentation.

**88.68(4) *Written record.*** All requests for review of contractor decisions and actions, including all informal or verbal complaints which must be referred or researched for resolution, shall be recorded in writing. A log shall be retained and made available at the request of the department. The log shall include progress notes and method of resolution to allow determination of compliance with subrules 88.68(1) and 88.68(3).

**88.68(5) *Information concerning procedures relating to the review of contractor decisions and actions.*** The contractor's written procedures for the review of contractor decisions and actions shall be provided to each new enrollee, to participating providers in a provider manual, and to nonparticipating providers upon request.

**88.68(6) *Periodic reports to the department.*** The contractor shall make reports to the department summarizing the review of contractor decisions and actions and resolutions to the reviews at a frequency specified in the contract.

**88.68(7) *Consent for state fair hearing.*** Network providers which are contracted and in good standing with the Iowa plan contractor 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. The network 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 network provider submits a document providing such member's approval of the request for a state fair hearing. 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 member's 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.

[ARC 0583C, IAB 2/6/13, effective 4/1/13]

#### **441—88.69(249A) Records and reports.**

**88.69(1) *Records system.*** The contractor shall document and maintain clinical and fiscal records throughout the course of the contract. The record system shall:

- a. Identify transactions with or on behalf of each enrollee by the state identification number assigned to the enrollee by the department.
- b. Provide a rationale for and documentation of clinical care decisions made by the contractor based upon psychosocial necessity for mental health services and service necessity for substance abuse services.
- c. Permit effective professional review for medical audit processes.
- d. Facilitate an adequate system for monitoring treatment reimbursed by the contractor including follow-up of the implementation of discharge plans and referral to other providers.
- e. Meet contract reporting requirements and federal reporting requirements applicable to prepaid health plans.

**88.69(2) *Content of individual treatment record.*** The contractor shall have contractual requirements with participating providers which ensure an adequate record-keeping system, including documentation

of all Iowa Plan services provided to each enrollee, in compliance with the provisions of rule 441—79.3(249A).

**88.69(3) Confidentiality of mental health information.** The contractor shall protect and maintain the confidentiality of mental health information by implementing policies for staff and through contract terms with participating providers which allow release of mental health information only as allowed by Iowa Code chapter 228.

**88.69(4) Confidentiality of substance abuse information.** The contractor shall protect and maintain the confidentiality of substance abuse information by implementing policies for staff and through contract terms with participating providers which allow release of substance abuse information only in compliance with policies set forth in the Code of Federal Regulations at Title 42, Part 2, as amended to May 5, 1995, and other applicable state and federal law and regulations.

**88.69(5) Reports to the department.** The contractor shall submit reports to the department as follows:

- a. Encounter data on a monthly basis.
- b. Annual audited financial statements no later than 180 days after the close of each contract year.
- c. Periodic financial, utilization, and statistical reports as required by the department in the contract.

- d. Other reporting requirements as specified in the contract.

**88.69(6) Audits.** The department or its designee and the U.S. Department of Health and Human Services (HHS) may evaluate through inspections or other means the quality, appropriateness, and timeliness of services performed by the contractor, participating providers, nonparticipating providers, and subcontractors pertaining to services performed and reimbursed under the contract. The department or its designee or HHS may audit and inspect any records of the contractor, participating providers, nonparticipating providers and subcontractors of the contractor, pertaining to services performed and the determination of amounts paid under the contract. These records shall be made available at times, places, and in a manner as authorized representatives of the department, its designee, or HHS may request.

**441—88.70(249A) Marketing.** The marketing of Iowa Plan services is prohibited.

**441—88.71(249A) Enrollee education.**

**88.71(1) Use of services.** The contractor shall provide written information to all enrollees on the use of services the contractor is responsible to ensure, arrange, monitor, and reimburse. Information must include services covered; how to access services; providers participating; explanation of the process for the review of contractor decisions and actions, including the enrollee's right to a fair hearing under 441—Chapter 7 and how to access that fair hearing process; provision of after-hours and emergency care; procedures for notifying enrollees of a change in benefits or office sites; how to request a change in providers; statement of consumer rights and responsibilities; out-of-area use of service; availability of toll-free telephone information and crisis assistance; appropriate use of the referral system; and the method of accessing Medicaid-funded services not covered by the Iowa Plan, especially pharmacy services.

**88.71(2) Outreach to members with special needs.** The contractor shall provide enhanced outreach to members with special needs including, but not limited to, persons with psychiatric disabilities, mental retardation or other cognitive impairments, homeless persons, illiterate persons, non-English-speaking persons and persons with visual or hearing impairments.

**88.71(3) Patient rights and responsibilities.** The contractor shall have in effect a written statement of patient rights and responsibilities which is available upon request as well as issued to all new enrollees. This statement shall be part of enrollment information provided to all new enrollees.

**441—88.72(249A) Payment to the contractor.**

**88.72(1) Capitation rate.** In consideration for all services rendered by the contractor under a Medicaid contract with the department, the contractor shall receive a payment each month for each enrollee. This Medicaid capitation rate represents the total obligation of the department with respect

to the costs of Medicaid mental health and substance abuse services provided to enrollees under the contract. The contractor accepts the rate as payment in full for the Medicaid-contracted services.

**88.72(2) *Determination of rate.*** The Medicaid capitation rates shall be established in the contract and shall not exceed the cost to the department of providing the same covered services on a fee-for-service basis to the same group of Medicaid members eligible for the plan.

**88.72(3) *Payment for services to other recipients.*** When the department chooses to include mental or substance abuse services for recipients other than enrollees, the department shall establish rates and reimbursement procedures in the contract.

**88.72(4) *Third-party liability.*** If an enrollee has health coverage or a responsible party other than the Medicaid program available for purposes of payment for mental health and substance abuse expenses, it is the right and responsibility of the contractor to investigate these third-party resources and attempt to obtain payment. The contractor may retain all funds collected through third-party sources. A complete record of third-party liability shall be maintained and made available to the department at the end of each contract year.

**441—88.73(249A) Claims payment.**

**88.73(1) *Claims payment by contractor.*** The contractor shall meet the following time lines for the payment of all claims for covered, required and optional mental health and substance abuse services submitted which meet the contractor's requirements for claim submission:

*a.* For at least 85 percent of claims submitted, payment shall be mailed or claims shall be denied within 14 days of the date the claim is received by the contractor.

*b.* For at least 90 percent of claims submitted, payment shall be mailed or claims shall be denied within 30 days of the date the claim is received by the contractor.

*c.* For 100 percent of claims submitted, payment shall be mailed or claims shall be denied within 90 days of the date the claim is received by the contractor.

**88.73(2) *Limits on payment responsibility for services.***

*a.* The contractor is not required to reimburse providers for the provision of mental health services that do not meet the criteria of psychosocial necessity.

*b.* The contractor is not required to reimburse providers for the provision of substance abuse services that do not meet the criteria of service necessity.

*c.* The contractor is not required to reimburse providers for the provision of MR/CMI/DD case management services that do not meet the criteria and requirements set forth in 441—Chapter 90.

*d.* The contractor has the right to require prior authorization of covered, required and optional services and to deny reimbursement to providers who do not comply with such requirements.

*e.* Payment responsibilities for emergency room services are as provided at subrule 88.66(2).

*f.* Payment responsibility for services provided under the “keep kids safe” policy is set forth at subrule 88.67(8).

**88.73(3) *Payment to nonparticipating providers.*** In reimbursing nonparticipating providers, the contractor is obligated to pay no more than the average rate of reimbursement which the contractor pays to participating providers for the same service.

**88.73(4) *Payment of crossover and copayments.*** Rescinded IAB 1/9/02, effective 3/1/02.

**441—88.74(249A) Quality assurance.** The contractor shall have in effect an internal quality assurance system which meets the requirements of 42 CFR, Part 434.34 as amended to March 12, 1984, and complies with all other requirements specified in the contract.

**441—88.75(249A) Iowa Plan advisory committee.** The department shall appoint an advisory committee to advise the department in the implementation and operation of the Plan and to provide for ongoing public input in its operation.

**441—88.76 to 88.80** Reserved.

DIVISION V  
PROGRAMS OF ALL-INCLUSIVE CARE FOR THE ELDERLY

**441—88.81(249A) Scope and definitions.**

**88.81(1) Purpose.** A program of all-inclusive care for the elderly (PACE) organization provides prepaid, capitated, comprehensive health care services designed to meet the following objectives:

- a. Enhance the quality of life and autonomy of frail older adults.
- b. Maximize the dignity of and respect for frail older adults.
- c. Enable frail older adults to live in the community as long as medically and socially feasible.
- d. Preserve and support frail older adults' family units.

**88.81(2) Scope.** PACE programs may serve Medicaid members, Medicare beneficiaries, persons eligible for both Medicare and Medicaid benefits, and private-pay individuals. Enrollment to receive services from a PACE organization is voluntary.

a. Enrollment is limited to persons who are 55 years of age or older and who need care at the nursing facility level but are able to live in a community setting without jeopardizing their health and safety.

b. If a Medicaid member chooses to enroll in a PACE program, the member must receive Medicaid benefits solely through the PACE organization while enrolled in the program.

**88.81(3) Authorization.** A PACE organization must enter into a three-way agreement with the department and the Centers for Medicare and Medicaid Services of the U.S. Department of Health and Human Services.

**88.81(4) Definitions.** For purposes of this division:

“*Alternate PACE service site*” means a location outside a primary or alternate PACE center in which one or more PACE services are offered to PACE enrollees.

“*Capitation rate*” means the monthly fee the department pays to a PACE organization for each Medicaid enrollee for the provision of covered medical and health services, whether or not the enrollee received services during the month for which the fee is intended.

“*CMS*” means the Centers for Medicare and Medicaid Services of the U.S. Department of Health and Human Services.

“*Contract year*” means the term of a PACE program agreement. The term is a calendar year, with the exception that a PACE organization's initial contract year is determined by CMS and may be from 12 to 23 months.

“*Department*” means the Iowa department of human services.

“*Enrollee*” means a person who is enrolled in a PACE program.

“*Federal PACE regulations*” means the standards published in 42 CFR Part 460, Programs of All-Inclusive Care for the Elderly. These rules shall be interpreted so as to comply with the federal PACE regulations.

“*Interdisciplinary team*” means the team designated by the PACE organization to assess the needs of and develop a comprehensive plan of care for each enrollee.

“*Medicaid enrollee*” means a Medicaid member who is enrolled in a PACE program.

“*Medicare beneficiary*” means a person who is entitled to Medicare Part A benefits, is enrolled under Medicare Part B, or both.

“*Medicare enrollee*” means a Medicare beneficiary who is enrolled in a PACE program.

“*PACE*” means programs of all-inclusive care for the elderly.

“*PACE center*” means a facility operated by a PACE organization where primary care is furnished to PACE enrollees. A primary PACE center is the principal facility operated by a PACE organization. An alternate PACE center is another facility operated by a PACE organization outside its primary center. “Primary care” shall include all program components in accordance with 42 CFR Section 460.92 as amended to December 8, 2006.

“*PACE enrollment agreement*” means the contract between the PACE organization and the enrollee that includes, at a minimum, all information identified in 42 CFR Section 460.154 as amended to December 8, 2006.

“*PACE organization*” means an entity that has in effect a PACE program agreement with the department and CMS to operate a PACE program in Iowa.

“*PACE program*” means a program of all-inclusive care for the elderly operated by an approved PACE organization that provides comprehensive health care services to enrollees in Iowa in accordance with a PACE program agreement.

“*PACE program agreement*” means a three-way agreement between CMS, the department, and an entity approved to be a PACE organization for the operation of a PACE program.

“*Service area*” means the specific counties in which a PACE provider may provide services, as identified in the PACE program agreement.

“*Services*” means both items and services provided to an enrollee by the PACE organization.

“*Trial period*” means the first three contract years in which a PACE organization operates under a PACE program agreement.

**441—88.82(249A) PACE organization application and waiver process.** This rule sets forth the application requirements for an entity that seeks approval from the department as a PACE organization and the process by which a prospective PACE organization may request department review and approval of requests to CMS for waiver of federal requirements.

**88.82(1) Application requirements.** A person authorized to act on behalf of an entity seeking approval as a PACE organization shall prepare an application in the format suggested by CMS at: [http://www.cms.hhs.gov/PACE/06\\_ProviderApplicationandRelatedResources.asp](http://www.cms.hhs.gov/PACE/06_ProviderApplicationandRelatedResources.asp).

a. The application shall:

(1) Describe how the entity meets the requirements of this division and of the federal PACE regulations; and

(2) Identify the counties in which the entity proposes to provide PACE services.

b. Upon completion of the application sections designated for PACE providers, the prospective PACE organization shall submit the application to the attention of the PACE program manager at the following address: Iowa Medicaid Enterprise, 100 Army Post Road, Des Moines, Iowa 50315.

**88.82(2) Waiver of federal requirements.** A prospective PACE organization must also receive CMS approval as a PACE organization. A prospective PACE organization must submit any request for waiver of federal PACE regulations to the department for initial review before submitting the request to CMS.

a. The waiver request shall be submitted as a document separate from the application. The request may be submitted:

(1) In conjunction with and at the same time as the application; or

(2) At any time during the approval process.

b. The prospective PACE organization shall submit the waiver request and documentation to the attention of the PACE program manager at the following address: Iowa Medicaid Enterprise, 100 Army Post Road, Des Moines, Iowa 50315.

**88.82(3) Review of applications and requests for waiver of federal requirements.** The department may conduct on-site visits and may request additional information from an entity in connection with an application for approval as a PACE organization or a request for waiver of federal requirements.

**88.82(4) Department action on applications.** Upon review of an application for approval as a PACE organization and action by CMS on any request for waiver of federal requirements, the department shall determine whether it considers the entity qualified to be a PACE organization and whether it is willing to enter into a PACE program agreement with the entity. If so, the department shall complete the application sections designated for the state administering agency and submit the completed application in its entirety to CMS.

**441—88.83(249A) PACE program agreement.** An entity that has been approved by the department and CMS to be a PACE organization must enter into an agreement with CMS and the department for the operation of a PACE program under Medicare and Medicaid. The agreement must be signed by an authorized official of CMS, the PACE organization, and the department.

**88.83(1)** *Content and terms of agreement.*

*a. Required content.* A PACE program agreement must include the following information:

(1) A designation of the service area of the PACE organization's program, identified by county. The department and CMS must approve any change in the designated service area.

(2) The PACE organization's commitment to meet all applicable requirements under federal, state, and local laws and regulations, including provisions of the Civil Rights Act, the Age Discrimination Act, and the Americans with Disabilities Act.

(3) The effective date and term of the agreement.

(4) A description of the organizational structure of the PACE organization and information on the organization's administrative contacts.

(5) An enrollee bill of rights approved by CMS and an assurance that the listed rights and protections will be provided.

(6) A description of the process for handling enrollee grievances and appeals.

(7) A statement of the PACE organization's policies on eligibility, enrollment, voluntary disenrollment, and involuntary disenrollment.

(8) A description of the services available to enrollees.

(9) A description of the PACE organization's quality assessment and performance improvement program.

(10) A statement of the levels of performance required in CMS standard quality measures.

(11) A statement of the data and information required by the department and CMS to be collected on enrollee care.

(12) The Medicaid capitation rate and the methodology used to calculate the Medicare capitation rate.

(13) A description of procedures that the PACE organization will follow if the PACE program agreement is terminated, including how the organization will:

1. Inform enrollees, the community, CMS, and the department, in writing, about the organization's termination and transition procedures.

2. Initiate contact with income maintenance staff in the local department office and assist enrollees in obtaining reinstatement of conventional Medicare and Medicaid benefits.

3. Transition enrollees' care to other providers.

4. Terminate marketing and enrollment activities.

*b. Optional content.* An agreement may:

(1) Provide additional requirements for individuals to qualify as PACE enrollees in accordance with subparagraph 88.84(1)"a"(5).

(2) Contain any additional terms and conditions agreed to by the parties.

**88.83(2)** *Duration of agreement.* A PACE program agreement shall be effective for a contract year but may be extended for additional contract years in the absence of a notice by a party to terminate.

**88.83(3)** *Enforcement of agreement.* If the department determines that the PACE organization is not in substantial compliance with requirements of the federal PACE regulations or of this division, the department may take one or more of the following actions:

*a.* Condition the continuation of the PACE program agreement upon timely execution of a corrective action plan.

*b.* Withhold some or all payments under the PACE program agreement until the PACE organization corrects the deficiency.

*c.* Terminate the PACE program agreement.

**88.83(4)** *Termination of agreement by the department.*

*a. Grounds for termination.* The department may terminate a PACE program agreement at any time for cause, including but not limited to the following circumstances:

(1) Termination due to uncorrected deficiencies. The department may terminate a PACE program agreement if both of the following circumstances exist:

1. The department has determined through a review pursuant to subrule 88.87(4) that the PACE organization has significant deficiencies in the quality of care furnished to enrollees or has failed to

comply substantially with the conditions for a PACE organization or PACE program under this division, the federal PACE regulations, or the terms of its PACE program agreement.

2. The PACE organization has failed to develop and successfully initiate a plan to correct the deficiencies within 30 days of the date of receipt of a written notice of deficiencies, as confirmed by certified mail, or has failed to continue implementation of the corrective action plan.

(2) Termination due to health and safety risk. The department may terminate a PACE program agreement if the department determines that the PACE organization cannot ensure the health and safety of its enrollees. This determination may result from the identification of deficiencies that the department determines cannot be corrected.

*b. Notice and opportunity for hearing.* Except as provided in paragraph “c” of this subrule, before terminating an agreement, the department shall furnish the PACE organization with the following:

(1) A reasonable opportunity to develop and implement a corrective action plan to correct the deficiencies that are the basis of the department’s determination that cause exists for termination.

(2) Reasonable notice and opportunity for hearing (including the right to appeal an initial determination) before terminating the agreement.

*c. Immediate termination.* The department may terminate an agreement without invoking the procedures described in paragraph “b” of this subrule if the department determines that a delay in termination resulting from compliance with those procedures before termination would pose an imminent and serious risk to the health of the enrollees.

**88.83(5) Termination of agreement by PACE organization.** A PACE organization may terminate an agreement after timely notice issued as follows:

*a.* To CMS and the department, 90 days before termination.

*b.* To enrollees, 60 days before termination.

**88.83(6) Transitional care during termination.** A PACE organization whose PACE program agreement is being terminated must provide assistance to each enrollee in obtaining necessary transitional care by making appropriate referrals and making the enrollee’s medical records available to new providers.

**441—88.84(249A) Enrollment and disenrollment.** A PACE organization must comply with the federal enrollment requirements stated in 42 CFR Sections 460.152 through 460.156 as amended to December 8, 2006.

**88.84(1) Eligibility for Medicaid enrollees.** To enroll in a PACE program as an Iowa Medicaid enrollee, a person must meet the eligibility requirements specified in this subrule.

*a. Basic eligibility requirements.*

(1) The person must be 55 years of age or older.

(2) The person must reside in the service area of the PACE organization.

(3) The person must be eligible for Medicaid pursuant to the provisions in 441—Chapter 75 for persons in a medical institution.

(4) The department must determine that the person is eligible for Iowa Medicaid pursuant to 441—Chapter 76.

(5) The department must determine that the person needs the nursing facility level of care.

(6) The person must meet any additional program-specific eligibility conditions imposed under the PACE program agreement. These additional conditions shall not modify the requirements stated in this subrule.

*b. Other eligibility requirements.*

(1) At the time of enrollment, the person must be able to live in a community setting without jeopardizing the person’s health or safety, pursuant to the criteria specified in the PACE program agreement.

(2) To continue to be eligible for PACE as an Iowa Medicaid enrollee, a person must meet the annual recertification requirements specified in subrule 88.84(4).

**88.84(2) *Effective date of enrollment.*** A person's enrollment in the program is effective on the first day of the calendar month following the date the PACE organization receives the signed enrollment agreement.

**88.84(3) *Duration of enrollment.*** Enrollment continues until the enrollee's death unless either of the following actions occurs:

*a.* The enrollee voluntarily disenrolls. An enrollee may voluntarily disenroll from the program without cause at any time.

*b.* The enrollee is involuntarily disenrolled, as described in subrule 88.84(5).

**88.84(4) *Annual recertification.***

*a.* At least annually, the department shall:

(1) Reevaluate whether each enrollee continues to need the nursing facility level of care; and

(2) Review all financial and nonfinancial eligibility requirements for Medicaid enrollees. The enrollee shall complete Form 470-3118 or 470-3118(S), Medicaid Review.

*b.* Deemed continued eligibility. If the department determines that an enrollee no longer needs the nursing facility level of care, the department, in consultation with the PACE organization, shall determine whether, in the absence of continued PACE coverage, the enrollee reasonably would be expected to meet the nursing facility level-of-care requirement within the next six months. This determination shall be based on a review of the enrollee's medical record and plan of care, applying criteria specified in the PACE program agreement. If the enrollee reasonably would be expected to meet the level-of-care requirement within six months, the enrollee's eligibility for the PACE program may continue until the next annual reevaluation.

**88.84(5) *Involuntary disenrollment.*** An involuntary disenrollment shall not become effective until the Department has determined that the PACE organization has adequately documented acceptable grounds for disenrollment.

*a. Reasons for involuntary disenrollment.* An enrollee may be involuntarily disenrolled for any of the following reasons:

(1) After a 30-day grace period, the enrollee fails to pay any amount due to the PACE organization pursuant to subrule 88.88(2) or refuses to make satisfactory arrangements to pay.

(2) The enrollee engages in disruptive or threatening behavior as described in paragraph 88.84(5) "b."

(3) The enrollee moves out of the PACE program service area or is out of the service area for more than 30 consecutive days, unless the PACE organization agrees to a longer absence due to extenuating circumstances.

(4) The department determines that the enrollee no longer needs the nursing facility level of care and the enrollee is not deemed eligible pursuant to paragraph 88.84(4) "b."

(5) The PACE program agreement with CMS and the department is not renewed or is terminated.

(6) The PACE organization is unable to offer health care services due to the loss of state licenses or contracts with outside providers.

*b. Disruptive or threatening behavior.* "Disruptive or threatening behavior" refers to either of the following:

(1) Behavior that jeopardizes the enrollee's health or safety or the safety of others; or

(2) Consistent refusal by the enrollee to comply with the enrollee's individual plan of care or the terms of the PACE enrollment agreement when the enrollee has decision-making capacity.

*c. Documentation of disruptive or threatening behavior.* If a PACE organization proposes to disenroll an enrollee who is disruptive or threatening, the organization must document the following information in the enrollee's medical record:

(1) The reasons for proposing to disenroll the enrollee.

(2) All efforts to remedy the situation.

*d. Noncompliant behavior.* A PACE organization may not disenroll an enrollee on the grounds that the enrollee has engaged in noncompliant behavior if the behavior is related to a mental or physical condition of the enrollee, unless the enrollee's behavior jeopardizes the enrollee's health or safety or the

safety of others. “Noncompliant behavior” includes repeated noncompliance with medical advice and repeated failure to keep appointments.

**88.84(6) Effective date of disenrollment.**

*a.* In disenrolling a Medicaid enrollee, the PACE organization must:

- (1) Use the most expedient process allowed under the PACE program agreement;
- (2) Coordinate the disenrollment date between Medicare and Medicaid for an enrollee who is eligible for both Medicare and Medicaid; and
- (3) Give reasonable advance notice to the enrollee.

*b.* Until the date when enrollment is terminated, the following requirements must be met:

- (1) The PACE organization must continue to furnish all needed services.
- (2) The enrollee must continue to use PACE organization services.

**88.84(7) Documentation of disenrollment.** A PACE organization must meet the following requirements:

*a.* Have a procedure in place to document the reasons for all voluntary and involuntary disenrollments.

*b.* Make documentation available for review by CMS and the department.

*c.* Use the information on voluntary disenrollments in the PACE organization's internal quality assessment and performance improvement program.

**88.84(8) Reinstatement in other Medicare and medicaid programs.** After a disenrollment, the PACE organization shall work with CMS and the department to facilitate the former enrollee's reinstatement in other Medicare and Medicaid programs by:

*a.* Making appropriate referrals to other Medicare and Medicaid programs for which the enrollee may be eligible; and

*b.* Ensuring that medical records are made available to new providers in a timely manner.

**88.84(9) Reinstatement in PACE.** A previously disenrolled enrollee may be reinstated in a PACE program.

[ARC 0758C, IAB 5/29/13, effective 8/1/13]

**441—88.85(249A) Program services.** A PACE organization shall furnish comprehensive medical, health, and social services that integrate acute and long-term care.

**88.85(1) Required services.** The PACE benefit package for all enrollees, regardless of the source of payment, must include the following:

*a.* All Medicare-covered items and services.

*b.* All Medicaid-covered items and services as specified in 441—Chapters 78, 81, 82, 85, and 90. Medicaid benefit limitations and conditions relating to amount, duration, scope of services, deductibles, copayments, coinsurance, or other cost sharing do not apply to PACE services.

*c.* Other services determined necessary by the enrollee's interdisciplinary team to improve or maintain the enrollee's overall health status.

**88.85(2) Excluded services.** The following services are excluded from coverage under PACE:

*a.* Any service that is not authorized by the enrollee's interdisciplinary team, even if it is a required service, unless it is an emergency service.

*b.* In an inpatient facility:

(1) A private room and private-duty nursing services unless medically necessary; and

(2) Nonmedical items for personal convenience, such as telephone charges and radio or television rental, unless specifically authorized by the interdisciplinary team as part of the enrollee's plan of care.

*c.* Cosmetic surgery. “Cosmetic surgery” does not include surgery that is required for improved functioning of a malformed part of the body resulting from an accidental injury or for reconstruction following mastectomy.

*d.* Experimental medical, surgical, or other health procedures.

*e.* Services furnished outside the United States, except in accordance with 42 CFR Sections 424.122 and 424.124 as amended to September 29, 1995, or as otherwise permitted under the Iowa Medicaid program.

**88.85(3) Service delivery.** The PACE organization must establish and implement a written plan to furnish care that meets the needs of each enrollee in all care settings 24 hours a day, every day of the year.

*a. Provision of services.* PACE services must be furnished in at least:

- (1) The PACE center,
- (2) The enrollee's home, and
- (3) Inpatient facilities.

*b. PACE center operation.* A PACE organization must ensure accessible and adequate services to meet the needs of its enrollees. The interdisciplinary team shall determine the frequency of each enrollee's attendance at a PACE center, based on the needs and preferences of the enrollee.

(1) A PACE organization must operate at least one PACE center either in or contiguous to its defined service area. A PACE center must be certified as an adult day services program pursuant to Iowa Code chapter 231D and the department of elder affairs' rules at 321—Chapter 24.

(2) If necessary to maintain sufficient capacity to allow routine attendance by enrollees, a PACE organization must add staff or develop alternate PACE centers or service sites. If a PACE organization operates more than one center, each alternate PACE center must offer the full range of services and have sufficient staff to meet the needs of enrollees.

**88.85(4) Minimum services furnished at a PACE center.** At a minimum, the following services must be furnished at each primary or alternate PACE center:

- a.* Primary care, including physician and nursing services.
- b.* Social services.
- c.* Restorative therapies, including physical therapy and occupational therapy.
- d.* Personal care and supportive services.
- e.* Nutritional counseling.
- f.* Recreational therapy.
- g.* Meals.

**88.85(5) Primary care.** Primary medical care must be furnished to an enrollee by a PACE primary care physician. Each primary care physician is responsible for:

- a.* Managing an enrollee's medical situations; and
- b.* Overseeing an enrollee's use of medical specialists and inpatient care.

**88.85(6) Out-of-network emergency care.** A PACE organization must pay for out-of-network emergency care when the care is needed immediately because of an injury or sudden illness and the time required to reach the PACE organization or one of its contract providers would cause risk of permanent damage to the enrollee's health.

*a. Definitions.* As used in this subrule, the following definitions apply:

*"Emergency medical condition"* means a condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent lay person with an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in any of the following:

1. Serious jeopardy to the health of the enrollee.
2. Serious impairment to bodily functions of the enrollee.
3. Serious dysfunction of any bodily organ or part of the enrollee.

*"Emergency services"* means inpatient and outpatient services that are needed to evaluate or stabilize an emergency medical condition and are furnished by a qualified emergency services provider other than the PACE organization or one of its contract providers, either inside or outside the PACE organization's service area.

*"Poststabilization care"* means services provided subsequent to an emergency that a treating physician views as medically necessary after an emergency medical condition has been stabilized but that do not meet the definition of emergency services.

*"Urgent care"* means care that is provided to an enrollee outside the service area because the enrollee believes that an illness or injury is too severe to postpone treatment until the enrollee returns to the service

area but that does not meet the definition of emergency services because the enrollee's life or functioning is not in severe jeopardy.

*b. Plan.* A PACE organization must establish and maintain a written plan to handle out-of-network emergency care. The plan must ensure that CMS, the department, and the enrollee are held harmless if the PACE organization does not pay for out-of-network emergency services. The plan must provide for the following:

(1) An on-call provider available 24 hours per day to address enrollee questions about out-of-network emergency services and to respond to requests for authorization of out-of-network urgent care and poststabilization care following emergency services.

(2) Coverage of out-of-network urgent care and poststabilization care when either of the following conditions is met:

1. The PACE organization has approved the services.

2. The PACE organization has not approved the services because the PACE organization did not respond to a request for approval within one hour after being contacted or because the PACE organization cannot be contacted for approval.

*c. Explanation to enrollee.* The organization must ensure that the enrollee or caregiver, or both, understand:

(1) When and how to access out-of-network emergency services, and

(2) That no prior authorization is needed.

**441—88.86(249A) Access to PACE services.** An enrollee's access to PACE services is governed by a comprehensive plan of care developed for each enrollee by an interdisciplinary team based on a comprehensive assessment of the enrollee's health and social status.

**88.86(1) Interdisciplinary team.** A PACE organization shall establish an interdisciplinary team at each PACE center to comprehensively assess and meet the individual needs of each enrollee.

*a. Team composition.* The members of the interdisciplinary team must primarily serve PACE enrollees. At a minimum, the interdisciplinary team shall be composed of the following members:

(1) Primary care physician.

(2) Registered nurse.

(3) Master's-level social worker.

(4) Physical therapist.

(5) Occupational therapist.

(6) Recreational therapist or activity coordinator.

(7) Dietitian.

(8) PACE center manager.

(9) Home care coordinator.

(10) Personal care attendant or attendant's representative.

(11) Driver or driver's representative.

*b. Team responsibilities.* Each enrollee shall be assigned to an interdisciplinary team functioning at the PACE center that the enrollee attends. The interdisciplinary team is responsible for the initial assessment, periodic reassessments, plan of care, and coordination of 24-hour care delivery for each assigned enrollee. Each interdisciplinary team member is responsible for the following:

(1) Regularly informing the team of the medical, functional, and psychosocial condition of each enrollee.

(2) Remaining alert to pertinent input from other team members, enrollees, and caregivers.

(3) Documenting changes in an enrollee's condition in the enrollee's medical record, consistent with documentation policies established by the medical director.

*c. Exchange of information.* The PACE organization must establish, implement, and maintain documented internal procedures governing the exchange of information between team members, contractors, and enrollees and their caregivers consistent with the federal requirements for confidentiality in 42 CFR Section 460.200(e) as amended to November 24, 1999.

**88.86(2) Initial assessment.** The interdisciplinary team must conduct an initial comprehensive assessment of each enrollee promptly following enrollment.

*a.* Each of the following members of the interdisciplinary team must evaluate the enrollee, at appropriate intervals, and develop a discipline-specific assessment of the enrollee's health and social status:

- (1) Primary care physician.
- (2) Registered nurse.
- (3) Master's-level social worker.
- (4) Physical therapist.
- (5) Occupational therapist.
- (6) Recreational therapist or activity coordinator.
- (7) Dietitian.
- (8) Home care coordinator.

*b.* At the recommendation of interdisciplinary team members, other professional disciplines (such as speech-language pathology, dentistry, or audiology) may be included in the comprehensive assessment process.

*c.* The assessment of each enrollee must include, but not be limited to, assessment of the following:

- (1) Physical and cognitive function and ability.
- (2) Medication use.
- (3) Enrollee and caregiver preferences for care.
- (4) Socialization and availability of family support.
- (5) Current health status and treatment needs.
- (6) Nutritional status.
- (7) Home environment, including home access and egress.
- (8) Enrollee behavior.
- (9) Psychosocial status.
- (10) Medical and dental status.
- (11) Enrollee language.

**88.86(3) Plan of care.** The interdisciplinary team must promptly consolidate discipline-specific assessments into a single plan of care for each enrollee through discussion in team meetings and consensus of the entire team.

*a. Development.* The interdisciplinary team must develop, review, and reevaluate the plan of care in collaboration with the enrollee or caregiver, or both, to ensure that there is agreement with the plan of care and that the enrollee's concerns are addressed. In developing the plan of care, female enrollees must be informed that they are entitled to choose a qualified specialist for women's health services from the PACE organization's network to furnish routine or preventive women's health services.

*b. Content.* The plan of care must:

(1) Specify the care needed to meet the enrollee's medical, physical, emotional, and social needs, as identified in the initial comprehensive assessment.

(2) Identify measurable outcomes to be achieved.

*c. Documentation.* The interdisciplinary team shall document in the enrollee's medical record the plan of care and any changes made to the plan of care.

*d. Implementation.* The interdisciplinary team shall:

(1) Implement, coordinate, and monitor the plan of care, whether the services are furnished by PACE employees or contractors; and

(2) Continuously monitor the enrollee's health and psychosocial status, as well as the effectiveness of the plan of care, through the provision of services, informal observation, input from enrollees and caregivers, and communications among team members and other providers.

*e. Evaluation.* On at least a semiannual basis, the interdisciplinary team shall reevaluate the plan of care, including defined outcomes, and make changes as necessary.

**88.86(4) Reassessment.**

*a. Semiannual reassessment.* On at least a semiannual basis, or more often if an enrollee's condition dictates, the following interdisciplinary team members must conduct an in-person reassessment:

- (1) Primary care physician.
- (2) Registered nurse.
- (3) Master's-level social worker.
- (4) Recreational therapist or activity coordinator.
- (5) Other interdisciplinary team members actively involved in the development or implementation of the enrollee's plan of care, such as the home care coordinator, physical therapist, occupational therapist, or dietitian.

*b. Annual reassessment.* On at least an annual basis, the following interdisciplinary team members must conduct an in-person reassessment:

- (1) Physical therapist.
- (2) Occupational therapist.
- (3) Dietitian.
- (4) Home care coordinator.

*c. Unscheduled reassessments.* In addition to annual and semiannual reassessments, unscheduled reassessments may be required based on the following:

(1) A change in enrollee status. If the health or psychosocial status of an enrollee changes, the interdisciplinary team members listed in paragraph 88.86(2) "a" must conduct an in-person reassessment.

(2) A request by the enrollee or designated representative. If an enrollee (or the enrollee's designated representative) believes that the enrollee needs to initiate, eliminate, or continue a particular service, the appropriate interdisciplinary team members, as identified by the interdisciplinary team, must conduct an in-person reassessment.

*d. Changes to plan of care.* Interdisciplinary team members who conduct a reassessment must:

- (1) Reevaluate the enrollee's plan of care.
- (2) Discuss any changes in the plan of care with the interdisciplinary team.
- (3) Obtain approval of the revised plan of care from the interdisciplinary team and the enrollee or the enrollee's designated representative.
- (4) Document all assessment and reassessment information in the enrollee's medical record.
- (5) Furnish to the enrollee any services included in the revised plan of care as a result of a reassessment as expeditiously as the enrollee's health condition requires.

**88.86(5) Procedures for resolving enrollee request to change the plan of care.** The PACE organization must have explicit procedures for timely resolution of a request by an enrollee or an enrollee's designated representative to initiate, eliminate, or continue a particular service.

*a.* Except as provided in paragraph "b" of this subrule, the interdisciplinary team must notify the enrollee or the enrollee's designated representative of its decision to approve or deny the request from the enrollee or the designated representative as expeditiously as the enrollee's condition requires, but no later than 72 hours after the date the interdisciplinary team receives the request.

*b.* The interdisciplinary team may extend the 72-hour period for notifying the enrollee or the designated representative of its decision to approve or deny the request by no more than five additional days if:

- (1) The enrollee or designated representative requests the extension; or
- (2) The interdisciplinary team documents its need for additional information and how the delay is in the interest of the enrollee.

*c.* The PACE organization must:

(1) Explain to the enrollee or the enrollee's designated representative orally and in writing any denial of a request to change the plan of care; and

(2) Provide the specific reasons for the denial in understandable language.

*d.* The PACE organization is responsible for:

(1) Informing the enrollee or the enrollee's designated representative of the enrollee's right to appeal the decision as specified in 42 CFR Section 460.122 as amended to December 8, 2006.

(2) Describing both the standard and expedited appeals processes of the PACE organization, including the right to obtain and conditions for obtaining expedited consideration of an appeal of a denial of services as specified in 42 CFR Section 460.122 as amended to December 8, 2006.

(3) Describing the right to and conditions for continuation of appealed services through the period of an appeal as specified in 42 CFR Section 460.122(e) as amended to December 8, 2006.

*e.* If the interdisciplinary team fails to provide the enrollee with timely notice of the resolution of the request or fails to furnish the services required by the revised plan of care, this failure constitutes an adverse decision. The enrollee's request must be automatically processed by the PACE organization as an appeal in accordance with 42 CFR Section 460.122 as amended to December 8, 2006.

*f.* The PACE organization must submit all documentation related to an appeal to the attention of the PACE program manager at the following address: Iowa Medicaid Enterprise, 100 Army Post Road, Des Moines, Iowa 50315.

**441—88.87(249A) Program administrative requirements.** A PACE organization shall comply with the federal administrative requirements stated in 42 CFR Sections 460.60 through 460.82 as amended to December 8, 2006, including requirements relating to organizational structure, governing body, qualifications for staff who have direct contact with enrollees, training, program integrity, contracted services, oversight of direct care services, physical environment, infection control, transportation services, dietary services, fiscal soundness, and marketing.

**88.87(1) Enrollee rights.** A PACE organization shall comply with the federal participant rights requirements stated in 42 CFR Sections 460.110 through 460.124 as amended to December 8, 2006. Upon exhaustion of the PACE organization's appeal process, a Medicaid enrollee has the right to appeal to the department any adverse coverage or payment decision regarding any service, including any denial, reduction, or termination of any service, pursuant to 441—Chapter 7.

**88.87(2) Data collection, record maintenance, and reporting.** A PACE organization shall comply with federal data collection, records maintenance, and reporting requirements stated in 42 CFR Sections 460.200 through 460.210 as amended to December 8, 2006.

**88.87(3) Quality assessment and performance improvement.** A PACE organization shall comply with the federal quality assessment and performance improvement requirements stated in 42 CFR Sections 460.130 through 460.140 as amended to November 24, 1999.

**88.87(4) Federal and state monitoring.**

*a.* The PACE program shall cooperate with federal and state monitoring pursuant to 42 CFR Sections 460.190 through 460.196 as amended to Nov. 24, 1999, including:

- (1) Corrective action required pursuant to 42 CFR Section 460.194; and
- (2) Disclosure of review results pursuant to 42 CFR Section 460.196(c) and (d).

*b.* The PACE program is subject to sanctions or termination pursuant to subrules 88.83(3) and 88.83(4).

*c.* During the trial period, CMS, in cooperation with the department, shall conduct comprehensive annual reviews of the operations of a PACE organization to ensure compliance with PACE federal regulations and 441—Chapter 88, Division V.

*d.* After the trial period, the department, in cooperation with CMS, shall conduct on-site reviews of a PACE organization at least every two years.

*e.* After a review, CMS and the department shall report the results of the review to the PACE organization, along with any recommendations for changes to the organization's program.

*f.* Within 30 days of issuance of the report, the PACE organization shall develop and implement a corrective action plan to address any deficiencies identified through the review.

*g.* CMS or the department shall monitor the effectiveness of the corrective actions implemented.

**441—88.88(249A) Payment.**

**88.88(1) Medicaid payment to PACE organization.** Under a PACE program agreement, the department shall make a prospective monthly payment to the PACE organization of a capitation amount for each Medicaid enrollee. The monthly capitation payment amount shall be negotiated between the PACE organization and the department and shall be specified in the PACE program agreement.

*a.* The amount of the capitation payment:

(1) Shall be less than the amount that would otherwise have been paid under the Medicaid program if the enrollees were not enrolled under the PACE program.

(2) Shall be a fixed amount regardless of changes in the enrollee's health status.

(3) May be renegotiated on an annual basis.

*b.* The PACE organization must accept the capitation payment amount as payment in full for Medicaid enrollees. The organization shall not collect or receive any other form of payment from the department or from, or on behalf of, the enrollee except for any amounts due from the enrollee pursuant to subrule 88.88(2).

**88.88(2) Liability of Medicaid enrollee.** A Medicaid enrollee shall contribute toward the cost of the enrollee's care according to the terms of this subrule. A PACE organization may not charge a premium to a Medicaid enrollee except for any amounts due pursuant to this subrule.

*a. Institutionalized enrollees.* Medicaid enrollees who reside in a medical facility are liable to the PACE organization for the Medicaid capitation payment to the extent of their total monthly income, with the exceptions allowed by 441—subrule 75.16(1) and the deductions allowed by 441—subrule 75.16(2).

*b. Noninstitutionalized enrollees.* Medicaid enrollees who do not reside in a medical facility are liable to the PACE organization for the Medicaid capitation payment to the extent of their total monthly income, with the deductions required by 42 CFR Section 435.726(c) as amended to July 25, 1994, with maintenance needs amounts set at the following levels:

(1) The amount for the maintenance needs of the enrollee is set at 300 percent of the maximum SSI grant for an individual.

(2) The additional amount for the maintenance needs of a spouse at home is set at the Iowa Medicaid program's medically needy income standard for one person.

(3) The additional amount for the maintenance needs of a family at home is set at the Iowa Medicaid program's medically needy income standard for a family of the same size, to the extent that amount exceeds any amount allowed for the maintenance needs of a spouse at home.

These rules are intended to implement Iowa Code section 249A.4.

[Filed 9/5/86, Notice 5/21/86—published 9/24/86, effective 11/1/86]

[Filed emergency 1/15/87—published 2/11/87, effective 1/15/87]

[Filed 3/4/88, Notice 1/27/88—published 3/23/88, effective 5/1/88]

[Filed 5/27/88, Notice 4/20/88—published 6/15/88, effective 8/1/88]<sup>1</sup>

[Filed 4/14/89, Notice 2/22/89—published 5/3/89, effective 7/1/89]

[Filed 1/17/90, Notice 8/23/89—published 2/7/90, effective 4/1/90]<sup>2</sup>

[Filed emergency 6/14/91 after Notice 5/1/91—published 7/10/91, effective 7/1/91]

[Filed 7/10/91, Notice 5/29/91—published 8/7/91, effective 10/1/91]

[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 without Notice 8/12/93—published 9/1/93, effective 11/1/93]

[Filed emergency 10/14/93—published 11/10/93, effective 11/1/93]

[Filed 12/16/93, Notice 9/1/93—published 1/5/94, effective 3/1/94]

[Filed 12/16/93, Notice 11/10/93—published 1/5/94, effective 3/1/94]

[Filed emergency 6/16/94—published 7/6/94, effective 7/1/94]

[Filed 9/15/94, Notice 7/6/94—published 10/12/94, effective 12/1/94]

[Filed emergency 6/7/95—published 7/5/95, effective 7/1/95]

[Filed 9/25/95, Notice 7/5/95—published 10/11/95, effective 12/1/95]

[Filed 6/13/96, Notice 4/24/96—published 7/3/96, effective 9/1/96]

[Filed emergency 1/15/97 after Notice 12/4/96—published 2/12/97, effective 2/1/97]

- [Filed 4/11/97, Notice 2/12/97—published 5/7/97, effective 7/1/97]
- [Filed 10/15/97, Notice 9/10/97—published 11/5/97, effective 1/1/98]
- [Filed emergency 11/12/97—published 12/3/97, effective 11/12/97]
- [Filed 1/14/98, Notice 12/3/97—published 2/11/98, effective 4/1/98]
- [Filed 4/8/98, Notice 2/11/98—published 5/6/98, effective 7/1/98]
- [Filed 7/15/98, Notice 5/20/98—published 8/12/98, effective 1/1/99]
- [Filed 6/8/00, Notice 4/19/00—published 6/28/00, effective 8/2/00]
- [Filed 10/11/00, Notice 8/23/00—published 11/1/00, effective 1/1/01]
- [Filed 12/14/00, Notice 11/1/00—published 1/10/01, effective 3/1/01]
- [Filed 9/11/01, Notice 7/11/01—published 10/3/01, effective 12/1/01]
- [Filed 12/12/01, Notice 10/17/01—published 1/9/02, effective 3/1/02]
- [Filed emergency 12/12/02 after Notice 10/16/02—published 1/8/03, effective 1/1/03]<sup>◇</sup>
  - [Filed emergency 6/12/03—published 7/9/03, effective 7/1/03]
  - [Filed 9/22/03, Notice 7/9/03—published 10/15/03, effective 12/1/03]
  - [Filed without Notice 5/4/05—published 5/25/05, effective 7/1/05]
  - [Filed without Notice 7/14/06—published 8/2/06, effective 10/1/06]
- [Filed emergency 10/12/06 after Notice 8/30/06—published 11/8/06, effective 11/1/06]
  - [Filed 2/15/07, Notices 8/2/06, 12/20/06—published 3/14/07, effective 5/1/07]
  - [Filed 5/16/07, Notice 2/14/07—published 6/6/07, effective 8/1/07]
  - [Filed 7/12/07, Notice 5/23/07—published 8/1/07, effective 9/5/07]
- [Filed emergency 7/9/08 after Notice 5/21/08—published 7/30/08, effective 7/9/08]
- [Filed ARC 9487B (Notice ARC 9399B, IAB 2/23/11), IAB 5/4/11, effective 7/1/11]
  - [Filed Emergency ARC 0191C, IAB 7/11/12, effective 7/1/12]
- [Filed ARC 0359C (Notice ARC 0193C, IAB 7/11/12), IAB 10/3/12, effective 12/1/12]
- [Filed ARC 0583C (Notice ARC 0435C, IAB 10/31/12), IAB 2/6/13, effective 4/1/13]
- [Filed ARC 0758C (Notice ARC 0639C, IAB 3/6/13), IAB 5/29/13, effective 8/1/13]
  - [Filed Emergency ARC 0848C, IAB 7/24/13, effective 7/1/13]
- [Filed ARC 1051C (Notice ARC 0847C, IAB 7/24/13), IAB 10/2/13, effective 11/6/13]

<sup>◇</sup> Two or more ARCs

<sup>1</sup> Effective date of 8/1/88 delayed 30 days by the Administrative Rules Review Committee at its July 1988 meeting.

<sup>2</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.



## CHAPTER 92 IOWACARE

### PREAMBLE

This chapter defines and structures the IowaCare program administered by the department pursuant to Iowa Code Supplement chapter 249J. It is the department's intent that all state expenditures under the IowaCare program shall qualify for federal financial participation under Title XIX of the Social Security Act (Medical Assistance or Medicaid), as allowed by waivers of Title XIX requirements granted by the Secretary of the U.S. Department of Health and Human Services pursuant to Section 1115 of the Social Security Act (42 U.S.C. §1315). Therefore, this chapter shall remain in effect only as long as such waivers are effective. Further, this chapter shall be construed to comply with the requirements of Title XIX or with the terms of any applicable waiver of Title XIX requirements. To the extent that these rules may be found to be inconsistent with any applicable requirement of Title XIX or the terms of any applicable waiver, the requirements of Title XIX or the terms of the waiver shall prevail.

#### **441—92.1(249A,249J) Definitions.**

*"Applicant"* means an individual who applies for medical assistance under the IowaCare program described in this chapter.

*"Clean claim"* means a claim that can be adjudicated in the Medicaid claims payment system to result in either a paid or denied status.

*"Department"* means the Iowa department of human services.

*"Dependent child"* means the child or stepchild of an applicant or member who is living in the applicant's or member's home and is under the age of 18 or is 18 years of age and will graduate from high school or an equivalent level of vocational or technical school or training leading to a certificate or diploma before reaching the age of 19. Correspondence school is not an allowable program of study. "Dependent child" shall also include a child attending college or a school of higher learning beyond high school if the parents will claim the child as a dependent on their state or federal income tax return.

*"Enrollment period"* means the entire period that a member receives IowaCare without a break, which may include multiple certification periods.

*"Federal poverty level"* means the poverty income guidelines revised annually and published in the Federal Register by the U.S. Department of Health and Human Services.

*"Group health insurance"* means any plan of or contributed by an employer (including a self-insured plan) to provide health care (directly or otherwise) to the employer's employees, former employees, or the families of the employees or former employees.

*"Indian"* means a Native American eligible, as an Indian, to receive health care services from an Indian health care provider as defined in this rule.

*"Indian health care provider"* means a health care program operated by the Indian Health Service of the U.S. Department of Health and Human Services or by an Indian tribe, tribal organization, or urban Indian organization as those terms are defined in 25 U.S.C. § 1603.

*"Initial application"* means the first application for IowaCare or an application that is filed after a break in assistance of one month or more.

*"IowaCare"* means the medical assistance program explained in this chapter.

*"Medical expansion services"* means the services described in Iowa Code section 249J.6.

*"Medical home"* means a team approach to providing health care that originates in a primary care setting; fosters a partnership among the patient, the personal provider, other health care professionals, and where appropriate, the patient's family; utilizes the partnership to access all medical and nonmedical health-related services needed by the patient and the patient's family to achieve maximum health potential; maintains a centralized, comprehensive record of all health-related services to promote continuity of care; and has all of the characteristics specified in Iowa Code section 135.158.

*"Member"* means an individual who is receiving assistance under the IowaCare program described in this chapter.

*"Newborn"* means an infant born to a woman as defined in paragraph 92.2(1) "b."

“*Nonparticipating provider*” means a hospital that is located in Iowa and licensed pursuant to Iowa Code chapter 135B but that is not an IowaCare provider pursuant to subrule 92.8(1).

“*Provider-directed care coordination services*” means provider-directed services in a clinical setting aimed at managing all aspects of a patient’s care to ensure quality of care and safety. All aspects of care are coordinated by the clinical team under the direction of a physician. The team must include a dedicated care coordinator.

[ARC 9135B, IAB 10/6/10, effective 10/1/10; ARC 0760C, IAB 5/29/13, effective 5/8/13]

**441—92.2(249A,249J) Eligibility.** IowaCare eligibility shall be determined according to the requirements of rules 441—75.2(249A) to 441—75.4(249A), 441—75.7(249A), 441—75.10(249A), and 441—75.12(249A) and the provisions of this rule.

**92.2(1) Persons covered.** Medical assistance under IowaCare shall be available to the following people as provided in this chapter:

a. Persons 19 through 64 years of age who:

- (1) Are not eligible for medical assistance under 441—subrules 75.1(1) through 75.1(40) or 75.1(42), including persons unable to meet spenddown under 441—subrule 75.1(35); and
- (2) Have countable income at or below 200 percent of the federal poverty level.

b. Pregnant women whose:

- (1) Gross countable income is below 300 percent of the federal poverty level; and
- (2) Allowable medical expenses reduce their countable income to 200 percent of the federal poverty level or below.

c. Newborn children born to women defined in paragraph “b.”

**92.2(2) Citizenship.** To be eligible for IowaCare benefits, a person must meet the requirements in 441—subrule 75.11(2). A person who claims a qualified alien status shall provide documentation of this status.

**92.2(3) Other disqualification.** A person who has been disqualified from Medicaid for reasons other than excess income, excess resources, or lack of categorical eligibility is not eligible for IowaCare benefits.

**92.2(4) Group health insurance.** A person who has access to group health insurance is not eligible for IowaCare. The department shall use Form 470-4542, IowaCare Insurance Information Request, to obtain information to confirm the status of an IowaCare member’s group health insurance. An applicant or member shall not be considered to have access to group health insurance if any of the following conditions exist:

a. The applicant or member is not enrolled in the available group health plan and states that:

- (1) The coverage is unaffordable; or
- (2) Exclusions for preexisting conditions apply; or
- (3) The needed services are not services covered by the plan.

b. The applicant or member is enrolled in a group health plan but states that:

- (1) Exclusions for preexisting conditions apply; or
- (2) The needed services are not covered by the plan; or
- (3) The limits of benefits under the plan have been reached; or
- (4) The plan includes only catastrophic health care coverage.

**92.2(5) Payment of assessed premiums.** IowaCare will be canceled if premiums are not paid in accordance with 441—92.7(249A,249J). However, an application for IowaCare shall not be affected by any unpaid premiums from any previous certification period.

**92.2(6) Availability of funds.** Eligibility for IowaCare shall not be approved when the department has determined that there are insufficient funds available to pay for additional enrollment, in accordance with 441—92.14(249A,249J).

[ARC 8505B, IAB 2/10/10, effective 4/1/10; ARC 9135B, IAB 10/6/10, effective 10/1/10]

**441—92.3(249A,249J) Application.** Medicaid application policies in 441—76.1(249A) and 441—76.8(249A) apply to IowaCare except as follows:

**92.3(1)** An application for IowaCare may also be submitted on Comm. 239, IowaCare Application, or Form 470-4364, IowaCare Renewal Application. An applicant who submits an application on another form allowed under 441—76.1(249A) and has income over 150 percent of the federal poverty level shall also sign Form 470-4194, IowaCare Premium Agreement, and submit it within ten days of the department's request.

**92.3(2)** A new application is required for each certification period.  
[ARC 9135B, IAB 10/6/10, effective 10/1/10; ARC 9982B, IAB 2/8/12, effective 4/1/12]

**441—92.4(249A,249J) Application processing.** Department staff shall process IowaCare applications. The department shall base eligibility decisions primarily on information declared by the applicant. A face-to-face interview is not required.

**92.4(1) Verification.** Applicants seeking eligibility under 92.2(1)“b” shall provide verification of medical expenses as required under 92.5(5)“b.” IowaCare applicants shall not be required to provide verification of income, household members, disability, social security number, age, HAWK-I premium, group health insurance, or pregnancy, unless the verification is specifically requested in writing.

*a.* The department shall notify the person in writing of any further verification requested. The person shall have five working days to supply the requested information. The local office may extend the deadline for a reasonable period when the person is making every effort but is unable to secure the required information or verification from a third party.

*b.* Failure of the person to supply requested information or refusal by the person to authorize the department to secure the information from other sources shall serve as a basis for denial of an application or cancellation of IowaCare benefits.

*c.* If benefits are denied or canceled for failure to provide information and the information is provided within 14 calendar days of the effective date of the denial or cancellation, the department shall complete the eligibility determination as though the information were received timely. If the fourteenth calendar day falls on a weekend or state holiday, the client shall have until the next business day to provide the information.

**92.4(2) Screening for full Medicaid.** The department shall screen each application for eligibility under coverage groups listed in 441—75.1(249A). If the applicant is eligible under another coverage group, the IowaCare application shall be considered an application for that coverage group.

**92.4(3) Time limit for decision.** The department shall make a determination of approval or denial as soon as possible, but no later than three working days after the filing date of the application, unless:

*a.* One or more conditions listed in 441—subrule 76.3(1), 76.3(3), 76.3(4), or 76.3(6) exist; or

*b.* The application is being processed for Medicaid eligibility under a coverage group listed in 441—75.1(249A).

[ARC 8500B, IAB 2/10/10, effective 3/1/10]

**441—92.5(249A,249J) Determining income eligibility.** The department shall determine the income of an applicant's household as of the date of decision. To be eligible, the household's income minus allowable deductions shall not exceed 200 percent of the federal poverty level for the household size.

**92.5(1) Household size.** The household size shall include the applicant and the applicant's dependent or unborn children and spouse living in the same home, except when a dependent child or spouse has elected to receive supplemental security income under Title XVI of the Social Security Act. A person who is absent from the home shall not be included in the household size, unless the absence is temporary.

*a.* An applicant's spouse shall not be considered absent from the home when:

(1) The spouse's absence is due solely to a pattern of employment, including active duty in the uniformed services of the United States.

(2) The spouse is a convicted offender but is permitted to live at home while serving a court-imposed sentence by performing unpaid public work or unpaid community service during the workday.

*b.* The conditions described in 441—paragraph 75.53(4)“b” shall be applied to determine whether a person's absence is temporary.

**92.5(2) Self-declaration of income.** Applicants shall self-declare the household's future unearned and earned income based on their best estimate.

*a.* Applicants who receive income on a regular basis shall declare their household's monthly income as described at 92.5(3) and 92.5(4).

*b.* Applicants who are self-employed, receive their income on an irregular basis, or are not currently employed shall declare their household's anticipated yearly income as described in 92.5(3) and 92.5(4).

**92.5(3) Earned income.** All earned income as defined in this subrule that is received by a person included in the household size shall be counted except for the earnings of a child who is a full-time student as defined in 441—subparagraphs 75.54(1) "b"(1), (2), and (3). Earned income shall include income in the form of a salary, wages, tips, or profit from self-employment.

*a.* For income from salary, wages, or tips, earned income shall mean the total gross amount of income irrespective of the expenses of employment.

*b.* For self-employment income, earned income shall mean the net profit from self-employment, defined as gross income less the costs of producing the income.

*c.* Gross income from providing child care in the applicant's or member's own home shall include the total payments received for the service and any payment received due to the Child Nutrition Amendments of 1978 for the cost of providing meals to children.

(1) In determining the net profit counted as earned income from providing child care services in the applicant's or member's own home, 40 percent of the total gross income received shall be deducted to cover the costs of producing the income, unless the applicant or member requests to have actual expenses in excess of the 40 percent considered.

(2) When the applicant or member verifies expenses in excess of 40 percent of the total gross income received, the net profit counted as earned income shall be determined in the same manner as specified at paragraph 92.5(3) "b."

**92.5(4) Unearned income.** Unearned income of all household members shall be counted unless exempted as income by:

*a.* 441—subrule 75.57(6), paragraph "b," "c," "d," "e," "f," "g," "h," "i," "j," "k," "l," "m," "p," "q," "r," "t," "u," "v," "w," "x," "y," "z," or "aa"; or

*b.* 441—subrule 75.57(7), paragraph "a," "b," "c," "d," "e," "f," "g," "h," "i," "j," "k," "l," "m," or "q."

**92.5(5) Deductions.** The department shall determine a household's countable income by deducting the following from the household's self-declared income:

*a.* Twenty percent of the household's self-declared earned income.

*b.* For women applying under 92.2(1) "b," medical expenses incurred for a person included in the household size that are unpaid and not subject to payment by a third party. Verification of the unpaid expenses must be provided in order to receive the deduction. The medical expenses that can be deducted are:

(1) Health insurance premiums, deductibles, or coinsurance charges; and

(2) Medical and dental expenses.

**92.5(6) Disregard of changes.**

*a.* A person found to be income-eligible upon application or recertification of eligibility shall remain income-eligible for 12 months regardless of any change in income or household size.

*b.* Persons income-eligible on June 30, 2013, shall remain income-eligible through December 31, 2013, regardless of any change in income or household size.

**92.5(7) Unearned nonrecurring lump-sum income.** All unearned nonrecurring lump-sum income shall be disregarded.

**92.5(8) Earned lump-sum income.** Anticipated earned lump-sum income shall be prorated over the period for which the income is received.

[ARC 0862C, IAB 7/24/13, effective 7/1/13; ARC 1059C, IAB 10/2/13, effective 11/6/13]

**441—92.6(249A,249J) Effective date.** The department shall issue Form 470-4164, IowaCare Medical Card, to persons enrolled in the IowaCare program.

**92.6(1) Certification period.** IowaCare eligibility shall be effective on the first day of the month of application or the first day of the month all eligibility requirements are met, whichever is later. The certification period shall continue for 12 consecutive months. EXCEPTIONS:

*a.* For women and newborns eligible under 92.2(1)“*b*” or “*c*,” the certification period shall continue until 60 days after the birth of the child.

*b.* Certification periods may be adjusted if two or more IowaCare members who were in two households are combined into one household for premium purposes.

**92.6(2) Retroactive eligibility.** IowaCare benefits shall also be available for the month preceding the month in which the application is filed if during that preceding month:

*a.* The applicant received Medicaid expansion services from a provider within the Medicaid expansion network; and

*b.* The applicant would have been eligible for IowaCare if application had been made.

**92.6(3) Care provided before eligibility.** No payment shall be made for medical care received before the effective date of eligibility.

**92.6(4) Reinstatement.** Eligibility for IowaCare may be reinstated without a new application when all information necessary to establish eligibility, including verification of any changes, is provided within 14 calendar days of the effective date of the cancellation. If the fourteenth calendar day falls on a weekend or state holiday, the client shall have until the next business day to provide the information. When eligibility can be reestablished, assistance shall be reinstated with an effective date of the first day of the month following the month of cancellation.

**92.6(5) Extension of certifications from June 30, 2013.** Any certification period in effect June 30, 2013, shall continue until December 31, 2013.

[ARC 8500B, IAB 2/10/10, effective 3/1/10; ARC 9135B, IAB 10/6/10, effective 10/1/10; ARC 0862C, IAB 7/24/13, effective 7/1/13; ARC 1059C, IAB 10/2/13, effective 11/6/13]

**441—92.7(249A,249J) Financial participation.** In addition to the copayments required by 441—subrule 79.1(13), IowaCare members, with the exception of newborns eligible pursuant to 92.2(1)“*c*” and members in households that include a considered person who pays a Medicaid premium, shall be assessed a sliding-scale monthly premium. A member shall be responsible for paying the premium for the first month after the month of decision and for the following three months, regardless of continued enrollment during the four-month period or during previous months, and for each month of continued enrollment after the required four months. If there is a break in enrollment of one month or more, a new four-month period of mandatory premiums shall be assessed, beginning with the month following the month of decision.

**92.7(1) Premium amount.** The monthly premium amount shall be established for the certification period determined pursuant to subrule 92.6(1) beginning with the first month of eligibility, based on projected monthly income for 12 months. On an initial application, no premium shall be assessed for months of eligibility before and including the month of decision, including the retroactive month.

*a.* The monthly premium is based on the household’s countable monthly income as a percentage of the federal poverty level for a household of that size. If there is more than one IowaCare member in a household, a single premium is established for coverage of all of the members in the household. Subject to the annual update pursuant to paragraph 92.7(1)“*b*,” for certification periods beginning on or after April 1, 2013, premiums are as follows:

When there is one IowaCare member in the household and the household's income is at or below:	The member's premium amount is:
150% of federal poverty level	\$0
160% of federal poverty level	\$52
170% of federal poverty level	\$56
180% of federal poverty level	\$59
190% of federal poverty level	\$62
200% of federal poverty level	\$66

When there are two or more IowaCare members in the household and the household's income is at or below:	The household's premium amount is:
150% of federal poverty level	\$0
160% of federal poverty level	\$70
170% of federal poverty level	\$74
180% of federal poverty level	\$79
190% of federal poverty level	\$83
200% of federal poverty level	\$87

*b.* The listed premium amount is calculated based on the lowest income level in each 10 percent increment of the federal poverty level for a household of one if there is one IowaCare member in the household or of the federal poverty level for a household of two if there are two or more IowaCare members in the household.

(1) Households with income at or below 150 percent of the poverty level are not subject to a premium.

(2) Premiums for households with income over 150 percent of the poverty level are 3.5 percent of the lowest applicable income level. The department will update these amounts effective the second month after the month federal poverty level guidelines are released.

*c.* The cost of HAWK-I premiums paid for household members shall be deducted from the premium assessed according to this subrule.

*d.* The monthly premium established for a certification period shall not be increased due to an increase in household income or a change in household size.

*e.* The premium may be reduced prospectively during the certification period if a member declares a reduction in projected average monthly household income or an increase in household size or is granted a hardship exemption.

**92.7(2) Billing and payment.** Form 470-4165, IowaCare Billing Statement, shall be used for billing and collection.

*a. Method of payment.* Members shall submit premium payments to the following address: Iowa Medicaid Enterprise, IowaCare Premiums, P.O. Box 10391, Des Moines, Iowa 50306-9013.

*b. Due date.* When the department notifies a member of the amount of the premium, the member or household shall pay any premiums due as follows:

(1) The premium for each month is due the last calendar day of the month the premium is to cover. EXCEPTION: The premiums for the months covered in the initial billing are due the last calendar day of the following month.

(2) If the last calendar day falls on a weekend or a state or federal holiday, payment is due the first working day following the holiday or weekend.

*c. Application of payment.* The department shall apply premium payments received to the oldest unpaid month in the current certification period. When premiums for all months in the certification period have been paid, the department shall hold any excess and apply it to any months for which eligibility is subsequently established.

**92.7(3) *Hardship exemption.*** A member or household that submits a written statement indicating that payment of the monthly premium will be a financial hardship shall be exempted from premium payment for that month, except as provided in paragraph “c.”

*a.* If the statement is not received by five working days after the premium due date, the member or household shall be obligated to pay the premium.

*b.* If the statement is timely submitted with a partial payment, exemption shall be granted for the balance owed for that month.

*c.* A member or household shall not be exempted from premium payment for a month in which the member misrepresented the household’s circumstances.

**92.7(4) *Failure to pay premium.*** If the member or household fails to pay the assessed premium or to declare a hardship by the date the premium is due, the department shall cancel IowaCare benefits effective 60 days after the due date and shall refer the unpaid premiums for collection. A member whose IowaCare benefits are canceled due to nonpayment of premiums must reapply to establish IowaCare eligibility.

**92.7(5) *Refund of premium.*** When a member’s IowaCare coverage is canceled due to a circumstance listed in paragraph “a,” premiums paid for any period after the cancellation date shall be refunded, except to the extent that premiums are still due for any household members whose IowaCare coverage is not canceled.

*a.* Premiums may be refunded when a member’s IowaCare coverage is canceled because the member:

- (1) Is determined eligible for medical assistance under 441—subrules 75.1(1) through 75.1(40);
- (2) Has access to group health insurance coverage as defined in subrule 92.2(4);
- (3) Reaches age 65;
- (4) Dies; or
- (5) No longer meets program requirements after the four mandatory premium months.

*b.* The amount of the refund shall be offset by any outstanding premiums owed.

*c.* Any excess premium received for a person who is not receiving IowaCare benefits shall be refunded:

(1) Two calendar months after eligibility ended unless an application or reapplication is pending, or

(2) Upon the person’s request.

*d.* Any excess premium received for an IowaCare member shall be refunded:

(1) After two calendar months of a zero premium, or

(2) Upon the member’s request.

[ARC 7667B, IAB 4/8/09, effective 4/1/09; ARC 9135B, IAB 10/6/10, effective 10/1/10; ARC 9532B, IAB 6/1/11, effective 7/6/11; ARC 9982B, IAB 2/8/12, effective 4/1/12; ARC 0151C, IAB 6/13/12, effective 7/18/12; ARC 0759C, IAB 5/29/13, effective 5/8/13]

**441—92.8(249A,249J) Benefits.** Under IowaCare, payment will be made only for services and providers as specified in this rule. No payment will be made for any service provided elsewhere or by another provider.

**92.8(1) *Provider network.*** Except as provided in subrules 92.8(3) through 92.8(7), IowaCare members shall have medical assistance only for services provided to the member by:

*a.* The University of Iowa Hospitals and Clinics; or

*b.* Broadlawns Medical Center in Des Moines; or

*c.* A federally qualified health center that the department has designated as part of the IowaCare network using a phased-in approach based on the degree to which the area is underserved, medical home readiness, and the availability of funds; or

*d.* Any physician, advanced registered nurse practitioner, or physician assistant who is part of a medical institution listed in this subrule. Physician assistants are able to render covered services as auxiliary personnel of a physician pursuant to 441—subrule 78.1(13); or

*e.* An Indian health care provider enrolled in the IowaCare program, for services provided to Indians.

**92.8(2) Covered services.** Services shall be limited to the services covered by the Iowa Medicaid program pursuant to 441—Chapter 78 or 441—79.9(249A) and to medical home services required by subrule 92.8(7). All conditions of service provision shall apply in the same manner as under the regular Iowa Medicaid program and pursuant to 441—Chapter 78, 441—79.3(249A), 441—79.5(249A), 441—79.6(249A), 441—79.8(249A) through 441—79.14(249A), and applicable provider manuals. These conditions include, but are not limited to, prior authorization requirements and exclusions for cosmetic procedures or those otherwise determined not to be required to meet the medical need of the patient.

**92.8(3) Obstetric and newborn coverage.** IowaCare members who qualify under 92.2(1) “b” or “c” are also eligible for the services specified in paragraph “a” or “b” from the providers specified in paragraph “c” or “d.”

a. Covered services for pregnant women shall be limited to:

(1) Inpatient hospital services when the diagnosis-related group (DRG) submitted for payment is between 370 and 384 and the primary or secondary diagnosis code is V22 through V24.9.

(2) Obstetrical services provided in an outpatient hospital setting when the primary or secondary diagnosis code is V22 through V24.9.

(3) Services from another provider participating in Medicaid if the claim form reflects that the primary or secondary diagnosis code is V22 through V24.9.

b. Newborns will be eligible while hospitalized and for a period not to exceed 60 days from the date of birth.

(1) Inpatient hospital services shall be payable when the diagnosis-related group (DRG) submitted for payment is between 385 and 391.7.

(2) Services provided by a health care provider other than a hospital shall be covered as provided in subrule 92.8(2).

c. For persons who reside in Cedar, Clinton, Iowa, Johnson, Keokuk, Louisa, Muscatine, Scott, or Washington County, the services listed in this subrule are covered only when provided by the University of Iowa Hospitals and Clinics or when provided by an Indian health care provider to an Indian.

d. Persons who do not live in Cedar, Clinton, Iowa, Johnson, Keokuk, Louisa, Muscatine, Scott, or Washington County may obtain the services listed in this subrule from any provider that participates in Iowa Medicaid.

**92.8(4) Routine preventive medical examinations.** A routine preventive medical examination is one that is performed without relationship to treatment or diagnosis for a specific illness, symptom, complaint, or injury.

a. IowaCare members who qualify under paragraph 92.2(1) “b” or “c” and who have not been enrolled with a medical home are eligible to receive routine preventive medical examinations from:

(1) Any provider specified under subrule 92.8(1), or

(2) Any physician, advanced registered nurse practitioner, or physician assistant who participates in Iowa Medicaid, including but not limited to providers available through a free clinic, a rural health clinic, or a federally qualified health center that has not been designated as an IowaCare provider pursuant to paragraph 92.8(1) “c.” Physician assistants are able to render covered services as auxiliary personnel of a physician pursuant to 441—subrule 78.1(13).

b. A provider that bills IowaCare for a routine preventive medical examination shall use diagnosis code V70 and evaluation and management CPT code 99202, 99203, 99204, 99212, 99213, or 99214, as appropriate to the level of service provided. Basic laboratory work may also be billed in association with the medical examination, as appropriate and necessary.

**92.8(5) Drugs for smoking cessation.** IowaCare members may obtain outpatient prescription drugs for smoking cessation that are related to another appropriately billed IowaCare service from any pharmacy participating in the Iowa Medicaid program.

**92.8(6) Medical home.** As a condition of participation in the IowaCare program, network providers designated pursuant to subrule 92.8(1) other than Indian health care providers must also qualify as medical homes, pursuant to Iowa Code chapter 135, division XXII.

*a.* The provider shall meet medical home standards. If the Iowa department of public health adopts rules that provide statewide medical home standards or provide for a statewide medical home certification process, those rules shall apply to IowaCare medical home providers and shall take precedence over the requirements in this paragraph. At a minimum, medical homes shall:

(1) Have National Committee for Quality Assurance (NCQA) Level 1 certification or equivalent certification. Effective July 1, 2011, medical homes that achieve a higher level of accreditation from NCQA or equivalent shall be designated as such for purposes of payment.

(2) Provide provider-directed care coordination services.

(3) Provide members with access to health care and information.

(4) Provide wellness and disease prevention services.

(5) Create and maintain chronic disease information in a searchable disease registry.

(6) Demonstrate evidence of implementation of an electronic health record system.

(7) Participate in and report on quality improvement processes.

*b.* The provider shall execute a contract with the department to be an IowaCare medical home and receive enhanced medical home reimbursements pursuant to subrule 92.9(4). The contract shall include performance measurements and specify expectations and standards for a medical home.

*c.* If an IowaCare member resides in a designated county near a designated medical home provider, the department shall assign the member to that provider. If an IowaCare member who is assigned to a medical home and who is not an Indian chooses to go to another provider without a referral from the medical home:

(1) The service is not covered by the IowaCare program, and

(2) The provider may bill the member according to the provider's established criteria for billing other patients.

*d.* Subject to subrule 92.8(1), services provided to Indians assigned to a medical home may be covered by the IowaCare program if:

(1) Provided by the assigned medical home or pursuant to a referral by the assigned medical home;

or

(2) Provided by an Indian health care provider enrolled in the IowaCare program or pursuant to a referral by an Indian health care provider enrolled in the IowaCare program.

**92.8(7) *Services from nonparticipating providers.***

*a.* A nonparticipating provider hospital may be reimbursed for covered IowaCare services subject to the following conditions and limitations:

(1) The patient is enrolled in IowaCare pursuant to the Iowa Medicaid enterprise eligibility verification system at the time the services are delivered.

(2) The services are emergency services, as designated by the department, and it is not medically possible to postpone provision of those services.

(3) It is not medically possible to transfer the member to an IowaCare provider, or the IowaCare provider does not have sufficient capacity to accept the member.

(4) The provision of emergency services is followed by an inpatient admission at the nonparticipating provider.

(5) Before submitting a medical claim for reimbursement, the treating nonparticipating provider has requested and received authorization for payment from the Iowa Medicaid enterprise medical services unit. The request shall include the claim listing the emergency and inpatient services.

*b.* If the conditions listed in paragraph "a" are met as specified, a nonparticipating provider may be reimbursed for covered services provided to the member from the point of emergency room admission to the point of discharge or transfer from the inpatient unit, up to the amount appropriated. This reimbursement does not include emergency or nonemergency transportation services.

*c.* Care coordination pool. A care coordination pool is established to provide payment for medically necessary services provided to IowaCare members for continuation of care provided by a participating IowaCare hospital. Reimbursement is available from designated care coordination pool funding subject to the following conditions:

(1) Payment may be made for continuing care that is related to an IowaCare member's hospital services as determined in a referral from the participating IowaCare hospital.

(2) Payment for continuing care is available to providers that are enrolled in the Iowa medical assistance program, regardless of whether the provider is a participating provider for IowaCare and regardless of the member's county of residence or medical home assignment.

(3) A provider of continuing care that does not participate in the IowaCare program must include information regarding the referral on the claim form.

(4) Payment shall be made only for services that are not otherwise covered under the IowaCare program. Payment shall not be made for services that would normally be provided by the IowaCare provider to other non-IowaCare patients.

(5) The type, scope, and duration of payable services shall be limited as determined by the department. Payable services are limited to:

1. Durable medical equipment.
2. Home health services.
3. Rehabilitation and therapy services, including intravenous antibiotics and parenteral therapy delivered at home.

(6) Types of items or services that are not covered include, but are not limited to:

1. Adult diapers.
2. Air compressors.
3. Bedside commodes.
4. Blood pressure kits or machines.
5. Cardiac event monitors.
6. Continuous passive motion machines.
7. Continuous positive air pressure (CPAP) machines.
8. Dental care (nonsurgical).
9. Eyeglasses, contact lenses, and eye prostheses.
10. Gel shoe inserts.
11. Hearing aids.
12. Heated oxygen.
13. Laboratory tests and radiology procedures.
14. Oral supplemental formula.
15. Outpatient pharmaceuticals not specifically identified in 92.8(7) "c"(5) above.
16. Ted hose, Sigvaris stockings, or Jobst stockings.
17. Tennis shoes.
18. Transcutaneous electrical nerve stimulation (TENS) units.
19. Transportation.
20. Work boots.

(7) All other medical assistance program policies affecting the payable services shall apply, including those regarding prior authorization and level of care determination.

(8) Payment is limited to the amount of available funds designated for the care coordination pool.

*d.* Laboratory tests and radiology services. Payment will be made to federally qualified health centers, as part of the per-IowaCare-patient-encounter payment made pursuant to 92.9(3) "b," for medically necessary laboratory tests and radiology services provided to enrolled IowaCare members when authorized by the federally qualified health center.

**92.8(8) Referral protocols.** When an IowaCare primary care provider refers the member to an IowaCare specialty provider, the following conditions shall apply:

*a.* By January 1, 2012, IowaCare providers shall ensure that referral and patient access processes for IowaCare members are no more restrictive than the processes required for any other payor.

*b.* After an IowaCare provider makes a referral, the IowaCare provider receiving the referral shall report the following information to the referring provider in a manner chosen by the provider receiving the referral:

(1) The date an appointment has been scheduled. The appointment date shall be reported to the referring provider within 15 calendar days of receiving the referral. If the referral is denied, the receiving provider shall offer a consultation by telephone, fax, E-mail, or Internet regarding the reason for the denial.

(2) If authorized by the IowaCare member, the outcome of the appointment, including whether the appointment was kept, the treatment plan, and any follow-up instructions. This report shall be made no later than 15 calendar days following the appointment date.

c. IowaCare providers shall work together to address any communication or coordination issues that arise. By October 1, 2011, IowaCare providers shall jointly develop and implement:

(1) A process to resolve disputes regarding care needs, payment and referrals that includes regular meetings between providers.

(2) A process to identify and address quality improvements with a goal to improve coordination of care between primary, specialty and hospital care. This process shall be monitored by the department but be managed and staffed by the providers.

**92.8(9) Other services provided by Broadlawns Medical Center.** Broadlawns Medical Center shall be reimbursed for outpatient prescription drugs, podiatry services, optometric services, and durable medical equipment provided to members of the expansion population. Payment is limited to the amount of funds appropriated for this purpose.

[**ARC 9135B**, IAB 10/6/10, effective 10/1/10; **ARC 9728B**, IAB 9/7/11, effective 9/1/11; **ARC 9890B**, IAB 11/30/11, effective 1/4/12; **ARC 9996B**, IAB 2/8/12, effective 1/19/12; **ARC 0200C**, IAB 7/11/12, effective 7/1/12; **ARC 0760C**, IAB 5/29/13, effective 5/8/13; **ARC 1072C**, IAB 10/2/13, effective 10/1/13]

#### **441—92.9(249A,249J) Claims and reimbursement methodologies.**

**92.9(1) Claims.** Claims for Medicaid expansion services provided to IowaCare members shall be submitted to the Iowa Medicaid Enterprise, P.O. Box 150001, Des Moines, Iowa 50315, as required by 441—Chapter 80. To facilitate tracking of expenditures, clean claims for IowaCare services shall be submitted to the Iowa Medicaid enterprise within 20 days from ending date of service.

**92.9(2) Payment for hospital services provided by IowaCare network.** Effective July 1, 2010:

a. Inpatient hospital services provided by University of Iowa Hospitals and Clinics will be paid based on 100 percent of reasonable and allowable costs.

(1) An interim rate based on the Medicaid reimbursement rates and methodologies as of November 30, 2009, shall be used to price submitted claims.

(2) At the end of the cost reporting period, a reconciliation will be performed based on the hospital's CMS-2552 cost report as filed for the payment period and IowaCare claims data as extracted by the department from the Medicaid management information system. The aggregate payments under the interim methodology will be determined and compared to the IowaCare program costs as determined from the hospital's cost report. For purposes of this rule, aggregate payments include amounts received for the IowaCare program, outlier payments, and patient and third-party payments up to the allowed amount.

(3) If the aggregate payments exceed the hospital's IowaCare costs, the amount by which payments exceed actual costs will be requested and collected from the hospitals.

(4) If the aggregate payments are less than actual IowaCare costs, an additional payment equal to the difference will be made to the hospital.

b. Inpatient hospital services provided by Broadlawns Medical Center shall be paid at the Medicaid reimbursement rates and methodologies in effect on November 30, 2009.

c. Outpatient hospital services provided by University of Iowa Hospitals and Clinics or Broadlawns Medical Center shall be paid at the Medicaid reimbursement rates and methodologies in effect on November 30, 2009.

**92.9(3) Payment for nonhospital services provided by IowaCare network.** Effective January 1, 2013, IowaCare network providers shall be paid for nonhospital services at the Medicaid fee schedule amounts, which are posted on the department's Web site at [http://www.ime.state.ia.us/Reports\\_Publications/FeeSchedules.html](http://www.ime.state.ia.us/Reports_Publications/FeeSchedules.html), with the following exceptions:

a. For preventive examination codes, the fee schedule amounts shall be based on the Medicaid physician fee schedule in effect on the date of service.

b. Services provided to IowaCare members by a federally qualified health center, including any medically necessary laboratory tests and radiology services authorized by the federally qualified health center, shall be reimbursed on the basis of a per-IowaCare-patient-encounter payment calculated for each participating federally qualified health center as follows:

(1) The initial encounter rates will be based on the total fees paid to the federally qualified health center under the IowaCare program for dates of service from July 1, 2012, through December 31, 2012 (the "initial rate period"), plus the total fees paid to third parties for laboratory and diagnostic services referred out from the particular federally qualified health center during the initial rate period. The rates shall exclude any fees charged by or through the University of Iowa Hospitals and Clinics or Broadlawns Medical Center or through any other federally qualified health center.

(2) The initial encounter rates will be reevaluated on or after April 15, 2013. If the reevaluation results in changes in the initial encounter rate, the department will mass-adjust all of the federally qualified health center's claims submitted for dates of service from January 1, 2013, through March 31, 2013.

(3) After the first quarter of calendar year 2013, the department shall establish a new encounter rate for the federally qualified health center following the end of the prior quarter, based on claims submitted for the prior quarter.

(4) The department shall reevaluate each new encounter rate 45 days after the start of each quarter to consider adjustments based on laboratory and diagnostic claims received with dates of service from the prior quarter submitted within the prior 45 days. If the reevaluation results in changes in the current encounter rate, the department will change the current encounter rate retroactively for the quarter and mass-adjust any claims submitted for the current quarter.

(5) Upon expiration or termination of the IowaCare medical home agreement, the department will reevaluate the encounter rate paid to the federally qualified health center in the final whole or partial quarter by taking into consideration any laboratory and diagnostic claims submitted within 45 days of the expiration or termination of the agreement with dates of service from that final quarter. If the reevaluation results in changes in that final quarter's encounter rate, the department will change the encounter rate for the final quarter and mass-adjust any prior claims submitted for that final quarter.

c. Physician services provided by University of Iowa Hospitals and Clinics physicians to IowaCare members will be reimbursed based on the Medicaid physician fee schedule in effect on the date of service, limited to the amount appropriated for the fiscal year.

**92.9(4) *Medical home payments.***

a. In addition to any other IowaCare reimbursement, IowaCare providers that meet the medical home standards pursuant to subrule 92.8(6) and have contracted with the department shall receive a monthly medical home payment for each member assigned to the medical home by the department. The medical home payment shall begin the first day of the month following the member's assignment to the medical home.

(1) The medical home payment will be on a per-member, per-month basis in an amount determined by the department, but no more than \$4 per member, per month.

(2) Effective July 1, 2011, the department shall implement a tiered per-member, per-month payment method that is based on the medical home's certification level as designated by a nationally recognized medical home accreditation organization.

b. IowaCare medical homes shall be eligible for a performance payment for achieving medical home performance benchmarks designated by the department as specified in the provider's contract with the department. The performance payment shall be paid by October 31 following the end of the state fiscal year and is in addition to any other IowaCare reimbursement.

**92.9(5) *Payment for services provided by nonparticipating hospitals.*** Nonparticipating hospitals shall be paid at the Medicaid reimbursement rates and methodologies in effect on December 1, 2009, up to the amount appropriated to the nonparticipating provider reimbursement fund created in 2009 Iowa Code Supplement section 249J.24A. No payment shall be made after appropriated funds are exhausted.

**92.9(6) *Payment for services provided by other nonparticipating providers.*** Nonparticipating providers other than hospitals shall be paid at the Medicaid reimbursement rates and methodologies in effect on the date of service.

[ARC 9135B, IAB 10/6/10, effective 10/1/10; ARC 1072C, IAB 10/2/13, effective 10/1/13]

**441—92.10(249A,249J) Reporting changes.**

**92.10(1) *Reporting requirements.*** A member shall report any of the following changes no later than ten calendar days after the change takes place:

- a. The member enters a nonmedical institution, including but not limited to a penal institution.
- b. The member abandons Iowa residency.
- c. The member obtains other health insurance coverage.

**92.10(2) *Untimely report.*** When a change is not timely reported, any incorrect program expenditures shall be subject to recovery in accordance with 441—92.13(249A,249J).

**92.10(3) *Effective date of change.*** After assistance has been approved, changes reported during the month that affect the member's eligibility or premium amount shall be effective the first day of the next calendar month unless:

- a. Timely notice of adverse action is required as specified in 441—subrule 7.7(1); or
- b. The certification has expired.

**441—92.11(249A,249J) Reapplication.** A new application is required when a member's 12-month certification period has expired or a member is seeking to regain eligibility after cancellation.

**92.11(1) *Reapplication at least three days before end of certification period.*** When a member submits an application before the last three working days of the member's current certification period, the department shall approve or deny the application by the last working day of the current certification period unless a condition described at 92.4(3) "a" or "b" applies.

**92.11(2) *Reapplication within three days of end of certification period or later.*** When a member submits an application during the last three working days of the member's current certification period or after the certification period ends, the department shall approve or deny the application as described at 92.4(3).

**441—92.12(249A,249J) Terminating eligibility.** IowaCare eligibility shall end when any of the following occur:

1. The certification period ends.
2. The member begins receiving medical assistance in a coverage group under 441—subrules 75.1(1) through 75.1(40).
3. The member does not pay premiums as required by 441—92.7(249A,249J).
4. The member no longer meets the nonfinancial eligibility requirements under 441—92.2(249A,249J).
5. The member is found to have been ineligible at the time the eligibility determination was made due to member misrepresentation or member or agency error.
6. The member dies.

**441—92.13(249A,249J) Recovery.** The department shall recover from a member all Medicaid funds incorrectly expended on behalf of the member and any unpaid premiums in accordance with 441—76.12(249A). For this purpose, unpaid premiums shall be treated as medical assistance incorrectly paid due to client error.

**92.13(1)** The department shall recover Medicaid funds expended on behalf of a member and any unpaid premiums from the member's estate in accordance with 441—76.12(249A).

**92.13(2)** Any funds recovered from third parties, including Medicare, by a provider other than a state mental health institute shall be submitted to the Iowa Medicaid enterprise, and an adjustment shall be made to a previously submitted claim.

[ARC 9135B, IAB 10/6/10, effective 10/1/10]

**441—92.14(249A,249J) Discontinuance of the program.** IowaCare is operated statewide and is funded on a fiscal-year basis (from July through June). When funds are expected to be expended before the end of the fiscal year, enrollment of new members into the program will be discontinued or limited to a reduced scope of services until funding is received for the next fiscal year.

**92.14(1) Suspension of enrollment.**

*a.* To ensure equitable treatment, applications shall be approved on a first-come, first-served basis and enrollment will be suspended when the likely costs of caring for those already enrolled will exhaust the available funding during the year. “First-come, first-served” status is determined by the date the application is approved for eligibility and entered into the computer system.

*b.* As required by the waiver of Title XIX requirements allowing for federal funding of the IowaCare program, and based on available funding for the 2013-2014 state fiscal year, enrollment of new members in IowaCare will be suspended for applications filed on or after July 1, 2013.

**92.14(2) Enrollment for limited services.** Eligibility or payment for services received cannot be approved beyond the amount of funds available. Because funds are limited, applications may be approved for a reduced scope of services.

[ARC 0862C, IAB 7/24/13, effective 7/1/13; ARC 1059C, IAB 10/2/13, effective 11/6/13]

**441—92.15(249A,249J) Right to appeal.** Decisions and actions by the department regarding eligibility or services provided under this chapter may be appealed pursuant to 441—Chapter 7. However, households will not be entitled to an appeal hearing if the sole basis for denying or limiting services is due to discontinuance or limitation of the program pursuant to 441—92.14(249A,249J).

These rules are intended to implement Iowa Code chapter 249J.

[Filed emergency 6/17/05—published 7/6/05, effective 7/1/05]

[Filed emergency 7/15/05—published 8/3/05, effective 7/15/05]

[Filed 12/14/05, Notices 7/6/05, 8/3/05—published 1/4/06, effective 3/1/06]

[Filed emergency 6/16/06—published 7/5/06, effective 7/1/06]

[Filed 7/14/06, Notice 6/7/06—published 8/2/06, effective 10/1/06]

[Filed 9/19/06, Notice 7/5/06—published 10/11/06, effective 11/16/06]

[Filed emergency 3/14/07—published 4/11/07, effective 4/1/07]

[Filed 5/16/07, Notice 2/14/07—published 6/6/07, effective 8/1/07]

[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 emergency 9/12/07 after Notice 7/18/07—published 10/10/07, effective 10/1/07]

[Filed 10/10/07, Notice 8/1/07—published 11/7/07, effective 1/1/08]

[Filed emergency 4/9/08—published 5/7/08, effective 4/9/08]

[Filed emergency 6/11/08 after Notice 3/12/08—published 7/2/08, effective 7/1/08]

[Filed emergency 6/12/08 after Notice 4/23/08—published 7/2/08, effective 7/1/08]

[Filed emergency 7/9/08 after Notice 5/21/08—published 7/30/08, effective 8/1/08]

[Filed Emergency ARC 7667B, IAB 4/8/09, effective 4/1/09]

[Filed ARC 8505B (Notice ARC 8256B, IAB 11/4/09), IAB 2/10/10, effective 4/1/10]

[Filed Emergency After Notice ARC 8500B (Notice ARC 8272B, IAB 11/4/09), IAB 2/10/10, effective 3/1/10]

[Filed Emergency After Notice ARC 9135B (Notice ARC 8977B, IAB 7/28/10), IAB 10/6/10, effective 10/1/10]

[Filed Without Notice ARC 9532B, IAB 6/1/11, effective 7/6/11]

[Filed Emergency ARC 9728B, IAB 9/7/11, effective 9/1/11]

[Filed ARC 9890B (Notice ARC 9729B, IAB 9/7/11), IAB 11/30/11, effective 1/4/12]

[Filed ARC 9982B (Notice ARC 9842B, IAB 11/16/11; Amended Notice ARC 9895B, IAB 11/30/11), IAB 2/8/12, effective 4/1/12]

[Filed Emergency ARC 9996B, IAB 2/8/12, effective 1/19/12]

[Filed Without Notice ARC 0151C, IAB 6/13/12, effective 7/18/12]

[Filed Emergency ARC 0200C, IAB 7/11/12, effective 7/1/12]

[Filed Emergency After Notice ARC 0760C (Notice ARC 0637C, IAB 3/6/13), IAB 5/29/13, effective 5/8/13]

[Filed Emergency After Notice ARC 0759C (Notice ARC 0638C, IAB 3/6/13), IAB 5/29/13, effective 5/8/13]

[Filed Emergency ARC 0862C, IAB 7/24/13, effective 7/1/13]

[Filed Emergency After Notice ARC 1072C (Notice ARC 0886C, IAB 7/24/13), IAB 10/2/13, effective 10/1/13]

[Filed ARC 1059C (Notice ARC 0861C, IAB 7/24/13), IAB 10/2/13, effective 11/6/13]



TITLE XIV  
GRANT/CONTRACT/PAYMENT ADMINISTRATION

CHAPTER 150  
PURCHASE OF SERVICE

[Prior to 7/1/83, Social Services[770] Ch 145]  
[Previously appeared as Ch 145—renumbered IAB 2/29/84]  
[Prior to 2/11/87, Human Services[498]]

DIVISION I  
TERMS AND CONDITIONS FOR IOWA PURCHASE OF SOCIAL SERVICES AGENCY AND  
INDIVIDUAL CONTRACTS, IOWA PURCHASE OF ADMINISTRATIVE SUPPORT, AND  
IOWA DONATIONS OF FUNDS CONTRACT AND PROVISIONS FOR PUBLIC ACCESS TO CONTRACTS

**441—150.1(234) Definitions.**

*“Accounting year”* means a 12 consecutive month period for which accounting records are maintained. It can be either a calendar year or another designated fiscal year.

*“Accrual basis accounting”* means the accounting basis which shows all expenses incurred and income earned for a given time even though the expenses may not have been paid or income received in cash during the period.

*“Administrative support”* means technical assistance, studies, surveys, or securing volunteers to assist the department in fulfilling its administrative responsibilities.

*“Agency”* means an organization or organizational unit that provides social services.

1. Public agency means a general or special-purpose unit of government and organizations administered by that unit to deliver social services, for example, county boards of supervisors, community colleges, and state agencies.

2. Private nonprofit agency means a voluntary agency operated under the authority of a board of directors for purposes other than generating profit and incorporated under Iowa Code chapter 504A. An out-of-state agency must meet requirements of similar laws governing nonprofit organizations in its state.

3. Private proprietary agency means a for-profit agency operated by an owner or board for the operator’s financial benefit.

*“Bureau of purchased services”* means a bureau of the division of fiscal management, which is responsible for administering the purchase of service system.

*“Cash basis accounting”* means the accounting basis which records expenses when bills are paid and income when money is received.

*“Ceiling”* means the maximum limit for payment for a service which has been established by an administrative rule or by the Iowa Code specifically for that service.

*“Client”* means an individual or family group who has applied for and been found to be eligible for social services from the Iowa department of human services.

*“Common ownership”* means that relationship existing when an individual or individuals possess significant ownership or equity in the provider and the institution or organization serving the provider.

*“Components of service”* means the elements or activities that make up a specific service.

*“Contract”* means formal written agreement between the Iowa department of human services and another legal entity, except for those government agencies whose services are covered under provision of Iowa Code chapter 28E.

*“Contractor”* means an institution, organization, facility or individual who is a legal entity and has entered into a contract with the department of human services.

*“Control”* means that relationship existing where an individual or an organization has the power, directly or indirectly, significantly to influence or direct the actions or policies of an organization or institution.

*“Department”* means the Iowa department of human services.

*“Direct cost”* means those expenses which can be identified specifically and solely to a particular program.

*“Donor”* means a local source of funding (public or private) that enters into an Iowa donation of funds contract.

*“Effective date.”*

1. Contract effective date for agency contracts means the first day of a month on which the contract shall become in force.

2. Effective date of rate means the date specified in a purchase of service contract on which the specified rate of payment for service provided begins.

*“Field staff”* means department employees outside of central office reporting to the deputy director of field operations.

*“Grant”* means an award of funds to develop specific programs or achieve specific outcomes.

*“Indirect cost”* means those expenses which cannot be related directly to a specific program and are, therefore, allocated to more than one program.

*“Project manager”* means a department employee who is assigned to assist in developing, monitoring and evaluating a contract and to provide related technical assistance.

*“Provider”* means an institution, organization, facility, or individual who is a legal entity and has entered into a contract with the department to provide social services to clients of the department.

*“Purchase of service system”* means the system within the department for contracting and payment for services, including contracts for funding and contracts for technical assistance.

*“Related to provider”* means that the provider to a significant extent is associated or affiliated with or has control of, or is controlled by, the organization furnishing the services, facilities, or supplies.

*“Relatives”* include the following persons: husband and wife, natural parent and child, sibling, adopted child and adoptive parent, stepparent, stepchild, stepbrother, stepsister, father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, sister-in-law, grandparent and grandchild.

*“Social services”* means a set of actions purposefully directed toward human needs which are socially identified as requiring assistance from others for their resolution.

*“Unit of service”* means a specified quantity of service or a specific outcome as a result of the service provided.

**441—150.2(234) Categories of contracts.**

**150.2(1)** *Iowa purchase of social services contract.* An Iowa purchase of social services contract is a legal contract between the department and a provider for a specified service or services to clients referred by the department. This contract establishes the components of service to be provided, the rate per unit of service, a maximum number of units to be available, and other negotiated conditions. The department has three types of contracts for purchasing social services.

*a.* An agency contract is a contract written with an agency. Iowa Purchase of Social Services Agency Contract, Form 470-0628, shall be completed prior to services being purchased from the agency.

*b.* A child care certificate is an agreement written with a licensed child care center, a family day care home, a group day care home, an in-home care provider, or a relative care provider. Policies governing child care certificates may be found in 441—Chapter 170.

*c.* An individual in-home health-related provider agreement is an agreement written with an individual provider of in-home health services. Policies governing individual in-home health-related provider agreements may be found in 441—Chapter 177.

**150.2(2)** *Iowa purchase of administrative support contract.* An Iowa purchase of administrative support contract is between the department and a contractor for the provision of administrative support. This contract establishes the support services to be provided, the rate and the method of payment, and other negotiated conditions. A contractor or the division of a contractor who is a multiservice organization holding an administrative support contract may not provide direct client services during the period of the contract.

*a.* A volunteer contract is the administrative support contract between an individual or agency and the department to secure volunteers to assist the department in service delivery.

*b.* A general use administrative support contract is between the department and a contractor for the provision of administrative support.

**150.2(3)** *County board of supervisors’ participation contract.* Rescinded IAB 7/8/92, effective 7/1/92.

**150.2(4) Iowa donation of funds contract.** The department may accept donated funds.

a. Upon mutual agreement regarding the scope and use of the funds to be donated, the department may negotiate and shall execute a contract between the department and the donor in accordance with department of administrative services rules in 11—Chapters 106 and 107. The contract shall contain specifications concerning amendment, termination, transmittal of funds, accounting, and reversion of unspent funds.

b. Except for restrictions permitted by the contract, all funds shall be donated on an unrestricted basis for use as if they were appropriated funds and shall be under the administrative control of the department. The donor may specify the geographic area to be served and the specific service to be provided.

c. No funds donated and transmitted to the department will be returned to the donor unless specified in the contract.

**441—150.3(234) Iowa purchase of social services agency contract.**

**150.3(1) Initiation of contract proposal.** When the department issues a request for proposal to select providers, the process and conditions for approving contract proposals shall be as specified in the request, and the department shall not be required to contract with a provider that is not selected. Otherwise, the following procedures for initiation of contract proposals shall apply.

a. *Right to request a contract.* All potential provider agencies have a right to request a contract.

b. *Initial contact.* The initial contact should be between the potential provider and the service area manager for the service area in which the provider's headquarters is located. In the case of out-of-state providers, this contact can be with the service area manager for either the closest service area or the service area initiating the contact. At the beginning of the process of developing a contract, the bureau of purchased services shall give the provider:

- (1) Information about the contracting process; and
- (2) Instructions on how to access the Purchase of Service Provider Handbook electronically.

c. *Contract proposal development.* When the service area manager determines that a contract is to be developed, a project manager will be assigned who will assist in contract development and processing. The project manager will assist the contractor in completing the contract proposal and fiscal information appropriate to the contract. This information shall include documentation that the conditions of participation are met. Form 470-0663, Iowa Purchase of Social Services Agency Contract Face Sheet, shall be completed at the same time as Form 470-0628, Iowa Purchase of Social Services Agency Contract, or Form 470-0630, Amendment or Renewal of the Iowa Purchase of Social Services Agency Contract, is prepared.

d. *Contract proposal approval or rejection.* Before a contract can be effective, it shall be signed by the following persons within the time frames provided:

- (1) Authorized representative of the provider agency.
- (2) Service area manager, within one week from receipt.
- (3) Rescinded IAB 5/11/05, effective 5/1/05.
- (4) Chief of the bureau of purchased services, within 30 days from receipt.

The provider shall be given a notice and explanation in writing of delays in the process or of rejection of the proposal. Payment cannot be made until the contract is signed by the provider's authorized representative and the chief of the bureau of purchased services.

e. *Criteria for rejection.* The following criteria may cause a proposed contract to be rejected:

- (1) The service is not needed by department clients.
- (2) The service is not in the social services block grant plan for the counties to be served by the program.
- (3) No funds are available for the service being proposed.
- (4) The proposed contract does not meet applicable rules, regulations, or guidelines, including service definition.

*f. Contract effective date.* When the agreed-upon contract conditions have been met, the effective date of the contract is the first day of an agreed-upon month following signature by the chief of the bureau of purchased services.

**150.3(2) Contract administration.**

*a. Contract management.* During the contract period the assigned project manager shall be the contract liaison between the department and the provider. The project manager shall be contacted on all interpretations and problems relating to the contract and shall follow the issues through to their resolution. The project manager shall also monitor performance under the contract and shall provide or arrange for technical assistance to improve the provider's performance, if needed. Report of On-Site Visit, Form 470-0670, may be used to monitor performance under the contract.

*b. Contract amendment.* The contract shall be amended only upon agreement of both parties. Amendments which affect the cost of services shall include reestablishment of applicable rates. Amendment or Renewal of Iowa Purchase of Social Services Agency Contract, Form 470-0630, shall be used to amend or renew the contract.

*c. Contract renewal.* A joint decision to pursue renewal of the contract must be made at least 60 days before the expiration date.

(1) Each contract shall be evaluated. The department shall take the results of the evaluation into consideration in making the decision on renewal. This evaluation may involve use of the Monitoring and Evaluation Review Guide, Form 470-2571, or other evaluation tools specified in the contract.

(2) Desk Audit for Civil Rights Contract Compliance, Form 470-2215, shall be completed by the provider.

*d. Contract termination.* Causes for termination during the period of the contract are:

- (1) Mutual agreement of the parties involved.
- (2) Demonstration that sufficient funds are unavailable to continue the services involved.
- (3) Failure to make required reporting.
- (4) Failure to make financial and statistical records available for review.
- (5) Failure to abide by the provisions of the contract.

**150.3(3) Conditions of participation.** The provider shall meet the following standards:

*a. Licensure, approval, or accreditation.* The provider shall have any license, approval, and accreditation required by law, regulation or administrative rules, or standards of operation required by the state or the federal government before the contract can be effective. Out-of-state providers shall meet Iowa licensing standards related to treatment, professional staff to client ratio, and staff qualifications.

*b. Signed contract.* A contract can be effective only when signed by all parties required in 150.3(1) "d."

*c. Civil rights laws.* The providers shall be in compliance with all federal, state and local civil rights laws and regulations with respect to equal employment opportunity, or have a written work plan approved by the diversity programs unit to come into compliance. Equal Opportunity Review, Form 470-0148, shall be completed by the provider. Equal Opportunity Review Status Report, Form 470-2194, shall be completed by the diversity programs unit.

*d. Title VI compliance.* The provider shall be in compliance with Title VI of the 1964 Civil Rights Act and all other federal, state, and local laws and regulations regarding the provision of services, or have a written plan approved by the diversity programs unit to come into compliance. Equal Opportunity Review, Form 470-0148, shall be completed by the provider. Equal Opportunity Review Status Report, Form 470-2194, shall be completed by the diversity programs unit.

*e. Section 504 compliance.* The provider shall be in compliance with Section 504 of the Rehabilitation Act of 1973 and with all federal, state, and local Section 504 laws and regulations, or have a written work plan approved by the diversity programs unit to come into compliance. Equal Opportunity Review, Form 470-0148, Plan Review Accessibility Checklist, Form 470-0149, and Section 504 Transition Plan: Structural Accessibility, Form 470-0150, shall be completed by the provider. Equal Opportunity Review Status Report, Form 470-2194, shall be completed by the diversity programs unit.

*f. Affirmative action.* The provider shall be in compliance with all federal, state, and local laws and regulations regarding affirmative action, or have a written work plan approved by the diversity programs unit to come into compliance. Equal Opportunity Review, Form 470-0148, shall be completed by the provider. Equal Opportunity Review Status Report, Form 470-2194, shall be completed by the diversity programs unit.

*g. Abuse reporting.* The provider shall have a written policy and procedure approved by the service area manager or designee for reporting abuse or denial of critical care of children or dependent adults.

*h. Confidentiality.* The provider shall comply with all applicable federal and state laws and regulations on confidentiality including rules on confidentiality contained in 441—Chapter 9. The provider shall have a written policy and procedure approved by the service area manager or designee for maintaining individual client confidentiality including client record destruction.

*i. Client appeals and grievances.* Clients receiving service through a purchase of service contract have the right to appeal adverse decisions made by the department or the provider. The provider shall have a written policy and procedure approved by the service area manager or designee for handling client appeals and grievances and shall provide information to clients about their rights to appeal.

*j. Client reports.* The provider shall maintain the following client records:

(1) Provider service plan or individual program plan. Providers shall develop a written service plan or individual program plan for each client within 30 days of service initiation. The plan shall include a concise description of the situation or area which will be the focus of the service; statement of the goals to be achieved through the delivery of services; time limited and measurable objectives which will lead to the attainment of the goal to be achieved; specific service components, frequency, and the assignment of responsibility for the provision of the components; and the month and year when it is estimated the client will be able to achieve the current goals and objectives. The provider service plan shall be updated upon receipt of a new departmental case plan, but at least once every six months.

(2) Quarterly progress reports. Quarterly progress reports shall be sent to the department service worker responsible for the client. The first report shall be submitted to the department three months after service is initiated. Reports shall be submitted quarterly thereafter, unless provided for otherwise in rules for a specific service.

The progress report shall include a description of the specific service components provided, their frequency, and who provided them; the client's progress with respect to the goals and service objectives; and any recommended changes in the service plan or individual program plan. For all placement cases the report shall include interpretation of the client's reaction to placement, a summary of medical or dental services that were provided, a summary of educational or vocational progress and participation, and a summary of the involvement of the family with the client and the services.

Reports for the supervised apartment living service shall also include supporting documentation for service provision. The documentation shall list dates of client and collateral contacts, type of contact, persons contacted, and a brief explanation of the focus of each contact. Each unit of service for which payment is sought should be the subject of a written progress note.

(3) Termination of service summary. A termination of service summary shall be sent to the department service worker responsible for the client within two weeks of service termination. The summary shall include the rationale for service termination and the impact of the service components on the client in relationship to the established goals and objectives.

*k. Financial and statistical records.* Each provider of service must maintain sufficient financial and statistical records, including program and census data, to document the validity of the reports submitted to the department.

(1) The records shall be available for review at any time during normal business hours by department personnel, the purchase of service fiscal consultant, and state or federal audit personnel.

(2) These records shall be retained for a period of five years after final payment.

*l. Reports on financial and statistical records.* Reports on financial and statistical records shall be submitted as required. Failure to do so within the required time limits is grounds for termination of the contract.

*m. Maintenance of client records.* Records for clients served through a purchase of service contract must be retained by the provider for a period of three years after service to the client terminates.

*n. Provider charges.* A provider shall not charge department clients more than it receives for the same services provided to nondepartmental clients.

*o. Special-purpose organizations.* A provider may establish a separate, special-purpose organization to conduct certain of the provider's client-related or nonclient-related activities. For example, a development foundation assumes the provider's fund-raising activity. Often, the provider does not own the special-purpose organization (e.g., a nonprofit, nonstock-issuing corporation), and has no common governing body membership. However, a special-purpose organization is considered to be related to a provider if:

(1) The provider controls the organization through contracts or other legal documents that give the provider the authority to direct the organization's activities, management, and policies; or

(2) The provider is, for all practical purposes, the primary beneficiary of the organization's activities. The provider should be considered the special-purpose organization's primary beneficiary if one or more of the following circumstances exist:

The organization has solicited funds on the provider's behalf with provider approval, and substantially all funds so solicited were contributed with intent of benefiting the provider.

The provider has transferred some of its resources to the organization, substantially all of whose resources are held for the benefit of the provider; or

The provider has assigned certain of its functions to a special-purpose organization that is operating primarily for the benefit of the provider.

*p. Certification by department of transportation.*

(1) If the provider furnishes public transit service as defined in 761—910.1(324A), the provider shall annually submit to the project manager information regarding compliance with or exemption from public transit coordination requirements as found in Iowa Code chapter 324A and department of transportation rules in 761—Chapter 910. This information shall include:

1. Form 020107, Certification Application for Coordination of Public Transit Services, which the project manager shall submit to the department of transportation; and

2. A copy of an ACORD Certificate of Insurance or similar self-insurance documentation, as applicable.

(2) If a provider believes it does not furnish public transit service as defined in 761—910.1(324A) and therefore is exempt from the requirements in subparagraph (1), the provider shall submit Form 020107 with only Section 1 completed when the provider enters into a new contract.

(3) If a provider that has furnished public transit service as defined in 761—910.1(324A) ceases to do so, the provider becomes exempt from the requirements in subparagraph (1).

(4) If an exempt provider begins to furnish public transit service as defined in 761—910.1(324A), the provider shall inform the project manager within 30 days of the change and shall adhere to the procedures in subparagraph (1).

(5) Failure of the provider to cooperate in obtaining or providing the required documentation for compliance or exemption is grounds for denial or termination of the contract.

*q. Services provided.* Services provided, as described in Form 470-0663, Iowa Purchase of Social Services Agency Contract Face Sheet, and attachments, shall at a minimum meet the rules found in the Iowa Administrative Code for a particular service or the contract may be terminated.

*r. Bonding, indemnity and insurance clauses.*

(1) Rescinded IAB 2/3/93, effective 4/1/93.

(2) Indemnity. The provider agrees that it will at all times during the existence of this contract indemnify and hold harmless the department and county against any and all liability, loss, damages, costs or expenses which the provider may hereafter sustain, incur or be required to pay:

1. By reason of any client's suffering personal injury, death or property loss or damages either while participating in or receiving from the provider the care and services to be furnished by the provider under this contract, or while on premises owned, leased, or operated by the provider, or while being

transported in any vehicle owned, operated, leased, chartered, or otherwise contracted for by the provider or any officer, agency, or employee thereof.

2. By reason of any client's causing injury to or damage to another person or property during any time when the provider or any officer, agency or employee thereof has undertaken or is furnishing the care and service called for under this contract.

(3) Insurance. The provider agrees that in order to protect itself as well as the department and county under the indemnity agreement above, it will at all times during the term of the contract have and keep in force a liability insurance policy, verification of which shall accompany Form 470-0663, Iowa Purchase of Social Services Agency Contract Face Sheet. The provider agrees that all employees, volunteers, or any other person, other than employees of the department acting within the scope of their employment in the department, authorized to transport clients in privately owned vehicles, have liability insurance in force.

*s. Renegotiation clause.* In the event there is a revision of federal or state laws or regulations and this contract no longer conforms to those laws or regulations, both parties will review the contract and renegotiate those items necessary to conform with the new federal or state laws or regulations.

*t. Performance measures.* The department may require performance measures.

**150.3(4) Establishment of rates.** The Financial and Statistical Report for Purchase of Service Contracts, Form 470-0664, is the basis for establishing the rates to be paid to all providers under an Iowa Purchase of Social Services Agency Contract, Form 470-0628, except as provided below.

*a. Injectable contraceptive unit.* Rescinded IAB 8/1/07, effective 9/5/07.

*b. Out-of-state providers.*

(1) Rescinded IAB 9/1/93, effective 11/1/93.

(2) Out-of-state providers of other services shall have rates established using the applicable portions of the Financial and Statistical Report for Purchase of Service Contracts, Form 470-0664.

*c. Family-centered flexible supportive services.* Rescinded IAB 5/6/09, effective 7/1/09.

**150.3(5) Financial and statistical report.** The Financial and Statistical Report for Purchase of Service Contracts, Form 470-0664, shall be completed by those providers as required in 150.3(4). The reports shall be based on the following rules.

*a. Accounting procedures.* 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 who are multiple program agencies shall submit a cost allocation schedule prepared in accordance with recognized methods and procedures.

(1) Direct program expense shall include all direct client contact personnel involved in a program including the time of a supervisor of a program, or the apportioned share of the supervisor's time when the supervisor supervises more than one program.

(2) Expenses other than salary and fringe benefits shall be charged as direct program expenses when the expenses are identifiable to a program. They may also be charged as direct program expenses when a method of distribution acceptable to the department is maintained on a consistent basis.

(3) Occupancy expenses shall be allocated to programs on a space utilization formula. The space utilization formula may be used for salaries and fringes of building maintenance and janitorial type personnel.

(4) All expenses which relate jointly to two or more programs shall be allocated to program service costs by utilizing a cost allocation method which fairly distributes costs to the related programs. Any expenses which relate directly to a particular program shall be reflected as such. All maintenance costs shall be charged directly or allocated proportionately to the related programs affected.

(5) Indirect program service costs shall be distributed over all applicable services.

(6) Expenses such as supplies, conferences, and similar expenses that cannot be directly related to a program shall be charged to indirect program service costs.

(7) A multiservice agency shall establish a method acceptable to the department of distributing indirect program service costs.

(8) Income received from fund-raising efforts or donations shall be reported as revenue on the financial and statistical report and used to offset fund-raising costs. Fund-raising costs remaining after the offset shall be an unallowable cost.

All contributions shall be accompanied by a schedule showing the contribution and anticipated designation by the agency. No private moneys contributed to the agency shall be included by the department in its reimbursement rate determination unless these moneys are contributed for services provided to specific individuals for whom the reimbursement rate is established by the department.

If a shelter care provider's actual and allowable costs for a child's shelter care placement exceed the amount the department is authorized to pay and the provider is reimbursed by the child's county of legal settlement for the difference between actual and allowable costs and the amount reimbursed by the department, the amount paid by the county shall not be included by the department in its reimbursement rate determination, as long as the amount paid is not greater than the provider's actual and allowable costs, or the statewide average of actual and allowable costs in May of the preceding year for juvenile shelter care homes, whichever is less.

(9) When an agency has a certified public accounting firm perform an audit of its financial statements, the resulting audit report shall follow one of the uniform audit report formats recommended by the American Institute of Certified Public Accountants. These formats are specified in the industry audit guide series, "Audits of Voluntary Health and Welfare Organizations," prepared by the Committee on Voluntary Health and Welfare Organizations, American Institute of Certified Public Accountants, New York, 1974. A copy of the certified audit report shall be submitted to the department within 60 days of receipt.

(10) All expenses reported on Form 470-0664 shall be supported by an agency's general ledger and documentation on file in the agency's office.

*b. Failure to maintain records.* Failure to maintain records adequate to support the Financial and Statistical Report for Purchase of Service Contracts, Form 470-0664, may result in termination of the contract. These records include, but are not limited to:

- (1) Reviewable, legible census reports.
- (2) Payroll information.
- (3) Capital asset schedules.
- (4) All canceled checks, deposit slips, invoices (paid and unpaid).
- (5) Audit reports (if any).
- (6) Board of directors' minutes.

*c. Submission of reports.* The financial and statistical report shall be submitted to the department no later than three months after the close of the provider's established fiscal year. At least one week must be allowed prior to this deadline for the project manager to review the report and transmit it to the bureau of purchased services in central office. Failure to submit the report in time without written approval from the chief of the bureau of purchased services may reduce payment to 75 percent of the current rate. Failure to submit the report within six months of the end of the fiscal year shall be cause for terminating the contract.

*d. Rate modification.* Modification of rates shall be made when required by changes in licensing requirements, changes in the law, or amendments to the contract. Requests for modification of a rate may be made when changes are because of program expansion or modification and have the approval of the service area where services are provided. Even if there is a modification of the rate, the modified rate is still subject to any maximum established in any law or rule.

*e. Payment of new rate.* New rates shall be effective for services provided beginning the first day of the second calendar month after receipt by the bureau of purchased services of a report sufficient to establish rates or, by mutual agreement, new rates shall be effective the first day of the month following completion of the fiscal review. Failure to submit a report sufficient to establish a rate will result in the effective date's being delayed. At least one week must be allowed prior to the deadline in paragraph "c" above for the project manager to review the report and transmit it to central office.

*f. Exceptions to costs.* Exceptions to costs identified by the bureau of purchased services or its fiscal consultant will be communicated to the provider in writing.

*g. Accrual basis.* Providers not using the accrual basis of accounting shall adjust amounts to the accrual basis when the financial and statistical report is completed. Records of cash receipts and disbursements shall be adjusted to reflect accruals of income and expenses.

*h. Census data.* Documentation of units of service provided which identifies the individual client shall be available on a daily basis and summarized on a monthly report. The documentation and reports shall be retained by the provider for review at the time the expenditure report is prepared and reviewed by the department's fiscal consultant.

*i. Opinion of accountant.* The department may require that an opinion of a certified public accountant or public accountant accompany the report when adjustments made to prior reports indicate noncompliance with reporting instructions.

*j. Revenues.* When the Financial and Statistical Report is completed, revenues shall be reported as recorded in the general books and records adjusted for accruals. Expense recoveries shall be reflected as revenues.

*k. Capital asset use allowance (depreciation) schedule.* The Capital Asset Use Allowance Schedule shall be prepared using the guidelines for provider reimbursement in the Medicare and Medicaid Guide, December 1981.

*l. The following expenses shall not be allowed:*

- (1) Fees paid directors and nonworking officers' salaries.
- (2) Bad debts.
- (3) Entertainment expenses.
- (4) Memberships in recreational clubs, paid for by an agency (country clubs, dinner clubs, health clubs, or similar places) which are primarily for the benefit of the employees of the agency.
- (5) Legal assistance on behalf of clients.
- (6) Costs eligible for reimbursement through the medical assistance program.
- (7) Food and lodging expenses for personnel incurred in the city or immediate area surrounding the personnel's residence or office of employment, except when the specific expense is required by the agency and documentation is maintained for audit purposes. Food and lodging expenses incurred as part of programmed activities on behalf of clients, their parents, guardians, or consultants are allowable expenses when documentation is available for audit purposes.
- (8) Business conferences and conventions. Meeting costs of an agency which are not required in licensure.
- (9) Awards and grants to recognize board members and community citizens for achievement. Awards and grants to clients as part of treatment program are reimbursable.
- (10) Survey costs when required certification is not attained.
- (11) Federal and state income taxes.

*m. Limited service—without a ceiling.* The following expenses are limited for service without a ceiling established by administrative rule or law for that service. This includes services with maximum rates, with the exception of shelter care.

(1) Moving and recruitment are allowed as a reimbursable cost only to the extent allowed for state employees. Expenses incurred for placing advertising for purposes of locating qualified individuals for staff positions are allowed for reimbursement purposes.

(2) and (3) Rescinded IAB 5/18/88, effective May 1, 1988.

(4) Costs for participation in educational conferences are limited to 3 percent of the agency's actual salary costs, less excluded or limited salary costs as recorded on the financial and statistical report.

(5) Costs of reference publications and subscriptions for program-related materials are limited to \$500 per year.

(6) Memberships in professional service organizations are allowed to the extent they do not exceed one-half of 1 percent of the total salary costs less excluded salary costs.

(7) In-state travel costs for mileage and per diem expenses are allowable to the extent they do not exceed the maximum mileage and per diem rates for state employees for travel in the state.

(8) Reimbursement for air travel shall not exceed the lesser of the minimum commercial rate or the rate allowed for mileage in subparagraph (7) above.

(9) The maximum reimbursable salary for the agency administrator or executive director charged to purchase of service is \$40,000 annually.

(10) Annual meeting costs of an agency which are required in licensure are allowed to the extent required by licensure.

*n. Limited service—with a ceiling.* The following expenses are limited for services with a ceiling established by administrative rule or law for that service. This includes shelter care.

(1) The maximum reimbursable compensation for the agency administrator or executive director charged to purchase of service annually is \$40,000.

(2) Annual meeting costs of an agency which are required for licensure are allowed to the extent required by licensure.

*o. Establishment of ceiling and reimbursement rate.*

(1) The maximum allowable rate ceiling applicable to each service is found in the rules for that particular service.

(2) When a ceiling exists, the reimbursement rate shall be established by determining on a per unit basis the allowable cost plus the current cost adjustment subject to the maximum allowable cost ceiling.

*p. Rate limits.* Interruptions in service programs will not affect the rate. If an agency assumes the delivery of service from another agency, the rate shall remain the same as for the former agency.

(1) The combined service and maintenance reimbursement rate paid to a shelter care provider shall be based on the financial and statistical report submitted to the department. For the fiscal year beginning July 1, 2013, the maximum reimbursement rate shall be \$96.98 per day, based on a 365-day year. If the department reimburses the provider at less than the maximum rate, the department shall adjust the provider's reimbursement rate to the provider's actual and allowable cost plus the inflation factor or to the maximum reimbursement rate, whichever is less.

(2) The initial reimbursement rate for any new service shall be based upon actual and allowable costs. A new service does not include a new building or location or other changes in method of service delivery for a service currently provided under the contract.

1. For shelter care, if the provider is currently offering shelter care under social services contract, the only time the provider shall be considered to be offering a new service is if the provider adds a service other than shelter care.

2. For supervised apartment living, the only time a provider shall be considered to be offering a new service is when the agency adds a cluster site or a scattered site for the first time. If, for example, the agency has a supervised apartment living cluster site, the addition of a new site does not constitute a new service.

3. If the department defines, in administrative rule, a new service as a social service that may be purchased, this shall constitute a new service for purposes of establishment of a rate. Once the rate for the new service is established for a provider, the rate will be subject to any limitations established by administrative rule or law.

(3) If a social service provider loses a source of income used to determine the reimbursement rate for the provider, the provider's reimbursement rate may be adjusted to reflect the loss of income, provided that the lost income was used to support actual and allowable costs of a service purchased under a purchase of service contract.

*q. Related party costs.* Direct and indirect costs applicable to services, facilities, equipment, and supplies furnished to the provider by organizations related to the provider are includable in the allowable cost of the provider at the cost to the related organization. All costs allowable at the provider level are also allowable at the related organization level, unless these related organization costs are duplicative of provider costs already subject to reimbursement.

(1) Allowable costs shall be all actual direct and indirect costs applying to any service or item interchanged between related parties, such as capital use allowance (depreciation), interest on borrowed money, insurance, taxes, and maintenance costs.

(2) When the related party's costs are used as the basis for allowable rental or supply costs, the related party shall supply documentation of these costs to the provider. The provider shall complete a

schedule displaying amount paid to related parties, related party cost, and total amount allowable. The resulting costs shall be allocated according to policies in 150.3(5) “a”(3) to (7).

Financial and statistical records shall be maintained by the related party under the provisions in 150.3(3) “k.”

(3) Tests for relatedness shall be those specified in rule 441—150.1(234) and 150.3(3) “o.” The department or the purchase of service fiscal consultant shall have access to the records of the provider and landlord or supplier to determine if relatedness exists. Applicable records may include financial and accounting records, board minutes, articles of incorporation, and list of board members.

*r. Day care increase.* Rescinded IAB 7/7/93, effective 7/1/93.

*s. Interest on unpaid invoices.* Any invoice that remains unpaid after 60 days following the receipt of a valid claim is subject to the payment of interest. The rate of interest is 1 percent per month beyond the 60-day period, on a simple interest basis. A separate claim for the interest is to be generated by the agency. If the original claim was paid with both federal and state funds, only that portion of the original claim paid with state funds will be subject to interest charges.

*t. Interest as an allowable cost.* Necessary and proper interest on both current and capital indebtedness is an allowable cost.

(1) “Interest” is the cost incurred for the use of borrowed funds. Interest on current indebtedness is the cost incurred for funds borrowed for a relatively short term. Interest on capital indebtedness is the cost incurred for funds borrowed for capital purposes.

(2) “Necessary” requires that the interest be incurred on a loan made to satisfy a financial need of the provider, be incurred on a loan made for a purpose reasonably required to operate a program, and be reduced by investment income except where the income is from gifts and grants whether restricted or unrestricted, and which are held separate and not commingled with other funds.

(3) “Proper” requires that interest be incurred at a rate not in excess of what a prudent borrower would have had to pay in the money market on the date the loan was made, and be paid to a lender not related through control or ownership to the borrowing organization.

*u. Rate formula.* Paragraph 150.3(5) “p” notwithstanding, when rates are determined based on cost of providing the service involved, they will be calculated according to the following mathematical formula:

$$\frac{\text{Net allowable expenditures}}{\text{Effective utilization level}} \times \text{Reimbursement factor} = \text{Base Rate}$$

(1) Net allowable expenditures are those expenditures attributable to service to clients which are allowable as set forth in subrule 150.3(5), paragraphs “a” to “t.”

(2) Effective utilization level shall be 80 percent or actual (whichever is greater) of the licensed or staffed capacity (whichever is less) of the program.

(3) Inflation factor is the percentage which will be applied to develop payment rates consistent with current policy and funding of the department. The inflation factor is intended to overcome the time lag between the time period for which costs were reported and the time period during which the rates will be in effect. The inflation factor shall be the amount by which the Consumer Price Index for all urban consumers increased during the preceding calendar year ending December 31.

(4) Base rate is the rate which is developed independent of any limits which are in effect. Actual rates paid are subject to applicable limits or maximums.

*v.* Rescinded IAB 5/13/92, effective 4/16/92.

**150.3(6) Client eligibility and referral.**

*a.* Program eligibility. To receive services through the purchase of service system, clients shall be determined eligible and be formally referred by the department.

(1) The department shall not make payment for services provided before the client’s application, eligibility determination, and referral. See “b” below for an exception to this requirement.

(2) Except as provided in paragraph “c,” the department shall use the following forms to authorize services:

1. Form 470-0622, Referral of Client for Purchase of Social Services.
2. Form 470-0719, Placement Agreement: Child Placing or Child Caring Agency (Provider).

*b.* When a court orders foster care and the department has no responsibility for supervision or placement of the client, the department will pay the rate established by these rules for maintenance and service provided by the facility.

*c.* Family-centered services. For family-centered services, the provisions in rule 441—172.3(234) relating to approval, authorization, and referral shall apply.

**150.3(7) Client fees.** The provider shall agree not to require any fee for service from departmental clients unless a fee is required by the department and is consistent with federal regulation and state policy. Rules governing client fees are found in 441—130.4(234).

The provider shall collect fees due from clients. The provider shall maintain records of fees collected, and these records shall be available for audit by the department or its representative. When a client does not pay the fee, the provider shall demonstrate that a reasonable effort has been made to collect the fee. Reasonable effort to collect means an original billing and two follow-up notices of nonpayment. When the second notice of nonpayment is sent, the provider shall send a copy of the notice to the department worker.

**150.3(8) Billing procedures.** At the end of each month the provider agency shall prepare Form 470-0020, Purchase of Service Provider Invoice, for contractual services provided by the agency during the month.

Separate invoices shall be prepared for each county from which clients were referred, each service, and each funding source involved in payment. Complete invoices shall be sent to the departmental county office responsible for the client for approval and forwarding for payment.

More frequent billings may be permitted on an exception basis with the written approval of the service area and the chief of the bureau of purchased services.

*a.* Time limit for submitting vouchers, invoices, or claims. The time limit for submission of original vouchers, invoices, or claims shall be three months from the date of service.

*b.* Resubmittals of rejected claims. Valid claims which were originally submitted within the time limit specified in paragraph “a” but were rejected because of an error shall be resubmitted without regard to time frames.

**150.3(9) Reviews of departmental actions.** A provider who is adversely affected by a departmental decision may request a review. A review request may cause the action to be stopped pending the outcome of the review, except in cases where it can be documented that to do so would be detrimental to the health and welfare of clients. The procedure for review is:

*a.* The provider shall send a written request for review to the project manager responsible for the contract within ten days of receipt of the decision in question. This request shall document the specific area in question and the remedy desired. The project manager shall provide a written response within ten days.

*b.* When dissatisfied with the response, the provider shall submit to the service area manager within ten days the original request, the response received, and any additional information desired. The service area manager shall study the concerns and the action taken, and render a decision in writing within 14 days. A meeting with the provider may be held to clarify the situation.

*c.* If still dissatisfied, the provider may within ten days request a review by the chief of the bureau of purchased services. The request for review should include copies of material from paragraphs “a” and “b” above. The bureau chief shall review the issues and positions of the parties involved and provide a written decision within 14 days. A meeting may be held with the provider, project manager, and service area manager or designee.

*d.* The provider may appeal this decision within ten days to the director of the department, who will issue the final department decision within 14 days.

**150.3(10) Review of financial and statistical reports.** Authorized representatives of the department or state or federal audit personnel shall have the right to review the general financial records of a provider. The purpose of the review is to determine if expenses reported to the department have been handled as required under 150.3(5). Representatives shall provide proper identification and shall use generally

accepted auditing principles. The reviews may include an on-site visit to the provider, the provider's central accounting office, the offices of the provider's agents, a combination of these, or, by mutual decision, to other locations.

**150.3(11)** Rescinded, effective 3/1/87.

This rule is intended to implement Iowa Code section 234.6.

[**ARC 7741B**, IAB 5/6/09, effective 7/1/09; **ARC 8447B**, IAB 1/13/10, effective 1/1/10; **ARC 8651B**, IAB 4/7/10, effective 5/12/10; **ARC 8902B**, IAB 6/30/10, effective 7/1/10; **ARC 0860C**, IAB 7/24/13, effective 7/1/13; **ARC 1060C**, IAB 10/2/13, effective 11/6/13]

**441—150.4(234) Iowa purchase of social services contract—individual providers.**

**150.4(1)** *Individual child day care provider agreement.* Rules governing individual child day care provider agreements may be found in 441—Chapter 170.

**150.4(2)** *Individual in-home health-related provider agreement.* Rules governing individual in-home health-related provider agreements may be found in 441—Chapter 177.

**441—150.5(234) Iowa purchase of administrative support.**

**150.5(1)** *Initiation of contract proposal.*

*a. Right to request a contract.* All potential contractors have a right to request a contract.

*b. Initial contact.*

(1) Volunteer contract. The initial contact for a volunteer contract may be between the potential contractor and the service area manager of the service area in which the individual or the contractor agency's headquarters is located or the contract may be between the potential contractor and the director of the state volunteer program in the central office of the department. If so, the director will communicate with the service area.

(2) General use administrative support contract. The initial contact for a general use administrative support contract may be between the potential contractor and the service area manager of the service area in which the individual or contractor organization's headquarters is located or the contract may be between the potential contractor and the chief of the bureau of purchased services, who will communicate with the service area.

*c. Contract proposal development.* When the service area manager determines that a contract is to be developed, a project manager will be assigned who will assist in contract development and processing. The project manager will assist the contractor in completing the contract proposal and fiscal information appropriate to the contract. This includes documentation that the conditions of participation required below are met.

*d. Contract proposal approval or rejection.* Before a contract can be effective it shall be signed by the following persons within the time frames provided:

(1) Volunteer contract.

Individual contractor or authorized representative of the contractor agency.

Service area manager within one week from receipt.

Director of the state volunteer program within 30 days from receipt.

(2) General use administrative support contract.

Individual contractor or authorized representative of the contractor agency.

Service area manager within one week from receipt.

Chief of the bureau of purchased services within two weeks from receipt.

Administrator of the division of fiscal management within two weeks from receipt.

The contractor shall be notified of delays in the process or of rejection of the proposal. This notification along with an explanation shall be in writing. The applicant has a right to have the decision reviewed by the director of the state volunteer program, or chief of the bureau of purchased services.

*e. Criteria for rejection.* The following criteria may cause a proposed contract to be rejected.

(1) The proposed activity is not needed by the department.

(2) No funds are available for the activity being proposed.

(3) The proposed contract does not meet applicable rules, regulations, or guidelines.

*f. Contract effective date.* If the agreed-upon contract conditions have been met, the effective date of the contract is the first day of an agreed-upon month following signature by the director of the state volunteer program, or the chief of the bureau of purchased services.

**150.5(2) Contract administration.**

*a. Contract management.* During the contract period, the assigned project manager shall be the liaison between the department and the contractor. The project manager shall be contacted on all interpretations and problems related to the contract and shall follow issues through to their resolution. The project manager shall also monitor performance under the contract and will provide or arrange for technical assistance to improve the contractor's performance, if needed.

*b. Contract amendments.* The contract shall be amended only upon agreement of both parties. Amendments which affect the cost of providing the volunteer services must include reestablishment of amounts to be paid.

*c. Contract renewal.* A joint decision to pursue renewal of the contract must be made at least 60 days prior to the expiration date. Each contract shall be evaluated. The results of the evaluation shall be taken into consideration in the decision on renewal. This evaluation may involve use of evaluation tools specified in the contract.

*d. Contract termination.* Causes for termination during the period of the contract are:

- (1) Mutual agreement of the parties involved.
- (2) Demonstration that sufficient funds are unavailable to continue the service(s) involved.
- (3) Failure to make reports required by the contract.
- (4) Failure to make financial, statistical, and program records available.
- (5) Failure to abide by the provisions of the contract.

**150.5(3) Conditions of participation.** The contractor shall meet the following standards:

*a. Licensure, approval, or accreditation.* The contractor shall have any license, approval, and third-party accreditation required by law, regulation, or administrative rules, or shall meet standards of operation required by state or federal regulation. This requirement must be met before the contract can be effective.

*b. Signed contract.* A contract can be effective only when signed by all parties required in 150.5(1) "d."

*c. Civil rights laws.* The contractors shall be in compliance with all federal, state, and local civil rights laws and regulations with respect to equal employment opportunity, or have a written work plan approved by the diversity programs unit to come into compliance.

*d. Title VI compliance.* The contractors shall be in compliance with Title VI of the 1964 Civil Rights Act and all other federal, state, and local laws and regulations regarding the provision of services, or have a written plan approved by the diversity programs unit to come into compliance.

*e. Section 504 compliance.* The contractors shall be in compliance with Section 504 of the Rehabilitation Act of 1973 and with all federal, state, and local Section 504 laws and regulations, or have a written work plan approved by the diversity programs unit to come into compliance.

*f. Affirmative action.* The contractors shall be in compliance with all federal, state, and local laws and regulations regarding affirmative action, or have a written work plan approved by the diversity programs unit to come into compliance.

*g. Abuse reporting.* The contractor shall have an approved policy and procedure for reporting abuse or denial of critical care of children or dependent adults.

*h. Confidentiality.* The contractor shall comply with all applicable federal and state laws and regulations on confidentiality.

*i. Financial and statistical records.* Each contractor of service shall maintain sufficient financial and statistical records, including program and census data, to document the validity of the reports submitted to the department.

(1) The records shall be available for review at any time during normal business hours by department personnel, the purchase of service fiscal consultant, or state or federal audit personnel.

(2) These records shall be retained for a period of five years after final payment.

*j. Certification by department of transportation.* Each contractor who supplies transportation services shall submit Form 020107, Certification Application for Coordination of Public Transit Services, and a copy of “Certificate of Insurance” (an ACORD form or similar or self-insurance documentation) to the applicable project manager annually showing information regarding compliance with, or exemption from, public transit coordination requirements as found in Iowa Code chapter 324A and department of transportation rules 761—Chapter 910.

Failure to provide the required documentation for compliance or exemption is grounds for denial or termination of the contract.

**150.5(4) *Establishing amounts to be paid.*** The amounts to be paid under purchase of administrative support contracts are actual approved expenses as negotiated in the contract. Approved items of cost are based on submission of a proposed budget listing those items necessary for provision of the volunteer coordination or technical assistance to be delivered. At the termination of the contract a statement of actual expenses incurred shall be submitted by the contractor.

**150.5(5) *Billing procedures.*** At the end of each month, or as otherwise provided in the contract, the contractor shall prepare a claim on Form GAX, General Accounting Expenditure, for expenses for which reimbursement is permitted in the contract. The claim shall be sent to the office of the department that administers the contract for approval and forwarding for payment.

*a. Time limit for submitting claims.* The time limit for submission of original claims shall be within 90 days of the provision of service.

*b. Resubmittals of rejected claims.* Valid claims which were originally submitted within this time limit but were rejected because of an error must be resubmitted, but without regard to time frames.

**150.5(6) *Reviews of department actions.*** A contractor who is adversely affected by a department decision may request a review. A review request may cause the action to be stopped pending the outcome of the review process, except in cases where it can be documented that to do so would be detrimental to the health and welfare of clients. The procedure for review is:

*a.* Within ten days of receipt of the decision in question the contractor shall send a written request for review to the project manager responsible for the contract. This request shall document the specific area in question and the remedy desired. A written response from the project manager shall be provided within ten days.

*b.* When dissatisfied with the response, the contractor shall submit the original request, the response received, and any additional information desired to the service area manager within ten days. The service area manager shall study the concerns, the action taken and render a decision in writing within 14 days. A meeting with the contractor may be held to clarify the situation.

*c.* If still dissatisfied, the contractor may within ten days request a review by the chief of the bureau of purchased services. The request for review should include copies of material from paragraphs “a” and “b” above. The bureau chief shall review the issues and positions of the parties involved and provide a written decision within 14 days. A meeting with the contractor, project manager, and service area manager or designee may be held.

*d.* The contractor may appeal this decision within ten days to the director of the department, who will issue the final department decision within 14 days.

**150.5(7) *Reviews.*** Authorized representatives of the department or state or federal audit personnel have the right to review the general financial records of a contractor. The purpose of the review is to determine if expenses reported to the department have been handled as required under 150.5(4). Representatives shall provide proper identification and shall use generally accepted auditing principles. The reviews may be on the basis of an on-site visit to the contractor, the contractor’s central accounting office, the offices of the contractor’s agents, a combination of these, or, by mutual decision, to other locations.

This rule is intended to implement Iowa Code sections 234.6 and 324A.5, subsection 3, paragraph “c.”

**441—150.6(234) County board of supervisors participation contract.** Rescinded IAB 7/8/92, effective 7/1/92.

**441—150.7(234) Iowa donation of funds contract.** Rescinded IAB 12/3/08, effective 2/1/09.

**441—150.8(234) Provider advisory committee.** Rescinded IAB 12/3/08, effective 2/1/09.

**441—150.9(234) Public access to contracts.** Subject to applicable federal and state laws and regulations on confidentiality including 441—Chapter 9, all material submitted to the department of human services pursuant to this chapter shall be considered public information.

These rules are intended to implement Iowa Code section 234.6 and 2001 Iowa Acts, House File 732, section 31, subsection 6, and Senate File 537, section 1, subsection 1, paragraph “d.”

**441—150.10 to 150.20** Reserved.

- DIVISION II  
PURCHASE OF SOCIAL SERVICES CONTRACTING ON BEHALF OF COUNTIES FOR  
LOCAL PURCHASE SERVICES FOR ADULTS WITH MENTAL ILLNESS,  
MENTAL RETARDATION, AND DEVELOPMENTAL DISABILITIES  
[Rescinded IAB 4/4/01, effective 7/1/01]
- [Filed 2/25/77, Notice 6/14/76—published 3/23/77, effective 4/27/77]
  - [Filed 9/28/77, Notice 8/10/77—published 10/19/77, effective 11/23/77]
  - [Filed 1/16/78, Notice 11/30/77—published 2/8/78, effective 3/15/78]
  - [Filed emergency 2/28/78—published 3/22/78, effective 4/1/78]
  - [Filed 5/24/78, Notice 3/22/78—published 6/14/78, effective 7/19/78]
  - [Filed 9/23/82, Notice 8/4/82—published 10/13/82, effective 11/17/82]
  - [Filed 3/25/83, Notice 9/1/82—published 4/13/83, effective 7/1/83]
  - [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 11/18/83, Notice 10/12/83—published 12/7/83, effective 2/1/84]
  - [Filed 12/16/83, Notice 11/9/83—published 1/4/84, effective 3/1/84]
  - [Filed emergency 2/10/84—published 2/29/84, effective 2/10/84]
  - [Filed emergency 6/15/84—published 7/4/84, effective 7/1/84]
  - [Filed emergency 8/31/84—published 9/26/84, effective 10/1/84]
  - [Filed 9/7/84, Notice 7/4/84—published 9/26/84, effective 11/1/84]
  - [Filed 5/29/85, Notice 3/27/85—published 6/19/85, effective 8/1/85]
  - [Filed emergency 6/14/85—published 7/3/85, effective 7/1/85]
  - [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 12/2/85, Notice 10/23/85—published 12/18/85, effective 2/1/86]
  - [Filed emergency 3/21/86 after Notice 11/6/85—published 4/9/86, effective 4/1/86]
  - [Filed emergency 6/26/86—published 7/16/86, effective 7/1/86]
  - [Filed 12/22/86, Notice 10/22/86—published 1/14/87, effective 3/1/87]
  - [Filed emergency 1/15/87—published 2/11/87, effective 1/15/87]
  - [Filed emergency 6/19/87—published 7/15/87, effective 7/1/87]
  - [Filed 10/23/87, Notice 7/15/87—published 11/18/87, effective 1/1/88]
  - [Filed 11/25/87, Notice 9/23/87—published 12/16/87, effective 2/1/88]
  - [Filed emergency 4/22/88 after Notice 3/9/88—published 5/18/88, effective 5/1/88]
  - [Filed emergency 6/9/88—published 6/29/88, effective 7/1/88]
  - [Filed 12/8/88, Notice 7/13/88—published 12/28/88, effective 2/1/89]
  - [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 emergency 6/20/90—published 7/11/90, effective 7/1/90]
  - [Filed 8/16/90, Notice 7/11/90—published 9/5/90, effective 11/1/90]

- [Filed emergency 6/14/91—published 7/10/91, effective 7/1/91]
- [Filed emergency 8/8/91—published 9/4/91, effective 9/1/91]
- [Filed without Notice 8/8/91—published 9/4/91, effective 11/1/91]
- [Filed 8/8/91, Notice 6/26/91—published 9/4/91, effective 11/1/91]
- [Filed 9/18/91, Notice 7/10/91—published 10/16/91, effective 12/1/91]
- [Filed 10/10/91, Notice 9/4/91—published 10/30/91, effective 1/1/92]
- [Filed 12/11/91, Notice 10/16/91—published 1/8/92, effective 3/1/92]
- [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 8/14/92, Notice 7/8/92—published 9/2/92, effective 11/1/92]
- [Filed 1/14/93, Notice 12/9/92—published 2/3/93, effective 4/1/93]
- [Filed emergency 6/11/93—published 7/7/93, effective 7/1/93]
- [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 7/21/93—published 10/13/93, effective 12/1/93]
- [Filed 12/16/93, Notice 9/1/93—published 1/5/94, effective 3/1/94]
- [Filed emergency 6/16/94—published 7/6/94, effective 7/1/94]
- [Filed 12/15/94, Notices 7/6/94, 10/12/94—published 1/4/95, effective 3/1/95]
- [Filed 4/13/95, Notice 2/15/95—published 5/10/95, effective 7/1/95]
- [Filed emergency 6/7/95—published 7/5/95, effective 7/1/95]
- [Filed 8/10/95, Notice 7/5/95—published 8/30/95, effective 11/1/95]
- [Filed emergency 6/13/96—published 7/3/96, effective 7/1/96]
- [Filed 8/15/96, Notice 7/3/96—published 9/11/96, effective 11/1/96]
- [Filed emergency 6/12/97—published 7/2/97, effective 7/1/97]
- [Filed 9/16/97, Notice 7/2/97—published 10/8/97, effective 12/1/97]
- [Filed emergency 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 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 9/13/99, Notice 7/28/99—published 10/6/99, effective 12/1/99]
- [Filed emergency 6/8/00—published 6/28/00, effective 7/1/00]
- [Filed 8/9/00, Notice 6/14/00—published 9/6/00, effective 11/1/00]
- [Filed 3/14/01, Notice 1/24/01—published 4/4/01, effective 7/1/01]
- [Filed emergency 6/13/01—published 7/11/01, effective 7/1/01]
- [Filed emergency 7/11/01—published 8/8/01, effective 7/11/01]
- [Filed 10/10/01, Notices 7/11/01, 8/8/01—published 10/31/01, effective 1/1/02]
- [Filed emergency 7/11/02—published 8/7/02, effective 7/11/02]
- [Filed 9/12/02, Notice 8/7/02—published 10/2/02, effective 12/1/02]
- [Filed emergency 6/12/03—published 7/9/03, effective 7/1/03]
- [Filed 9/22/03, Notice 7/9/03—published 10/15/03, effective 12/1/03]
- [Filed 3/11/04, Notice 1/21/04—published 3/31/04, effective 6/1/04]
- [Filed emergency 6/14/04—published 7/7/04, effective 7/1/04]
- [Filed 9/23/04, Notice 7/7/04—published 10/13/04, effective 11/17/04]
- [Filed emergency 4/15/05—published 5/11/05, effective 5/1/05]
- [Filed emergency 6/17/05—published 7/6/05, effective 7/1/05]
- [Filed 10/21/05, Notice 7/6/05—published 11/9/05, effective 12/14/05]
- [Filed 10/21/05, Notices 5/11/05, 6/8/05—published 11/9/05, effective 12/14/05]
- [Filed emergency 6/16/06—published 7/5/06, effective 7/1/06]
- [Filed 9/19/06, Notice 7/5/06—published 10/11/06, effective 11/16/06]
- [Filed emergency 6/13/07—published 7/4/07, effective 7/1/07]
- [Filed 7/12/07, Notice 5/9/07—published 8/1/07, effective 9/5/07]

[Filed 9/12/07, Notice 7/4/07—published 10/10/07, effective 11/14/07]  
[Filed emergency 6/12/08—published 7/2/08, effective 7/1/08]  
[Filed 8/19/08, Notice 7/2/08—published 9/10/08, effective 10/15/08]  
[Filed 11/12/08, Notice 9/24/08—published 12/3/08, effective 2/1/09]  
[Filed ARC 7741B (Notice ARC 7526B, IAB 1/28/09), IAB 5/6/09, effective 7/1/09]  
[Filed Emergency ARC 8447B, IAB 1/13/10, effective 1/1/10]  
[Filed ARC 8651B (Notice ARC 8448B, IAB 1/13/10), IAB 4/7/10, effective 5/12/10]  
[Filed Emergency ARC 8902B, IAB 6/30/10, effective 7/1/10]  
[Filed Emergency ARC 0860C, IAB 7/24/13, effective 7/1/13]  
[Filed ARC 1060C (Notice ARC 0859C, IAB 7/24/13), IAB 10/2/13, effective 11/6/13]

<sup>1</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.

CHAPTER 156  
PAYMENTS FOR FOSTER CARE

[Prior to 7/1/83, Social Services[770] Ch 137]  
[Previously appeared as Ch 137—renumbered IAB 2/29/84]  
[Prior to 2/11/87, Human Services[498]]

**441—156.1(234) Definitions.**

“*Child welfare services*” means age-appropriate activities to maintain a child’s connection to the child’s family and community, to promote reunification or other permanent placement, and to facilitate a child’s transition to adulthood.

“*Cost of foster care*” means the maintenance and supervision costs of foster family care, the maintenance costs and child welfare service costs of group care, and the maintenance and service costs of supervised apartment living and shelter care. The cost for foster family care supervision and for supervised apartment living services provided directly by the department caseworker shall be \$250 per month. When using this average monthly charge results in unearned income or parental liability being collected in excess of the cost of foster care, the excess funds shall be placed in the child’s escrow account. The cost for supervised apartment living services purchased from a private provider shall be the actual costs paid by the department.

“*Department*” means the Iowa department of human services.

“*Director*” means the director of the child support recovery unit of the department or the director’s designee.

“*Earned income*” means income in the form of a salary, wages, tips, bonuses, commissions earned as an employee, income from job corps or profit from self-employment.

“*Escrow account*” means an interest bearing account in a bank or savings and loan association which is maintained by the department in the name of a particular child.

“*Family foster care supervision*” means the support, assistance, and oversight provided by department caseworkers to children in family foster care and directed toward achievement of the child’s permanency plan goals.

“*Foster care*” means substitute care furnished on a 24-hour-a-day basis to an eligible child in a licensed or approved facility by a person or agency other than the child’s parent or guardian but does not include care provided in a family home through an informal arrangement for a period of 20 days or less. Child foster care shall include but is not limited to the provision of food, lodging, training, education, supervision and health care.

“*Foster family care*” means foster care provided by a foster family licensed by the department according to 441—Chapter 113 or licensed or approved by the placing state. The care includes the provision of food, lodging, clothing, transportation, recreation, and training that is appropriate for the child’s age and mental and physical capacity.

“*Group care maintenance*” means food, clothing, shelter, school supplies, personal incidentals, daily care, general parenting, discipline, and supervision of children to ensure their well-being and safety, and administration of maintenance items provided in a group care facility.

“*Income*” means earned and unearned income.

“*Mental health professional*” means a person who meets all of the following conditions:

1. Holds at least a master’s degree in a mental health field including, but not limited to, psychology, counseling and guidance, psychiatric nursing and social work; or is a doctor of medicine or osteopathic medicine; and

2. Holds a current Iowa license when required by the Iowa professional licensure laws (such as a psychiatrist, a psychologist, a marital and family therapist, a mental health counselor, an advanced registered nurse practitioner, a psychiatric nurse, or a social worker); and

3. Has at least two years of postdegree experience supervised by a mental health professional in assessing mental health problems, mental illness, and service needs and in providing mental health services.

“*Mental retardation professional*” means a psychologist, physician, registered nurse, educator, social worker, physical or occupational therapist, speech therapist or audiologist who meets the

educational requirements for the profession, as required in the state of Iowa, and has one year of experience working with persons with mental retardation.

“*Parent*” means the biological or adoptive parent of the child.

“*Parental liability*” means a parent’s liability for the support of a child during the period of foster care placement. Liability shall be determined pursuant to 441—Chapter 99, Division I.

“*Physician*” means a licensed medical or osteopathic doctor as defined in rule 441—77.1(249A).

“*Service area manager*” means the department employee or designee responsible for managing department offices within a department service area and for implementing policies and procedures of the department.

“*Special needs child*” means a child with needs for emotional care, behavioral care, or physical and personal care which require additional skill, knowledge, or responsibility on the part of the foster parents, as measured by Form 470-4401, Foster Child Behavioral Assessment. See subrule 156.6(4).

“*Unearned income*” means any income which is not earned income and includes supplemental security income (SSI) and other funds available to a child residing in a foster care placement.

This rule is intended to implement Iowa Code section 234.39.

[ARC 7606B, IAB 3/11/09, effective 5/1/09; ARC 7741B, IAB 5/6/09, effective 7/1/09; ARC 8010B, IAB 7/29/09, effective 10/1/09]

**441—156.2(234) Foster care recovery.** The department shall recover the cost of foster care provided by the department pursuant to the rules in this chapter and the rules in 441—Chapter 99, Division I, which establishes policies and procedures for the computation and collection of parental liability.

**156.2(1)** Funds shall be applied to the cost of foster care in the following order and each source exhausted before utilizing the next funding source:

- a. Unearned income of the child.
- b. Parental liability of the noncustodial parent.
- c. Parental liability of custodial parent(s).

**156.2(2)** The department shall serve as payee to receive the child’s unearned income. When a parent or guardian is not available or is unwilling to do so, the department shall be responsible for applying for benefits on behalf of a child placed in the care of the department. Until the department becomes payee, the payee shall forward benefits to the department. For voluntary foster care placements of children aged 18 and over, the child is the payee for the unearned income. The child shall forward these benefits, up to the actual cost of foster care, to the department.

**156.2(3)** The custodial parent shall assign child support payments to the department.

**156.2(4)** Unearned income of a child and parental liability of the noncustodial parent shall be placed in an account from whence it shall be applied toward the cost of the child’s current foster care and the remainder placed in an escrow account.

**156.2(5)** When a child has funds in escrow these funds may be used by the department to meet the current needs of the child not covered by the foster care payments and not prohibited by the source of the funds.

**156.2(6)** When the child leaves foster care, funds in escrow shall be paid to the custodial parent(s) or guardian or to the child when the child has attained the age of majority, unless a guardian has been appointed.

**156.2(7)** When a child who has unearned income returns home after the first day of a month, the remaining portion of the unearned income (based on the number of days in the particular month) shall be made available to the child and the child’s parents, guardian or custodian, if the child is eligible for the unearned income while in the home of a parent, guardian or custodian.

This rule is intended to implement Iowa Code section 234.39.

**441—156.3(252C) Computation and assessment of parental liability.** Rescinded IAB 3/13/96, effective 5/1/96.

**441—156.4(252C) Redetermination of liability.** Rescinded IAB 3/13/96, effective 5/1/96.

**441—156.5(252C) Voluntary payment.** Rescinded IAB 3/13/96, effective 5/1/96.

**441—156.6(234) Rate of maintenance payment for foster family care.**

**156.6(1) Basic rate.** A monthly payment for care in a foster family home licensed in Iowa shall be made to the foster family based on the following schedule:

<u>Age of child</u>	<u>Daily rate</u>
0 through 5	\$16.78
6 through 11	\$17.45
12 through 15	\$19.10
16 or over	\$19.35

**156.6(2) Out-of-state rate.** A monthly payment for care in a foster family home licensed or approved in another state shall be made to the foster family based on the rate schedule in effect in Iowa, except that the service area manager or designee may authorize a payment to the foster family at the rate in effect in the other state if the child's family lives in that state and the goal is to reunite the child with the family.

**156.6(3) Mother and child in foster care.** When the child in foster care is a mother whose young child is in placement with her, the rate paid to the foster family shall be based on the daily rate for the mother according to the rate schedule in subrules 156.6(1) and 156.6(4) and for the child according to the rate schedule in subrule 156.6(1). The foster parents shall provide a portion of the young child's rate to the mother to meet the partial maintenance needs of the young child as defined in the case permanency plan.

**156.6(4) Difficulty of care payment.**

*a.* For placements made before January 1, 2007, when foster parents provide care to a special needs child, the foster family shall be paid the basic maintenance rate plus \$5 per day for extra expenses associated with the child's special needs. This rate shall continue for the duration of the placement.

*b.* When a foster family provides care to a sibling group of three or more children, an additional payment of \$1 per day per child may be authorized for each nonspecial needs child in the sibling group.

*c.* When the foster family's responsibilities in the case permanency plan include providing transportation related to family or preplacement visits outside the community in which the foster family lives, the department worker may authorize an additional maintenance payment of \$1 per day. Expenses over the monthly amount may be reimbursed with prior approval by the worker. Eligible expenses shall include the actual cost of the most reasonable passenger fare or gas.

*d.* Effective January 1, 2007, when a foster family provides care to a child who was receiving behavioral management services for children in therapeutic foster care in that placement as of October 31, 2006, the foster family shall be paid the basic maintenance rate plus \$15 per day for that child. This rate shall continue for the duration of the placement.

*e.* Effective January 1, 2007, when a service area manager determines that as of October 31, 2006, a foster family was providing care for a child comparable to behavioral management services for children in therapeutic foster care, except that the placement is supervised by the department and the child's treatment plan is supervised by a physician, mental health professional, or mental retardation professional, the foster family shall be paid the basic maintenance rate plus \$15 per day for that child. This rate shall continue for the duration of the placement.

*f.* For placements made on or after January 1, 2007, the supervisor may approve an additional maintenance payment above the basic rate in subrule 156.6(1) to meet the child's special needs as identified by the child's score on Form 470-4401, Foster Child Behavioral Assessment. The placement worker shall complete Form 470-4401 within 30 days of the child's initial entry into foster care.

(1) Additional maintenance payments made under this paragraph shall begin no earlier than the first day of the month following the month in which Form 470-4401 is completed and shall be awarded as follows:

1. Behavioral needs rated at level 1 qualify for a payment of \$4.81 per day.
2. Behavioral needs rated at level 2 qualify for a payment of \$9.62 per day.
3. Behavioral needs rated at level 3 qualify for a payment of \$14.44 per day.

(2) The department shall review the child's need for this difficulty of care maintenance payment using Form 470-4401:

1. Whenever the child's behavior changes significantly;
2. When the child's placement changes;
3. After termination of parental rights, in preparation for negotiating an adoption subsidy or pre-subsidy payment; and
4. Before a court hearing on guardianship subsidy.

g. All maintenance payments, including difficulty of care payments, shall be documented on Form 470-0716, Foster Family Placement Contract.

h. Rescinded IAB 1/3/07, effective 1/1/07.

**156.6(5) *Payment method.*** All foster family maintenance payments shall be made directly to the foster family.

**156.6(6) *Return of overpayments.*** When a foster family has received payments in excess of those allowed under this chapter, the department caseworker shall ask the foster family to return the overpayment. If the foster family is returning the overpayment to the department, the caseworker will note the monthly amount the foster family agrees to pay in the family's case file. The amount returned shall not be less than \$50 per month.

This rule is intended to implement Iowa Code section 234.38 and 2013 Iowa Acts, Senate File 446, sections 18 and 19.

[**ARC 8010B**, IAB 7/29/09, effective 10/1/09; **ARC 8451B**, IAB 1/13/10, effective 1/1/10; **ARC 8653B**, IAB 4/7/10, effective 5/12/10; **ARC 8904B**, IAB 6/30/10, effective 7/1/10; **ARC 9778B**, IAB 10/5/11, effective 11/9/11; **ARC 0240C**, IAB 8/8/12, effective 7/11/12; **ARC 0419C**, IAB 10/31/12, effective 12/5/12; **ARC 0858C**, IAB 7/24/13, effective 7/1/13; **ARC 1061C**, IAB 10/2/13, effective 11/6/13]

**441—156.7(234) Purchase of family foster care services.** Rescinded IAB 5/6/09, effective 7/1/09.

**441—156.8(234) Additional payments.**

**156.8(1) *Clothing allowance.*** When, in the judgment of the worker, clothing is needed at the time the child is removed from the child's home and placed in foster care, an allowance may be authorized, not to exceed \$237.50, to purchase clothing.

a. Once during each calendar year that the child remains in foster care, the department worker may authorize another clothing allowance, not to exceed \$190 for family foster care and \$100 for all other levels when:

- (1) The child needs clothing to replace lost clothing or because of growth or weight change, and
- (2) The child does not have escrow funds to cover the cost.

b. When clothing is purchased by the foster family, the foster family shall submit receipts to the worker within 30 days of purchase for auditing purposes, using Form 470-1952, Foster Care Clothing Allowance.

**156.8(2) *Supervised apartment living.*** Effective July 1, 2013, when a child is initially placed in supervised apartment living, the service area manager or designee may authorize an allowance not to exceed \$630 if the child does not have sufficient resources to cover initial costs.

**156.8(3) *Medical care.*** When a child in foster care needs medical care or examinations which are not covered by the Medicaid program and no other source of payment is available, the cost may be paid from foster care funds with the approval of the service area manager or designee. Eligible costs shall include emergency room care, medical treatment by out-of-state providers who refuse to participate in the Iowa Medicaid program, and excessive expenses for nonprescription drugs or supplies. Requests for payment for out-of-state medical treatment and for nonprescription drugs or supplies shall be approved prior to the care being provided or the drugs or supplies purchased. Claims shall be submitted to the department on Form GAX, General Accounting Expenditure, within 90 days after the service is provided. The rate of payment shall be the same as allowed under the Iowa Medicaid program.

**156.8(4) *Transportation for medical care.*** When a child in foster family care has expenses for transportation to receive medical care which cannot be covered by the Medicaid program, the expenses may be paid from foster care funds, with the approval of the service area manager. The claim for all the

expenses shall be submitted to the department on Form GAX, General Accounting Expenditure, within 90 days after the trip. This payment shall not duplicate or supplement payment through the Medicaid program. The expenses may include the actual cost of meals, parking, child care, lodging, passenger fare, or mileage at the rate granted state employees.

**156.8(5) *Funeral expense.*** When a child under the guardianship of the department dies, the department will pay funeral expenses not covered by the child's resources, insurance or other death benefits, the child's legal parents, or the child's county of legal settlement, not to exceed \$650.

The total cost of the funeral and the goods and services included in the total cost shall be the same as defined in rule 441—56.3(239,249).

The claim shall be submitted by the funeral director to the department on Form GAX, General Accounting Expenditure, and shall be approved by the service area manager. Claims shall be submitted within 90 days after the child's death.

**156.8(6) *School fees.*** Payment for required school fees of a child in foster family care or supervised apartment living that exceed \$5 may be authorized by the department worker in an amount not to exceed \$50 per calendar year if the child does not have sufficient escrow funds to cover the cost. Required school fees shall include:

- a. Fees required for participation in school or extracurricular activities; and
- b. Fees related to enrolling a child in preschool when a mental health professional or a mental retardation professional has recommended school attendance.

**156.8(7) *Respite care.*** The service area manager or designee may authorize respite for a child in family foster care for up to 24 days per calendar year per placement. Respite shall be provided by a licensed foster family. The payment rate to the respite foster family shall be the rate authorized under rule 441—156.6(234) to meet the needs of the child.

**156.8(8) *Tangible goods, child care, and ancillary services.*** To the extent that a foster child's escrow funds are not available, the service area manager or designee may authorize reimbursement to foster parents for the following:

a. Tangible goods for a special needs child including, but not limited to, building modifications, medical equipment not covered by Medicaid, specialized educational materials not covered by educational funds, and communication devices not covered by Medicaid.

b. Child care services when the foster parents are working, the child is not in school, and the provision of child care is identified in the child's case permanency plan.

(1) Child care services shall be provided by a licensed foster parent or a licensed or registered child care provider when available.

(2) When foster parents elect to become child care providers, they shall be registered pursuant to 441—Chapter 110.

c. Ancillary services needed by the foster parent to meet the needs of a special needs child including, but not limited to, specialized classes when directed by the case permanency plan.

d. Ancillary services needed by the special needs child including, but not limited to, recreation fees, in-home tutoring and specialized classes not covered by education funds.

e. Requests for tangible goods, child care, and ancillary services shall be submitted to the service area manager for approval on Form 470-3056, Request for Tangible Goods, Child Care, and Ancillary Services. Payment rates for tangible goods and ancillary services shall be comparable to prevailing community standards. Payment rates for child care shall be established pursuant to 441—subrule 170.4(7).

f. Prior payment authorization shall be issued by the service area manager before tangible goods, child care, and ancillary services are purchased by or for foster parents.

This rule is intended to implement Iowa Code section 234.35.

[ARC 7606B, IAB 3/11/09, effective 5/1/09; ARC 8010B, IAB 7/29/09, effective 10/1/09; ARC 8451B, IAB 1/13/10, effective 1/1/10; ARC 8653B, IAB 4/7/10, effective 5/12/10; ARC 9778B, IAB 10/5/11, effective 11/9/11; ARC 0856C, IAB 7/24/13, effective 7/1/13; ARC 1062C, IAB 10/2/13, effective 11/6/13]

**441—156.9(234) Rate of payment for foster group care.**

**156.9(1) In-state reimbursement.** Effective November 1, 2006, public and private foster group care facilities licensed or approved in the state of Iowa shall be paid for group care maintenance and child welfare services in accordance with the rate-setting methodology in this subrule.

*a.* A provider of group care services shall maintain at least the minimum staff-to-child ratio during prime programming time as established in the contract. Staff shall meet minimum qualifications as established in 441—Chapters 114 and 115. The actual number and qualifications of the staff will vary depending on the needs of the children.

*b.* Additional payment for group care maintenance may be authorized if a facility provides care for a mother and her young child according to subrule 156.9(4).

*c.* Reimbursement rates shall be adjusted based on the provider's rate in effect on October 31, 2006, to reflect an estimate that group care providers will provide an average of one hour per day of group remedial services and one hour per week of individual remedial services. The reimbursement rate shall be calculated as follows:

(1) Step 1. Annualize the provider's combined daily reimbursement rate for maintenance and service in effect on October 31, 2006, by multiplying that combined rate by 365 days.

(2) Step 2. Annualize the provider's remedial services reimbursement rate for one hour per day of remedial services code 96153 (health and behavioral interventions - group), as established by the Iowa Medicaid enterprise, by multiplying that rate by 365 days.

(3) Step 3. Annualize the provider's remedial services reimbursement rate for one hour per week of remedial services code 96152 (health and behavioral interventions - individual), as established by the Iowa Medicaid enterprise, by multiplying that rate by 52 weeks.

(4) Step 4. Add the amounts determined in Steps 2 and 3.

(5) Step 5. Subtract the amount determined in Step 4 from the amount determined in Step 1.

(6) Step 6. Divide the amount determined in Step 5 by 365 to compute the new combined maintenance and child welfare service per diem rate.

(7) Step 7. Determine the maintenance portion of the per diem rate by multiplying the new combined per diem rate determined in Step 6 by 85.62 percent.

(8) Step 8. Determine the child welfare service portion of the per diem rate by multiplying the new combined per diem rate determined in Step 6 by 14.38 percent.

EXAMPLE: Provider A has the following rates as of October 31, 2006:

- A combined daily maintenance and service rate of \$121.45;
- A Medicaid rate for service code 96153 of \$5.10 per 15 minutes, or \$20.40 per hour;
- A Medicaid rate for service code 96152 of \$19.92 per 15 minutes, or \$79.68 per hour.

Step 1.  $\$121.45 \times 365 \text{ days} = \$44,329.25$

Step 2.  $\$20.40 \times 365 \text{ days} = \$7,446.00$

Step 3.  $\$79.68 \times 52 \text{ weeks} = \$4,143.36$

Step 4.  $\$7,446.00 + \$4,143.36 = \$11,589.36$

Step 5.  $\$44,329.25 - \$11,589.36 = \$32,739.89$

Step 6.  $\$32,739.89 \div 365 \text{ days} = \$89.70$

Step 7.  $\$89.70 \times 0.8562 = \$76.80$  maintenance rate

Step 8.  $\$89.70 \times 0.1438 = \$12.90$  child welfare service rate

Provider A's rates are \$76.80 for maintenance and \$12.90 for child welfare services.

*d.* No less than annually, the department shall redetermine the allocation of the combined child welfare service per diem rate between the maintenance and service portions based on review of verified remedial services cost reports for foster group care services providers. If the new allocation differs from the current allocation, the department shall:

(1) Reallocate the combined child welfare service per diem for foster group care between the maintenance and service portions of the combined rate; and

(2) Notify all providers of any change in the allocation between maintenance and service rates and the effective date.

**156.9(2) *Out-of-state group care payment rate.*** The payment rate for maintenance and child welfare services provided by public or private agency group care licensed or approved in another state shall be established using the same rate-setting methodology as that in subrule 156.9(1), unless the director determines that appropriate care is not available within the state pursuant to the following criteria and procedures.

*a. Criteria.* When determining whether appropriate care is available within the state, the director shall consider each of the following:

- (1) Whether the child's treatment needs are exceptional.
- (2) Whether appropriate in-state alternatives are available.
- (3) Whether an appropriate in-state alternative could be developed by using juvenile court-ordered service fund or wrap-around funds.
- (4) Whether the placement and additional payment are expected to be time-limited with anticipated outcomes identified.
- (5) If the placement has been approved by the service area manager or chief juvenile court officer.

*b. Procedure.* The service area manager or chief juvenile court officer shall submit the request for director's exception to the Appeals Section, Department of Human Services, Fifth Floor, Hoover State Office Building, Des Moines, Iowa 50319-0114. This request shall be made in advance of placing the child and should allow a minimum of two weeks for a response. The request shall contain documentation addressing the criteria for director's approval listed in 156.9(2) "a."

*c. Appeals.* The decision of the director regarding approval of an exception to the rate determination in rule 441—152.3(234) is not appealable.

**156.9(3) *Supplemental payments for in-state facilities.*** Rescinded IAB 9/1/93, effective 8/12/93.

**156.9(4) *Mother-young child rate.*** When a group foster care facility provides foster care for a mother and her young child, the maintenance rate for the mother shall include an additional amount to cover the actual and allowable maintenance needs of the young child. No additional amount shall be allowed for service needs of the child.

*a.* The rate shall be determined according to the policies in rule 441—152.3(234) and added to the maintenance rate for the mother. The young child portion of the maintenance rate shall be limited to the costs associated with food, clothing, shelter, personal incidentals, and supervision for each young child and shall not exceed the maintenance rate for the mother. Costs for day care shall not be included in the maintenance rate.

*b.* Rescinded IAB 6/8/94, effective 6/1/94.

*c.* Unless the court has transferred custody from the mother, the mother shall have primary responsibility for providing supervision and parenting for the young child. The facility shall provide services to the mother to assist her to meet her parenting responsibilities and shall monitor her care of the young child.

*d.* The facility shall provide services to the mother to assist her to:

- (1) Obtain a high school diploma or general education equivalent (GED).
- (2) Develop preemployment skills.
- (3) Establish paternity for her young child whenever appropriate.
- (4) Obtain child support for the young child whenever paternity is established.

*e.* The agency shall maintain information in the mother's file on:

- (1) The involvement of the mother's parents or of other adults.
- (2) The involvement of the father of the minor's child, including steps taken to establish paternity, if appropriate.
- (3) A decision of the minor to keep and raise her young child.
- (4) Plan for the minor's completion of high school or a GED program.
- (5) The parenting skills of the minor parent.
- (6) Child care and transportation plans for education, training or employment.
- (7) Ongoing health care of the mother and child.
- (8) Other services as needed to address personal or family problems or to facilitate the personal growth and development toward economic self-sufficiency of the minor parent and young child.

*f.* The agency shall designate \$35 of the young child rate as an allowance to the mother to meet the maintenance needs of her young child, as defined in her case permanency plan.

This rule is intended to implement Iowa Code sections 234.6 and 234.38.  
[ARC 7741B, IAB 5/6/09, effective 7/1/09; ARC 8715B, IAB 5/5/10, effective 7/1/10; ARC 9778B, IAB 10/5/11, effective 11/9/11]

#### **441—156.10(234) Payment for reserve bed days.**

**156.10(1) Group care facilities.** The department shall provide payment for group care maintenance and child welfare services according to the following policies.

*a. Family visits.* Reserve bed payment shall be made for days a child is absent from the facility for family visits when the absence is in accord with the following:

- (1) The visits shall be consistent with the child's case permanency plan.
- (2) The facility shall notify the worker of each visit and its planned length prior to the visit.
- (3) The intent of the department and the facility shall be for the child to return to the facility after the visit.
- (4) Staff from the facility shall be available to provide support to the child and family during the visit.
- (5) Payment shall be canceled and payments returned if the facility refuses to accept the child back.
- (6) If the department and the facility agree that the return would not be in the child's best interest, payment shall be canceled effective the day after the joint decision not to return the child.
- (7) Payment shall be canceled effective the day after a decision is made by the court or parent in a voluntary placement not to return the child.

(8) Payment shall not exceed 14 consecutive days, except upon prior written approval of the service area manager. In no case shall payment exceed 30 consecutive days.

(9) The provider shall document the use of reserve bed days in the daily log and report the number of reserve bed days claimed in the quarterly report.

*b. Hospitalization.* Reserve bed payment shall be made for days a child is absent from the facility for hospitalization when the absence is in accord with the following:

- (1) The facility shall contact the worker at least 48 hours in advance of a planned hospitalization and within 24 hours after an unplanned hospitalization.
- (2) The intent of the department and the facility shall be for the child to return to the facility after the hospitalization.
- (3) Staff from the facility shall be available to provide support to the child and family during the hospitalization.
- (4) Payment shall be canceled and payments returned if the facility refuses to accept the child back.
- (5) If the department and the facility agree that the return would not be in the child's best interest, payment shall be canceled effective the day after the joint decision not to return the child.
- (6) Payment shall be canceled effective the day after a decision is made by the court or parent in a voluntary placement not to return the child.
- (7) Payment shall not exceed 14 consecutive days, except upon prior written approval of the service area manager. In no case shall payment exceed 30 consecutive days.
- (8) The provider shall document the use of reserve bed days in the daily log and report the number of reserve bed days claimed in the quarterly report.

*c. Runaways.* Reserve bed payment shall be made for days a child is absent from the facility after the child has run away when the absence is in accord with the following:

- (1) The facility shall notify the worker within 24 hours after the child runs away.
- (2) The intent of the department and the facility shall be for the child to return to the facility once the child is found.
- (3) Payment shall be canceled and payments returned if the facility refuses to accept the child back.
- (4) If the department and the facility agree that the return would not be in the child's best interest, payment shall be canceled effective the day after the joint decision not to return the child.
- (5) Payment shall be canceled effective the day after a decision is made by the court or parent in a voluntary placement not to return the child.

(6) Payment shall not exceed 14 consecutive days, except upon prior written approval of the service area manager. In no case shall payment exceed 30 consecutive days.

(7) The provider shall document the use of reserve bed days in the daily log and report the number of reserve bed days claimed in the quarterly report.

*d. Preplacement visits.* Reserve bed payment shall be made when a child is making a planned preplacement visit to another foster care placement or an adoptive placement when the absence is in accord with the following:

(1) The visits shall be consistent with the child's case permanency plan.

(2) The intent of the department and the facility shall be for the child to return to the facility.

(3) Staff from the facility shall be available to provide support to the child and provider during the visit.

(4) Payment shall be canceled and payment returned if the facility refuses to accept the child back.

(5) Payment shall not exceed two consecutive days.

(6) The provider shall document the use of reserve bed days in the daily log and report the number of reserve bed days claimed in the quarterly report.

**156.10(2) Foster family care.**

*a. Family visits.* Reserve bed payment shall be made for days a foster child is absent from the foster family home for family visits when the absence is in accord with the following:

(1) The visits shall be consistent with the child's case permanency plan.

(2) The intent of the department and the foster family shall be for the child to return to the foster family home after the visit.

(3) Payment shall be canceled and payments returned if the foster family refuses to accept the child back.

(4) If the department and the foster family agree that the return would not be in the child's best interest, payment shall be canceled effective the day after the joint decision not to return the child.

(5) Payment shall be canceled effective the day after a decision is made by the court or parent in a voluntary placement not to return the child.

(6) Payment shall not exceed 14 consecutive days, except upon prior written approval of the service area manager. In no case shall payment exceed 30 consecutive days.

*b. Hospitalization.* Reserve bed payment shall be made for days a foster child is absent from the foster family home for hospitalization when the absence is in accord with the following:

(1) The intent of the department and the foster family shall be for the child to return to the foster family home after the hospitalization.

(2) Payment shall be canceled and payments returned if the foster family refuses to accept the child back.

(3) If the department and the foster family agree that the return would not be in the child's best interest, payment shall be canceled effective the day after the joint decision not to return the child.

(4) Payment shall be canceled effective the day after a decision is made by the court or parent in a voluntary placement not to return the child.

(5) Payment shall not exceed 14 consecutive days, except upon prior written approval of the service area manager. In no case shall payment exceed 30 consecutive days.

*c. Runaways.* Reserve bed payment shall be made for days a foster child is absent from the foster family home after the child has run away when the absence is in accord with the following:

(1) The foster family shall notify the worker within 24 hours after the child runs away.

(2) The intent of the department and the foster family shall be for the child to return to the foster family home once the child is found.

(3) Payment shall be canceled and payments returned if the foster family refuses to accept the child back.

(4) If the department and the foster family agree that the return would not be in the child's best interest, payment shall be canceled effective the day after the joint decision not to return the child.

(5) Payment shall be canceled effective the day after a decision is made by the court or parent in a voluntary placement not to return the child.

(6) Payment shall not exceed 14 consecutive days, except upon prior written approval of the service area manager. In no case shall payment exceed 30 consecutive days.

*d. Preplacement visits.* Reserve bed payment shall be made when a foster child is making a planned preplacement visit to another foster care placement or an adoptive placement when the absence is in accord with the following:

- (1) The visits shall be consistent with the child's case permanency plan.
- (2) The intent of the department and the foster family home shall be for the child to return to the foster family home.
- (3) Payment shall be canceled and payment returned if the foster family home refuses to accept the child back.
- (4) Payment shall not exceed two consecutive days.

**156.10(3) Shelter care facilities.**

*a. Hospitalization.* Reserve bed payment shall be made for days a child is absent from the facility for hospitalization when the absence is in accord with the following:

- (1) The facility shall contact the worker at least 48 hours in advance of a planned hospitalization and within 24 hours after an unplanned hospitalization.
- (2) The intent of the department and the facility shall be for the child to return to the facility after the hospitalization.
- (3) Staff from the facility shall be available to provide support to the child and family during the hospitalization.
- (4) Payment shall be canceled and payments returned if the facility refuses to accept the child back.
- (5) If the department and the facility agree that the return would not be in the child's best interest, payment shall be canceled effective the day after the joint decision not to return the child.
- (6) Payment shall be canceled effective the day after a decision is made by the court or parent in a voluntary placement not to return the child.
- (7) Payment shall not exceed 14 consecutive days, except upon prior written approval of the service area manager. In no case shall payment exceed 30 consecutive days.
- (8) The provider shall document the use of reserve bed days in the daily log and report the number of reserve bed days claimed in the quarterly report.

*b. Preplacement visits.* Reserve bed payment shall be made when a child is making a planned preplacement visit to another foster care placement or an adoptive placement when the absence is in accord with the following:

- (1) The visits shall be consistent with the child's case permanency plan.
- (2) The intent of the department and the facility shall be for the child to return to the facility.
- (3) Staff from the facility shall be available to provide support to the child and provider during the visit.
- (4) Payment shall be canceled and payment returned if the facility refuses to accept the child back.
- (5) Payment shall not exceed two consecutive days.
- (6) The provider shall document the use of reserve bed days in the daily log and report the number of reserve bed days claimed in the quarterly report.

This rule is intended to implement Iowa Code sections 234.6 and 234.35.  
[ARC 8010B, IAB 7/29/09, effective 10/1/09]

**441—156.11(234) Emergency care.**

**156.11(1) and 156.11(2)** Rescinded IAB 3/11/09, effective 5/1/09.

**156.11(3)** Shelter care payment. Public and private juvenile shelter care facilities approved or licensed in Iowa shall be paid according to the rate-setting methodology in 441—paragraph 150.3(5)“p.”

*a.* Facilities shall bill for actual units of service provided in accordance with 441—subrule 150.3(8). In addition, facilities may be guaranteed a minimum level of payment to the extent determined by the department through a request-for-proposal process.

- (1) Guaranteed payment shall be calculated monthly.

(2) The guaranteed level of payment shall be calculated by multiplying the number of beds for which payment is guaranteed by the number of days in the month.

(3) When the actual unit billings for a facility do not equal the guaranteed level of payment for the month, the facility may submit a supplemental billing for the deficiency.

(4) The amount of the supplemental billing shall be determined by multiplying the facility's unit cost for shelter care by the number of units below the guaranteed level for the month for which the facility was not reimbursed.

*b.* The total reimbursement to the agency shall not exceed the agency's allowable costs as defined in 441—subrule 150.3(5). Agencies shall refund any payments which have been made in excess of the agencies' allowable costs.

*c.* Shelter contracts for the state fiscal year beginning July 1, 2007, shall provide for the statewide availability of a daily average of 273 guaranteed emergency juvenile shelter care beds during the fiscal year.

This rule is intended to implement Iowa Code section 234.35.

[ARC 7606B, IAB 3/11/09, effective 5/1/09]

#### **441—156.12(234) Supervised apartment living.**

**156.12(1) Maintenance.** Effective July 1, 2013, when a child at least aged 16½ but under the age of 20 is living in a supervised apartment living situation, the monthly maintenance payment for the child shall be \$787.50. This payment may be paid to the child or another payee, other than a department employee, for the child's living expenses.

**156.12(2) Service.** When services for a youth in supervised apartment living are purchased, the service components and number of hours purchased shall be specified by the service worker in the youth's case permanency plan.

This rule is intended to implement Iowa Code section 234.35 and 2011 Iowa Acts, House File 649, section 28(4).

[ARC 8451B, IAB 1/13/10, effective 1/1/10; ARC 8653B, IAB 4/7/10, effective 5/12/10; ARC 9778B, IAB 10/5/11, effective 11/9/11; ARC 0856C, IAB 7/24/13, effective 7/1/13; ARC 1062C, IAB 10/2/13, effective 11/6/13]

#### **441—156.13(234) Excessive rates.** Rescinded IAB 6/9/93, effective 8/1/93.

**441—156.14(234,252C) Voluntary placements.** When placement is made on a voluntary basis, the parent or guardian shall complete and sign Form 470-0715, Voluntary Placement Agreement.

**441—156.15(234) Child's earnings.** Earned income of a child who is not in a supervised apartment living arrangement and who is a full-time student or engaged in an educational or training program shall be reported to the department and its use shall be a part of a plan for service, but the income shall not be used towards the cost of the child's care as established by the department. When the earned income of children in supervised apartment living arrangements or of other children exceeds the foster care standard, the income in excess of the standard shall be applied to meet the cost of the child's care. When the income of the child exceeds twice the cost of maintenance, the child shall be discontinued from foster care.

#### **441—156.16(234) Trust funds and investments.**

**156.16(1)** When the child is a beneficiary of a trust and the proceeds therefrom are not currently available, or are not sufficient to meet the child's needs, the worker shall assist the child in having a petition presented to the court requesting release of funds to help meet current requirements. When the child and responsible adult cooperate in necessary action to obtain a ruling of the court, income shall not be considered available until the decision of the court has been rendered and implemented. When the child and responsible adult do not cooperate in the action necessary to obtain a ruling of the court, the trust fund or investments shall be considered as available to meet the child's needs immediately. When the child or responsible adult does not cooperate within 90 days in making the income available the maintenance payment shall be terminated.

**156.16(2)** The Iowa department of human services shall be payee for income from any trust funds or investments unless limited by the trust.

**156.16(3)** Savings accounts from any income and proceeds from the liquidation of securities shall be placed in the child's account maintained by the department and any amount in excess of \$1,500 shall be applied towards cost of the child's maintenance.

This rule is intended to implement Iowa Code section 234.39.

**441—156.17(234) Preadoptive homes.** Payment for a foster child placed in a preadoptive home shall be limited to the amount negotiated pursuant to rule 441—201.5(600) and shall not exceed the foster care maintenance amount paid in family foster care.

This rule is intended to implement Iowa Code section 234.38.  
[ARC 8010B, IAB 7/29/09, effective 10/1/09]

**441—156.18(237) Foster parent training expenses.** Rescinded IAB 7/29/09, effective 10/1/09.

**441—156.19(237) Rate of payment for care in a residential care facility.** When a child is receiving group care maintenance and child welfare services in a licensed residential care facility and is not eligible for supplemental security income or state supplementary assistance, the department will pay for the group care maintenance and child welfare services in accordance with subrule 156.9(1). When a child receives group care maintenance and child welfare services in a licensed residential care facility and is eligible for supplemental security income or state supplementary assistance, the department will pay for child welfare services in accordance with subrule 156.9(1).

This rule is intended to implement Iowa Code section 237.1(3)“e.”

**441—156.20(234) Eligibility for foster care payment.**

**156.20(1) Client eligibility.** Foster care payment shall be limited to the following populations.

*a.* Youth under the age of 18 shall be eligible based on legal status, subject to certain limitations.

(1) Legal status. The youth's placement shall be based on one of the following legal statuses:

1. The court has ordered foster care placement pursuant to Iowa Code section 232.52, subsection 2, paragraph “d,” Iowa Code section 232.102, subsection 1, Iowa Code section 232.117, or Iowa Code section 232.182, subsection 5.

2. The child is placed in shelter care pursuant to Iowa Code section 232.20, subsection 1, or Iowa Code section 232.21.

3. The department has agreed to provide foster care pursuant to rule 441—202.3(234).

(2) Limitations. Department payment for group care shall be limited to placements which have been authorized by the department and which conform to the service area group care plan developed pursuant to rule 441—202.17(232). Payment for an out-of-state group care placement shall be limited to placements approved pursuant to 441—subrule 202.8(2).

*b.* Youth aged 18 and older who meet the definition of child in rule 441—202.1(234) shall be eligible based on age, a voluntary placement agreement pursuant to 441—subrule 202.3(3), and type of placement.

(1) Except as provided in subparagraph 156.20(1)“b”(3), payment for a child who is 18 years of age shall be limited to family foster care or supervised apartment living.

(2) Except as provided in subparagraph 156.20(1)“b”(3), payment for a child who is 19 years of age shall be limited to supervised apartment living.

(3) Exceptions. An exception to subparagraphs (1) and (2) shall be granted for all unaccompanied refugee minors. The service area manager or designee shall grant an exception for other children when the child meets all of the following criteria. The child's eligibility for the exception shall be documented in the case record.

1. The child does not have mental retardation. Funding for services for persons with mental retardation is the responsibility of the county or state pursuant to Iowa Code section 222.60.

2. The child is at imminent risk of becoming homeless or of failing to graduate from high school or obtain a general equivalency diploma. "At imminent risk of becoming homeless" shall mean that a less restrictive living arrangement is not available.

3. The placement is in the child's best interests.

4. Funds are available in the service area's allocation. When the service area manager has approved payment for foster care pursuant to this subparagraph, funds which may be necessary to provide payment for the time period of the exception, not to exceed the current fiscal year, shall be considered encumbered and no longer available. Each service area's funding allocation shall be based on the service area's portion of the total number of children in foster care on March 31 preceding the beginning of the fiscal year, who would no longer be eligible for foster care during the fiscal year due to age, excluding unaccompanied refugee minors.

c. A young mother shall be eligible for the extra payment for her young child living with her in care as set forth in subrule 156.6(4), paragraph "a," and subrule 156.9(4) if all of the following apply:

(1) The mother is placed in foster care.

(2) The mother's custodian determines, as documented in the mother's case permanency plan, that it is in her best interest and the best interest of the young child that the child remain with her.

(3) A placement is available.

(4) The mother agrees to refund to the department any child support payments she receives on behalf of the child and to allow the department to be made payee for any other unearned income for the child.

**156.20(2) Provider eligibility for payment.**

a. Providers of shelter care services and supervised apartment living services shall have a purchase of service contract under 441—Chapter 150 in force.

b. Providers of group care services shall have a foster group care services contract under 441—Chapter 152 in force.

This rule is intended to implement Iowa Code sections 232.143, 234.35 and 234.38.  
[ARC 8010B, IAB 7/29/09, effective 10/1/09]

[Filed 7/1/74; amended 9/4/74]

[Filed emergency 10/31/75—published 11/17/75, effective 11/1/75]

[Filed 12/23/75, Notice 11/17/75—published 1/12/76, effective 2/16/76]

[Filed 2/19/76, Notice 1/12/76—published 3/8/76, effective 4/12/76]

[Filed emergency 7/29/76—published 8/23/76, effective 9/1/76]

[Filed 10/7/76, Notice 8/23/76—published 11/3/76, effective 12/8/76]

[Filed 6/10/77, Notice 5/4/77—published 6/29/77, effective 8/3/77]

[Filed 5/24/78, Notice 3/22/78—published 6/14/78, effective 7/19/78]

[Filed emergency 7/28/78—published 8/23/78, effective 8/1/78]

[Filed emergency 6/26/79—published 7/25/79, effective 7/1/79]

[Filed emergency 6/30/80—published 7/23/80, effective 7/1/80]

[Filed 10/24/80, Notice 9/3/80—published 11/12/80, effective 12/17/80]

[Filed emergency 6/30/81—published 7/22/81, effective 7/1/81]

[Filed 6/30/81, Notice 4/29/81—published 7/22/81, effective 9/1/81]

[Filed emergency 8/20/82—published 9/15/82, effective 9/1/82]

[Filed 2/25/83, Notice 12/22/82—published 3/16/83, effective 5/1/83]

[Filed emergency after Notice 6/17/83—published 7/6/83, effective 7/1/83]

[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 11/18/83, Notice 10/12/83—published 12/7/83, effective 2/1/84]

[Filed emergency 2/10/84—published 2/29/84, effective 2/10/84]

[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 emergency 11/16/84—published 12/5/84, effective 12/1/84]
- [Filed 1/21/85, Notice 12/5/84—published 2/13/85, effective 4/1/85]
- [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 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 12/2/85, Notice 10/23/85—published 12/18/85, effective 2/1/86]
- [Filed 12/12/85, Notice 10/9/85—published 1/1/86, effective 3/1/86]
- [Filed emergency 6/26/86—published 7/16/86, effective 7/1/86]
- [Filed emergency 1/15/87—published 2/11/87, effective 1/15/87]
- [Filed emergency 6/19/87—published 7/15/87, effective 7/1/87]<sup>o</sup>
- [Filed 8/28/87, Notice 7/15/87—published 9/23/87, effective 11/1/87]<sup>o</sup>
- [Filed emergency 9/21/87—published 10/21/87, effective 9/22/87]
- [Filed 10/23/87, Notice 7/15/87—published 11/18/87, effective 1/1/88]
- [Filed 12/10/87, Notice 10/21/87—published 12/30/87, effective 3/1/88]
- [Filed emergency 6/9/88—published 6/29/88, effective 7/1/88]
- [Filed 4/13/89, Notice 1/11/89—published 5/3/89, effective 7/1/89]
- [Filed emergency 6/9/89—published 6/28/89, effective 7/1/89]
- [Filed 7/13/89, Notice 5/31/89—published 8/9/89, effective 10/1/89]
- [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 emergency 6/20/90—published 7/11/90, effective 7/1/90]
- [Filed 8/16/90, Notice 7/11/90—published 9/5/90, effective 11/1/90]
- [Filed 10/12/90, Notice 7/11/90—published 10/31/90, effective 1/1/91]
- [Filed 11/15/91, Notice 9/18/91—published 12/11/91, effective 2/1/92]
- [Filed 12/11/91, Notice 10/16/91—published 1/8/92, effective 3/1/92]<sup>1</sup>
- [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 8/14/92, Notice 7/8/92—published 9/2/92, effective 11/1/92]
- [Filed 5/14/93, Notice 3/17/93—published 6/9/93, effective 8/1/93]
- [Filed emergency 6/11/93—published 7/7/93, effective 7/1/93]
- [Filed without Notice 8/12/93—published 9/1/93, effective 11/1/93]
- [Filed 8/12/93, Notice 2/17/93—published 9/1/93, effective 11/1/93]
- [Filed 9/17/93, Notice 7/21/93—published 10/13/93, effective 1/1/94]
- [Filed emergency 10/14/93—published 11/10/93, effective 11/1/93]
- [Filed 11/12/93, Notice 9/15/93—published 12/8/93, effective 2/1/94]
- [Filed 12/16/93, Notices 10/13/93, 11/10/93—published 1/5/94, effective 3/1/94]
- [Filed emergency 5/11/94 after Notice 3/16/94—published 6/8/94, effective 6/1/94]
- [Filed emergency 6/16/94—published 7/6/94, effective 7/1/94]
- [Filed 8/12/94, Notice 7/6/94—published 8/31/94, effective 11/1/94]
- [Filed emergency 12/15/94—published 1/4/95, effective 2/1/95]
- [Filed 12/15/94, Notice 10/26/94—published 1/4/95, effective 3/1/95]
- [Filed 2/16/95, Notice 1/4/95—published 3/15/95, effective 5/1/95]
- [Filed 3/20/95, Notice 1/18/95—published 4/12/95, effective 6/1/95]
- [Filed 4/13/95, Notices 2/15/95, 3/1/95—published 5/10/95, effective 7/1/95]
- [Filed emergency 6/7/95—published 7/5/95, effective 7/1/95]
- [Filed emergency 7/12/95—published 8/2/95, effective 9/1/95]
- [Filed 8/10/95, Notice 7/5/95—published 8/30/95, effective 11/1/95]
- [Filed 9/25/95, Notice 8/2/95—published 10/11/95, effective 12/1/95]
- [Filed 2/14/96, Notice 12/20/95—published 3/13/96, effective 5/1/96]
- [Filed emergency 6/13/96—published 7/3/96, effective 7/1/96]
- [Filed emergency 6/13/96—published 7/3/96, effective 8/1/96]

- [Filed 8/15/96, Notices 6/19/96, 7/3/96—published 9/11/96, effective 11/1/96]  
 [Filed 9/17/96, Notice 7/17/96—published 10/9/96, effective 12/1/96]  
 [Filed emergency 6/12/97—published 7/2/97, effective 7/1/97]  
 [Filed 8/13/97, Notice 7/2/97—published 9/10/97, effective 11/1/97]  
 [Filed 10/15/97, Notice 7/30/97—published 11/5/97, effective 1/1/98]  
 [Filed emergency 6/10/98—published 7/1/98, effective 7/1/98]  
 [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 emergency 10/14/98 after Notice 8/26/98—published 11/4/98, effective 11/1/98]  
 [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 emergency 10/13/99 after Notice 8/25/99—published 11/3/99, effective 11/1/99]  
 [Filed emergency 6/8/00—published 6/28/00, effective 7/1/00]  
 [Filed 8/9/00, Notice 6/14/00—published 9/6/00, effective 11/1/00]  
 [Filed 1/10/01, Notice 11/15/00—published 2/7/01, effective 4/1/01]  
 [Filed emergency 6/13/01—published 7/11/01, effective 7/1/01]  
 [Filed 9/11/01, Notice 7/11/01—published 10/3/01, effective 12/1/01]  
 [Filed 11/18/02, Notice 8/21/02—published 12/11/02, effective 2/1/03]  
 [Filed 3/11/04, Notice 1/21/04—published 3/31/04, effective 6/1/04]  
 [Filed emergency 6/17/05—published 7/6/05, effective 7/1/05]  
 [Filed 10/21/05, Notice 7/6/05—published 11/9/05, effective 12/14/05]  
 [Filed emergency 6/16/06—published 7/5/06, effective 7/1/06]<sup>◇</sup>  
 [Filed 9/19/06, Notices 7/5/06—published 10/11/06, effective 11/16/06]  
 [Filed emergency 10/12/06—published 11/8/06, effective 11/1/06]  
 [Filed emergency 12/13/06 after Notice 11/8/06—published 1/3/07, effective 1/1/07]  
 [Filed 3/14/07, Notice 8/30/06—published 4/11/07, effective 7/1/07]  
 [Filed emergency 6/13/07—published 7/4/07, effective 7/1/07]  
 [Filed 9/12/07, Notice 7/4/07—published 10/10/07, effective 11/14/07]  
 [Filed emergency 6/12/08—published 7/2/08, effective 7/1/08]  
 [Filed 8/19/08, Notice 7/2/08—published 9/10/08, effective 10/15/08]  
 [Filed ARC 7606B (Notice ARC 7372B, IAB 12/3/08), IAB 3/11/09, effective 5/1/09]  
 [Filed ARC 7741B (Notice ARC 7526B, IAB 1/28/09), IAB 5/6/09, effective 7/1/09]  
 [Filed ARC 8010B (Notice ARC 7712B, IAB 4/8/09), IAB 7/29/09, effective 10/1/09]  
 [Filed Emergency ARC 8451B, IAB 1/13/10, effective 1/1/10]  
 [Filed ARC 8653B (Notice ARC 8452B, IAB 1/13/10), IAB 4/7/10, effective 5/12/10]  
 [Filed ARC 8715B (Notice ARC 8490B, IAB 1/27/10), IAB 5/5/10, effective 7/1/10]  
 [Filed Emergency ARC 8904B, IAB 6/30/10, effective 7/1/10]  
 [Filed ARC 9778B (Notice ARC 9625B, IAB 7/27/11), IAB 10/5/11, effective 11/9/11]  
 [Filed Emergency ARC 0240C, IAB 8/8/12, effective 7/11/12]  
 [Filed ARC 0419C (Notice ARC 0241C, IAB 8/8/12), IAB 10/31/12, effective 12/5/12]  
 [Filed Emergency ARC 0858C, IAB 7/24/13, effective 7/1/13]  
 [Filed Emergency ARC 0856C, IAB 7/24/13, effective 7/1/13]  
 [Filed ARC 1061C (Notice ARC 0857C, IAB 7/24/13), IAB 10/2/13, effective 11/6/13]  
 [Filed ARC 1062C (Notice ARC 0855C, IAB 7/24/13), IAB 10/2/13, effective 11/6/13]

<sup>◇</sup> Two or more ARCs

<sup>1</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.



TITLE XV  
*INDIVIDUAL AND FAMILY SUPPORT  
AND PROTECTIVE SERVICES*

CHAPTER 170  
CHILD CARE SERVICES  
[Prior to 7/1/83, Social Services[770] Ch 132]  
[Previously appeared as Ch 132—renumbered IAB 2/29/84]  
[Prior to 2/11/87, Human Services[498]]

PREAMBLE

The intent of this chapter is to establish requirements for the payment of child care services. Child care services are for children of low-income parents who are in academic or vocational training; or employed or looking for employment; or for a limited period of time, unable to care for children due to physical or mental illness; or needing protective services to prevent or alleviate child abuse or neglect. Services may be provided in a licensed child care center, a registered child development home, the home of a relative, the child's own home, a nonregistered family child care home, or in a facility exempt from licensing or registration.

**441—170.1(237A) Definitions.**

*“Agency error”* means child care assistance incorrectly paid for the client because of action attributed to the department as the result of one or more of the following circumstances:

1. Loss or misfiling of forms or documents.
2. Errors in typing or copying.
3. Computer input errors.
4. Mathematical errors.
5. Failure to determine eligibility correctly or to certify assistance in the correct amount when all essential information was available to the department.
6. Failure to make timely changes in assistance following amendments of policies that require the changes by a specific date.

*“Child care”* means a service that provides child care in the absence of parents for a portion of the day, but less than 24 hours. Child care supplements parental care by providing care and protection for children who need care in or outside their homes for part of the day. Child care provides experiences for each child's social, emotional, intellectual, and physical development. Child care may involve comprehensive child development care or it may include special services for a child with special needs. Components of this service shall include supervision, food services, program and activities, and may include transportation.

*“Child with protective needs”* means a child who is not in foster care and has a case file that identifies child care as a safety or well-being need to prevent or alleviate the effects of child abuse or neglect. Child care is provided as part of a safety plan during a child abuse or child in need of assistance assessment or as part of the service plan established in the family's case plan. The child must have:

1. An open child abuse assessment;
2. An open child in need of assistance assessment;
3. An open child welfare case as a result of a child abuse assessment;
4. A petition on file for a child in need of assistance adjudication; or
5. Adjudication as a child in need of assistance.

*“Child with special needs”* means a child with one or more of the following conditions:

1. The child has been diagnosed by a physician or by a person endorsed for service as a school psychologist by the Iowa department of education to have a developmental disability which substantially limits one or more major life activities, and the child requires professional treatment, assistance in self-care, or the purchase of special adaptive equipment.
2. The child has been determined by a qualified mental retardation professional to have a condition which impairs the child's intellectual and social functioning.

3. The child has been diagnosed by a mental health professional to have a behavioral or emotional disorder characterized by situationally inappropriate behavior which deviates substantially from behavior appropriate to the child's age, or which significantly interferes with the child's intellectual, social, or personal adjustment.

*"Client"* means a current or former recipient of the child care assistance program.

*"Client error"* means and may result from:

1. False or misleading statements, oral or written, regarding the client's income, resources, or other circumstances which affect eligibility or the amount of assistance received;
2. Failure to timely report changes in income, resources, or other circumstances which affect eligibility or the amount of assistance received;
3. Failure to timely report the receipt of child care units in excess of the number approved by the department;
4. Failure to comply with the need for service requirements.

*"Department"* means the Iowa department of human services.

*"Food services"* means the preparation and serving of nutritionally balanced meals and snacks.

*"Fraudulent means"* means knowingly making or causing to be made a false statement or a misrepresentation of a material fact, knowingly failing to disclose a material fact, or committing a fraudulent practice.

*"In-home"* means care which is provided within the child's own home.

*"Migrant seasonal farm worker"* means a person to whom all of the following conditions apply:

1. The person performs seasonal agricultural work which requires travel so that the person is unable to return to the person's permanent residence within the same day.
2. Most of the person's income is derived from seasonal agricultural work performed during the months of July through October. Most shall mean the simple majority of the income.
3. The person generally performs seasonal agricultural work in Iowa during the months of July through October.

*"On-line or distance learning"* means training such as, but not limited to, training conducted over the Iowa communications network, on-line courses, or Web conferencing. The training includes:

1. Interaction between the instructor and the student, such as required chats or message boards;
2. Mechanisms for evaluation and measurement of student achievement.

*"Overpayment"* means any benefit or payment received in an amount greater than the amount the client or provider is entitled to receive.

*"Parent"* means the parent or the person who serves in the capacity of the parent of the child receiving child care assistance services.

*"Program and activities"* means the daily schedule of experiences in a child care setting.

*"PROMISE JOBS"* means the department's training program, promoting independence and self-sufficiency through employment job opportunities and basic skills, as described in 441—Chapter 93.

*"Provider"* means a licensed child care center, a registered child development home, a relative who provides care in the relative's own home solely for a related child, a caretaker who provides care for a child in the child's home, a nonregistered child care home, or a child care facility which is exempt from licensing or registration.

*"Provider error"* means and may result from:

1. Presentation for payment of any false or fraudulent claim for services or merchandise;
2. Submittal of false information for the purpose of obtaining greater compensation than that to which the provider is legally entitled;
3. Failure to report the receipt of a child care assistance payment in excess of that approved by the department;
4. Charging the department an amount for services rendered over and above what is charged private pay clients for the same services;
5. Failure to maintain a copy of Form 470-4535, Child Care Assistance Billing/Attendance Provider Record, signed by the parent and the provider.

“*Recoupment*” means the repayment of an overpayment by a payment from the client or provider or both.

“*Relative*” means an adult aged 18 or older who is a grandparent, aunt or uncle to the child being provided child care.

“*Supervision*” means the care, protection, and guidance of a child.

“*Transportation*” means the movement of children in a four or more wheeled vehicle designed to carry passengers, such as a car, van, or bus, between home and facility.

“*Unit of service*” means a half day which shall be up to 5 hours of service per 24-hour period.

“*Vocational training or education*” means a training plan which includes a specific goal, that is, high school completion, improved English skills, or development of specific academic or vocational skills.

1. Training may be approved for high school completion activities, adult basic education, GED, English as a second language, or postsecondary education, up to and including an associate or a baccalaureate degree program.

2. Training shall be on a full-time basis. The training facility shall define what is considered as full-time. Part-time plans may be approved only if the number of credit hours to complete training is less than full-time status, the required prerequisite credits or remedial course work is less than full-time status, or training is not offered on a full-time basis.

[ARC 8506B, IAB 2/10/10, effective 3/1/10; ARC 9651B, IAB 8/10/11, effective 10/1/11]

**441—170.2(237A,239B) Eligibility requirements.** A person deemed eligible for benefits under this chapter is subject to all other state child care assistance requirements including, but not limited to, provider requirements under Iowa Code chapter 237A and provider reimbursement methodology. The department shall determine the number of units of service to be approved.

**170.2(1) Financial eligibility.** Financial eligibility for child care assistance shall be based on federal poverty levels as determined by the Office of Management and Budget and on Iowa’s median family income as determined by the U.S. Census Bureau. Poverty guidelines and median family income amounts are updated annually. Changes shall go into effect for the child care assistance program on July 1 of each year.

a. *Income limits.* For initial and ongoing eligibility, a family’s nonexempt gross monthly income as established in paragraph 170.2(1)“c” cannot exceed:

(1) 145 percent of the federal poverty level applicable to the family size for children needing basic care, or

(2) 200 percent of the federal poverty level applicable to the family size for children needing special-needs care, or

(3) 85 percent of Iowa’s median family income, if that figure is lower than the standard in subparagraph (1) or (2).

b. *Exceptions to income limits.*

(1) A person who is participating in activities approved under the PROMISE JOBS program is eligible for child care assistance without regard to income if there is a need for child care services.

(2) A person who is part of the family investment program or whose earned income was taken into account in determining the needs of a family investment program recipient is eligible for child care assistance without regard to income if there is a need for child care services.

(3) Protective child care services are provided without regard to income.

(4) In certain cases, the department will provide child care services directed in a court order.

c. *Determining gross income.* Eligibility shall be determined using a projection of income based on the best estimate of future income. In determining a family’s gross monthly income, the department shall consider all income received by a family member from sources identified by the U.S. Census Bureau in computing median income, unless excluded under paragraph 170.2(1)“d.”

(1) Income considered shall include wages or salary, net profit from farm or nonfarm self-employment, social security, dividends, interest, income from estates or trusts, net rental income and royalties, public assistance or welfare payments, pensions and annuities, unemployment compensation, workers’ compensation, alimony, child support, veterans pensions, cash payments, casino profits,

railroad retirement, permanent disability insurance, strike pay and living allowance payments made to participants of the AmeriCorps program. "Net profit from self-employment" means gross income less the costs of producing the income other than depreciation. A net loss in self-employment income cannot be offset from other earned or unearned income.

(2) For migrant seasonal farm workers, the monthly gross income shall be determined by calculating the total amount of income earned in a 12-month period preceding the date of application and dividing the total amount by 12.

(3) When income received weekly or once every two weeks is projected for future months, income shall be projected by adding all income received in the period being used for the projection and dividing the result by the number of instances of income received in that period. The result shall be multiplied by four if the income is received weekly, or by two if the income is received biweekly, regardless of the number of weekly or biweekly payments to be made in future months.

*d. Income exclusions.* The following sources are excluded from the computation of monthly gross income:

(1) Per capita payments from or funds held in trust in satisfaction of a judgment of the Indian Claims Commission or the court of claims.

(2) Payments made pursuant to the Alaska Claims Settlement Act, to the extent the payments are exempt from taxation under Section 21(a) of the Act.

(3) Money received from the sale of property, unless the person was engaged in the business of selling property.

(4) Withdrawals of bank deposits.

(5) Money borrowed.

(6) Tax refunds.

(7) Gifts.

(8) Lump-sum inheritances or insurance payments or settlements.

(9) Capital gains.

(10) The value of the food assistance allotment under the Food and Nutrition Act of 2008.

(11) The value of USDA donated foods.

(12) The value of supplemental food assistance under the Child Nutrition Act of 1966 and the special food program for children under the National School Lunch Act.

(13) Earnings of a child 14 years of age or younger.

(14) Loans and grants obtained and used under conditions that preclude their use for current living expenses.

(15) Any grant or loan to any undergraduate student for educational purposes made or insured under the Higher Education Act.

(16) Home produce used for household consumption.

(17) Earnings received by any youth under the Workforce Investment Act (WIA).

(18) Stipends received for participating in the foster grandparent program.

(19) The first \$65 plus 50 percent of the remainder of income earned in a sheltered workshop or work activity setting.

(20) Payments from the Low-Income Home Energy Assistance Program.

(21) Agent Orange settlement payments.

(22) The income of the parents with whom a teen parent resides.

(23) For children with special needs, income spent on any regular ongoing cost that is specific to that child's disability.

(24) Moneys received under the federal Social Security Persons Achieving Self-Sufficiency (PASS) program or the Income-Related Work Expense (IRWE) program.

(25) Income received by a Supplemental Security Income recipient if the recipient's earned income was considered in determining the needs of a family investment program recipient.

(26) The income of a child who would be in the family investment program eligible group except for the receipt of Supplemental Security Income.

(27) Any adoption subsidy payments received from the department.

- (28) Federal or state earned income tax credit.
- (29) Payments from the Iowa individual assistance grant program (IIAGP).
- (30) Payments from the transition to independence program (TIP).
- (31) Payments to volunteers participating in the Volunteers in Service to America (VISTA) program.

EXCEPTION: This exemption will not be applied when the director of ACTION determines that the value of all VISTA payments, adjusted to reflect the number of hours the volunteer is serving, is equivalent to or greater than the minimum wage then in effect under the Fair Labor Standards Act of 1938 or the minimum wage under the laws of the state where the volunteer is serving, whichever is greater.

- (32) Reimbursement from the employer for job-related expenses.
- (33) Stipends from the preparation for adult living (PAL) program.
- (34) Payments from the subsidized guardianship waiver program.
- (35) The earnings of a child aged 18 or under who is a full-time student.
- (36) Census earnings received by temporary workers from the Bureau of the Census.
- (37) Payments for major disaster and emergency assistance provided under the Disaster Relief Act of 1974 as amended by Public Law 100-707, the Disaster Relief and Emergency Assistance Amendments of 1988.

*e. Family size.* The following people shall be included in the family size for the determination of eligibility:

- (1) Legal spouses (including common law) who reside in the same household.
- (2) Natural mother or father, adoptive mother or father, or stepmother or stepfather, and children who reside in the same household.
- (3) A child or children who live with a person or persons not legally responsible for the child's support.

*f. Effect of temporary absence.* The composition of the family does not change when a family member is temporarily absent from the household. "Temporary absence" means:

- (1) An absence for the purpose of education or employment.
- (2) An absence due to medical reasons that is anticipated to last less than three months.
- (3) Any absence when the person intends to return home within three months.

**170.2(2) General eligibility requirements.** In addition to meeting financial requirements, the child needing services must meet age, citizenship, and residency requirements. Each parent in the household must have at least one need for service and shall cooperate with the department's quality control review and with investigations conducted by the department of inspections and appeals.

*a. Age.* Child care shall be provided only to children up to age 13, unless they are children with special needs, in which case child care shall be provided up to age 19.

*b. Need for service.* Except for assistance provided under subparagraph 170.2(2)"b"(3), assistance shall be provided to a two-parent family only during the parents' coinciding hours of participation in training, employment, or job search. Each parent in the household shall meet one or more of the following requirements:

(1) The parent is in academic or vocational training. Child care services may be provided for the parent's hours of participation in the academic or vocational training and for actual travel time between the child care location and the training facility.

1. Child care provided while the parent participates in postsecondary education leading up to and including a baccalaureate degree program or vocational training shall be limited to a 24-month lifetime limit. A month is defined as a fiscal month or part thereof and shall generally have starting and ending dates that fall within two adjacent calendar months but shall only count as one month. Time spent in high school completion, adult basic education, GED, or English as a second language does not count toward the 24-month limit. PROMISE JOBS child care allowances provided while the parent is a recipient of the family investment program and participating in PROMISE JOBS components in postsecondary education or training shall count toward the 24-month lifetime limit.

2. Payment shall not be approved for child-care during training in the following circumstances:

- Labor market statistics for a local area indicate low employment potential for workers with that training. Exceptions may be made when the parent has a job offer before entering the training or

if a parent is willing to relocate after training to an area where there is employment potential. Parents willing to relocate must provide documentation from the department of workforce development, private employment agencies, or employers that jobs paying at least minimum wage for which training is being requested are available in the locale specified by the parent.

- The training is for jobs paying less than minimum wage.
- A parent who possesses a baccalaureate degree wants to take additional college coursework unless the coursework is to obtain a teaching certificate or complete continuing education units.
- The course or training is one that the parent has previously completed.
- The parent was previously unable to maintain the cumulative grade point average required by the training or academic facility in the same training for which application is now being made. This does not apply to parents under the age of 18 who are enrolled in high school completion activities.
- The education is in a field in which the parent will not be able to be employed due to known criminal convictions or founded child or dependent adult abuse.
- The parent wants to participate in on-line or distance learning from the parent's own home, and the training facility does not require specified hours of attendance.

(2) The parent is employed 28 or more hours per week or an average of 28 or more hours per week during the month. Child care services may be provided for the hours of employment and for actual travel time between the child care location and the place of employment. If the parent works a shift consisting of at least six hours of employment between the hours of 8 p.m. and 6 a.m. and needs to sleep during daytime hours, child care services may also be provided to allow the parent to sleep during daytime hours.

(3) The parent has a child with protective needs for child care.

(4) The parent is absent from the home due to inpatient hospitalization or outpatient treatment because of physical or mental illness, or is present but due to medical incapacity is unable to care for the child or participate in work or training, as verified by a physician.

1. Eligibility under this paragraph is limited to parents who become medically incapacitated while eligible for child care assistance based on the need criteria in subparagraph 170.2(2) "b"(1) or 170.2(2) "b"(2).

2. Child care assistance shall continue to be available for up to 30 consecutive days after the parent becomes medically incapacitated. Assistance beyond 30 days may be approved by the service area manager or designee if extenuating circumstances are verified by a physician.

3. The number of units of service authorized shall be determined as follows:

- For a single parent family or for a two-parent family where both parents are incapacitated, the number of units authorized for the period of incapacity shall not exceed the number of units authorized for the family before the onset of incapacity.
- For a two-parent family where only one parent is incapacitated, the units of service authorized shall be based on the need of the parent who is not incapacitated.

(5) The parent is looking for employment. Child care for job search hours shall be limited to only those hours the parent is actually looking for employment including travel time.

1. A job search plan shall be approved by the department and be limited to a maximum of 30 consecutive calendar days in a 12-month period. EXCEPTION: Additional job search hours may be paid for PROMISE JOBS participants if approved by the PROMISE JOBS worker.

2. Documentation of job search contacts shall be furnished to the department. The department may enter into a nonfinancial coordination agreement for information exchange concerning job search documentation.

(6) The parent needs child care services due to participation in activities approved under the PROMISE JOBS program.

(7) The family is part of the family investment program and there is a need for child care services due to employment or participation in vocational training or education. A family who meets this requirement due to employment is not required to work a minimum number of hours. If a parent in a family investment program household remains in the home, child care assistance can be paid if that parent receives Supplemental Security Income.

*c. Residency.* To be eligible for child care services, the person must be living in the state of Iowa. “Living in the state” shall include those persons living in Iowa for a temporary period, other than for the purpose of vacation.

*d. Citizenship.* As a condition of eligibility, the applicant shall attest to the child’s citizenship or alien status by signing Form 470-3624 or 470-3624(S), Child Care Assistance Application, or Form 470-0462 or 470-0462(S), Health and Financial Support Application. Child care assistance payments may be made only for a child who:

(1) Is a citizen or national of the United States; or

(2) Is a qualified alien as defined at 8 U.S.C. Section 1641. The applicant shall furnish documentation of the alien status of any child declared to be a qualified alien. A child who is a qualified alien is not eligible for child care assistance for a period of five years beginning on the date of the child’s entry into the United States with qualified alien status.

EXCEPTION: The five-year prohibition from receiving assistance does not apply to:

1. Qualified aliens described at 8 U.S.C. Section 1613; or

2. Qualified aliens as defined at 8 U.S.C. Section 1641 who entered the United States before August 22, 1996.

*e. Cooperation.* Parents shall cooperate with the department when the department selects the family’s case for quality control review to verify eligibility. Parents shall also cooperate with investigations conducted by the department of inspections and appeals to determine whether information supplied by the parent regarding eligibility for child care assistance is complete and correct. (See 481—Chapter 72.)

(1) Failure to cooperate shall serve as a basis for cancellation or denial of the family’s child care assistance.

(2) Once denied or canceled for failure to cooperate, the family may reapply but shall not be considered for approval until cooperation occurs.

**170.2(3) Priority for assistance.** Child care services shall be provided only when funds are available. Funds available for child care assistance shall first be used to continue assistance to families currently receiving child care assistance and to families with protective child care needs. When funds are insufficient, families applying for services must meet the specific requirements in this subrule.

*a. Priority groups.* As funds are determined available, families shall be served on a statewide basis from a service-area-wide waiting list as specified in subrule 170.3(4) based on the following schedule in descending order of prioritization.

(1) Families with an income at or below 100 percent of the federal poverty level whose members are employed at least 28 hours per week, and parents with a family income at or below 100 percent of the federal poverty level who are under the age of 21 and are participating in an educational program leading to a high school diploma or equivalent.

(2) Parents under the age of 21 with a family income at or below 100 percent of the federal poverty guidelines who are participating, at a satisfactory level, in an approved training program or in an education program.

(3) Families with an income of more than 100 percent but not more than 145 percent of the federal poverty guidelines whose members are employed at least 28 hours per week.

(4) Families with an income at or below 200 percent of the federal poverty guidelines whose members are employed at least 28 hours per week with a special-needs child as a member of the family.

*b. Exceptions to priority groups.* The following are eligible for child care assistance notwithstanding waiting lists for child care services:

(1) Families with protective child care needs.

(2) Recipients of the family investment program or those whose earned income was taken into account in determining the needs of family investment program recipients.

(3) Families that receive a state adoption subsidy for a child.

*c. Effect on need for service.* Families approved under a priority group are not required to meet the requirements in paragraph 170.2(2) “b” except at review or redetermination.

**170.2(4) Reporting changes.** The parent must report any changes in circumstances affecting these eligibility requirements and changes in the choice of provider to the department worker or the PROMISE JOBS worker within ten calendar days of the change.

a. If the change is timely reported within ten calendar days, the effective date of the change shall be the date when the change occurred.

b. If the change is not timely reported, the effective date of the change shall be the date when the change is reported to the department office or PROMISE JOBS office.

[ARC 8506B, IAB 2/10/10, effective 3/1/10; ARC 9651B, IAB 8/10/11, effective 10/1/11]

**441—170.3(237A,239B) Application and determination of eligibility.**

**170.3(1) Application process.**

a. Application for child care assistance may be made at any local office of the department on:

(1) Form 470-3624 or 470-3624(S), Child Care Assistance Application,

(2) Form 470-0462 or 470-0462(S), Health and Financial Support Application, or

(3) Form 470-4377 or 470-4377(S), Child Care Assistance Review, when returned after the end of the certification period.

b. The application may be filed by the applicant, by the applicant's authorized representative or, when the applicant is incompetent or incapacitated, by a responsible person acting on behalf of the applicant.

c. The date of application is the date a signed application form containing a legible name and address is received in the department office. An electronic or paper application delivered to a closed office is considered to be received on the first day following the day the office was last open that is not a weekend or state holiday.

d. Families who are determined eligible for child care assistance shall be approved for a certification period of no longer than six months. Families who fail to complete the review and redetermination process as described at subrule 170.3(5) will lose eligibility at the end of the certification period.

**170.3(2) Exceptions to application requirement.** An application is not required for:

a. A person who is participating in activities approved under the PROMISE JOBS program.

b. Recipients of the family investment program or those whose earned income was taken into account in determining the needs of family investment program recipients. The date of application is the date the family requests child care assistance from the department.

c. Children with protective needs.

d. Child care services provided under a court order.

e. Families whose application has been denied for failure to provide requested information who have provided all necessary information to determine eligibility within 14 days of the denial of the application, or by the next working day if the fourteenth day falls on a weekend or state holiday.

**170.3(3) Application processing.** The department shall approve or deny an application as soon as possible, but no later than 30 days following the date the application was received. This time limit shall apply except in unusual circumstances, such as when the department and the applicant have made every reasonable effort to secure necessary information that has not been supplied by the date the time limit expires, or because of emergency situations, such as fire, flood or other conditions beyond the administrative control of the department.

a. The department worker or PROMISE JOBS worker shall determine the number of units of service authorized for each eligible family and shall:

(1) Inform the family through the notice of decision; and

(2) Inform the family's provider through the notice of decision or through Form 470-4444, Certificate of Enrollment.

b. The department shall issue a written notice of decision to the applicant by the next working day following a determination of eligibility.

c. The effective date of assistance shall be the date of application or the date the need for service began, whichever is later. When an application is not required as described under subrule 170.3(2), the effective date shall be as follows:

(1) For a person participating in activities under the PROMISE JOBS program, the effective date of child care assistance shall be the date the person becomes a PROMISE JOBS participant as defined in rule 441—93.1(239B) or the date the person has a need for child care assistance to participate in an approved PROMISE JOBS activity as described in 441—Chapter 93, whichever is later.

(2) For a family receiving family investment program benefits, the effective date of child care assistance shall be no earlier than the effective date of family investment program benefits, or 30 days before the date of application for child care assistance, or the date the need for service began, whichever is the latest.

(3) For a family with protective service needs, the effective date of assistance shall be the date the family signs Form 470-0615 or 470-0615(S), Application for All Social Services.

(4) When child care services are provided under a court order, the effective date of assistance shall be the date specified in the court order or the date of the court order if no date is specified.

(5) For a family whose application was denied for failure to provide requested information but who provides all information necessary to determine eligibility, including verification of all changes in circumstances, within 14 days of the denial, the effective date of assistance shall be the date that all information required to establish eligibility is provided. If the fourteenth calendar day falls on a weekend or state holiday, the family shall have until the next business day to provide the information.

**170.3(4) *Waiting lists for child care services.*** When the department has determined that there may be insufficient funding, applications for child care assistance shall be taken only for the priority groups for which funds have been determined available according to subrule 170.2(3).

a. The department shall maintain a log of families applying for child care services that meet the requirements within the priority groups for which funds may be available.

(1) Each family shall be entered on the logs according to their eligibility priority group and in sequence of their date of application.

(2) If more than one application is received on the same day for the same priority group, families shall be entered on the log based on the day of the month of the birthday of the oldest eligible child. The lowest numbered day shall be first on the log. Any subsequent tie shall be decided by the month of birth, January being month one and the lowest number.

b. When the department determines that there is adequate funding, the department shall notify the public regarding the availability of funds.

**170.3(5) *Review and redetermination.*** The department shall redetermine a family's financial and general eligibility for child care assistance at least every six months. EXCEPTION: The department shall redetermine only general eligibility for recipients of the family investment program (FIP), persons whose earned income was taken into account in determining the needs of FIP recipients, and parents who have children with protective needs, because these families are deemed financially eligible so long as the FIP eligibility or need for protective services continues.

a. If FIP or protective services eligibility ends, the department shall redetermine financial and general eligibility for child care assistance according to the requirements in rule 441—170.2(237A,239B). The redetermination of eligibility shall be completed within 30 days.

b. The department shall use information gathered on Form 470-4377 or 470-4377(S), Child Care Assistance Review, to redetermine eligibility, except when the family is not required to complete a review form as provided in paragraph 170.3(5)“c.”

(1) The department shall issue a notice of expiration for the child care assistance certification period on Form 470-4377 or 470-4377(S).

(2) If the family does not return a complete review form to the department by the end of the certification period, the family must reapply for benefits, except as provided in paragraph 170.3(6)“b.” A complete review form is Form 470-4377 or 470-4377(S) with all items answered that is signed and dated by the applicant and is accompanied by all verification needed to determine continued eligibility.

c. Families who have children with protective needs and families who are receiving child care assistance because the parent is participating in activities under the PROMISE JOBS program are not required to complete Form 470-4377 or 470-4377(S).

(1) The department shall issue a notice of expiration for the child care assistance certification period on the notice of decision when the department approves the family's certification period.

(2) The department shall gather information needed to redetermine general eligibility. If the department needs information from the family, the department will send a written request to the family. If the family does not return the requested information by the due date, the family must reapply for child care assistance, except as provided in paragraph 170.3(6) "b."

d. Families who are receiving child care assistance because the parent is seeking employment are not subject to review requirements because eligibility is limited to 30 consecutive calendar days. This waiver of the review requirement applies only when the parent who is seeking employment does not have another need for service.

**170.3(6) Reinstatement.**

a. Assistance shall be reinstated without a new application when all necessary information is provided before the effective date of cancellation and eligibility can be reestablished. If there is a change in circumstances, the change must be verified before the case will be reinstated.

b. Assistance shall be reinstated without a new application when the case was canceled for failure to provide requested information but all information necessary to determine eligibility, including verification of all changes in circumstances, is provided within 14 days of the effective date of cancellation and eligibility can be reestablished. If the fourteenth calendar day falls on a weekend or state holiday, the family shall have until the next business day to provide the information. The effective date of child care assistance shall be the date that all information required to establish eligibility is provided.

[ARC 8506B, IAB 2/10/10, effective 3/1/10; ARC 9651B, IAB 8/10/11, effective 10/1/11]

**441—170.4(237A) Elements of service provision.**

**170.4(1) Case file.** The child welfare case file shall document the eligibility for service under 170.2(2) "b"(3).

**170.4(2) Fees.** Fees for services received shall be charged to clients according to the schedules in this subrule, except that fees shall not be charged to clients receiving services without regard to income. The fee is a per-unit charge that is applied to the child in the family who receives the largest number of units of service. The fee shall be charged for only one child in the family, regardless of how many children receive assistance.

a. *Sliding fee schedule.*

(1) The fee schedule shown in the following table is effective for eligibility determinations made on or after July 1, 2013:

Level	Monthly Income According to Family Size										Unit Fee Based on Number of Children in Care		
	1	2	3	4	5	6	7	8	9	10	1	2	3 or more
A	\$910	\$1,228	\$1,547	\$1,865	\$2,183	\$2,501	\$2,820	\$3,138	\$3,456	\$3,774	\$0.00	\$0.00	\$0.00
B	\$958	\$1,293	\$1,628	\$1,963	\$2,298	\$2,633	\$2,968	\$3,303	\$3,638	\$3,973	\$0.20	\$0.45	\$0.70
C	\$985	\$1,329	\$1,674	\$2,018	\$2,362	\$2,707	\$3,051	\$3,395	\$3,740	\$4,084	\$0.45	\$0.70	\$0.95
D	\$1,012	\$1,365	\$1,719	\$2,073	\$2,427	\$2,780	\$3,134	\$3,488	\$3,842	\$4,195	\$0.70	\$0.95	\$1.20
E	\$1,040	\$1,404	\$1,767	\$2,131	\$2,495	\$2,858	\$3,222	\$3,586	\$3,949	\$4,313	\$0.95	\$1.20	\$1.45
F	\$1,068	\$1,442	\$1,815	\$2,189	\$2,563	\$2,936	\$3,310	\$3,683	\$4,057	\$4,430	\$1.20	\$1.45	\$1.70
G	\$1,098	\$1,482	\$1,866	\$2,250	\$2,634	\$3,018	\$3,402	\$3,786	\$4,170	\$4,554	\$1.45	\$1.70	\$1.95
H	\$1,128	\$1,523	\$1,917	\$2,312	\$2,706	\$3,101	\$3,495	\$3,890	\$4,284	\$4,679	\$1.70	\$1.95	\$2.20
I	\$1,160	\$1,565	\$1,971	\$2,376	\$2,782	\$3,187	\$3,593	\$3,998	\$4,404	\$4,810	\$1.95	\$2.20	\$2.45

Level	Monthly Income According to Family Size										Unit Fee Based on Number of Children in Care		
	1	2	3	4	5	6	7	8	9	10	1	2	3 or more
J	\$1,191	\$1,608	\$2,024	\$2,441	\$2,858	\$3,274	\$3,691	\$4,107	\$4,524	\$4,941	\$2.20	\$2.45	\$2.70
K	\$1,225	\$1,653	\$2,081	\$2,509	\$2,938	\$3,366	\$3,794	\$4,222	\$4,651	\$5,079	\$2.45	\$2.70	\$2.95
L	\$1,258	\$1,698	\$2,138	\$2,578	\$3,018	\$3,458	\$3,897	\$4,337	\$4,777	\$5,217	\$2.70	\$2.95	\$3.20
M	\$1,293	\$1,745	\$2,198	\$2,650	\$3,102	\$3,554	\$4,007	\$4,459	\$4,911	\$5,363	\$2.95	\$3.20	\$3.45
N	\$1,328	\$1,793	\$2,258	\$2,722	\$3,187	\$3,651	\$4,116	\$4,580	\$5,045	\$5,509	\$3.20	\$3.45	\$3.70
O	\$1,366	\$1,843	\$2,321	\$2,798	\$3,276	\$3,753	\$4,231	\$4,709	\$5,186	\$5,664	\$3.45	\$3.70	\$3.95
P	\$1,403	\$1,893	\$2,384	\$2,875	\$3,365	\$3,856	\$4,346	\$4,837	\$5,327	\$5,818	\$3.70	\$3.95	\$4.20
Q	\$1,442	\$1,946	\$2,451	\$2,955	\$3,459	\$3,964	\$4,468	\$4,972	\$5,477	\$5,981	\$3.95	\$4.20	\$4.45
R	\$1,481	\$1,999	\$2,517	\$3,036	\$3,554	\$4,072	\$4,590	\$5,108	\$5,626	\$6,144	\$4.20	\$4.45	\$4.70
S	\$1,523	\$2,055	\$2,588	\$3,121	\$3,653	\$4,186	\$4,718	\$5,251	\$5,783	\$6,316	\$4.45	\$4.70	\$4.95
T	\$1,564	\$2,111	\$2,658	\$3,205	\$3,753	\$4,300	\$4,847	\$5,394	\$5,941	\$6,488	\$4.70	\$4.95	\$5.20
U	\$1,608	\$2,171	\$2,733	\$3,295	\$3,858	\$4,420	\$4,982	\$5,545	\$6,107	\$6,669	\$4.95	\$5.20	\$5.45
V	\$1,652	\$2,230	\$2,807	\$3,385	\$3,963	\$4,540	\$5,118	\$5,696	\$6,273	\$6,851	\$5.20	\$5.45	\$5.70
W	\$1,698	\$2,292	\$2,886	\$3,480	\$4,074	\$4,667	\$5,261	\$5,855	\$6,449	\$7,043	\$5.45	\$5.70	\$5.95
X	\$1,744	\$2,355	\$2,965	\$3,575	\$4,185	\$4,795	\$5,405	\$6,015	\$6,625	\$7,235	\$5.70	\$5.95	\$6.20
Y	\$1,793	\$2,420	\$3,048	\$3,675	\$4,302	\$4,929	\$5,556	\$6,183	\$6,810	\$7,437	\$5.95	\$6.20	\$6.45
Z	\$1,842	\$2,486	\$3,131	\$3,775	\$4,419	\$5,063	\$5,707	\$6,351	\$6,996	\$7,640	\$6.20	\$6.45	\$6.70
AA	\$1,894	\$2,556	\$3,218	\$3,880	\$4,543	\$5,205	\$5,867	\$6,529	\$7,192	\$7,854	\$6.45	\$6.70	\$6.95
BB	\$1,945	\$2,626	\$3,306	\$3,986	\$4,666	\$5,347	\$6,027	\$6,707	\$7,387	\$8,068	\$6.70	\$6.95	\$7.20

(2) To use the chart:

1. Find the family size used in determining income eligibility for service.
2. Move across the monthly income table to the column headed by that number. (See paragraph "5" if the family has more than ten members.)
3. Move down the column for the applicable family size to the highest figure that is equal to or less than the family's gross monthly income. Income at or above that amount (but less than the amount in the next row) corresponds to the fees in the last three columns of that row.
4. Choose the fee that corresponds to the number of children in the family who receive child care assistance.
5. When a family has more than ten members, determine the income level by multiplying the figures in the four-member column for the rows closest to the family's income level by 0.03. Round the numbers to the nearest dollar and multiply by the number of family members in excess of ten. Add the results to the amounts in the ten-member column to determine the threshold amounts.

(3) EXAMPLES:

1. Family 1 has two members, monthly income of \$1,250, and one child in care. Since the income is at or above the Level A amount but less than the Level B amount, Family 1 pays \$0.00 for each unit of child care service that the child receives.
2. Family 2 has three members, monthly income of \$1,650, and one child in care. Since the income is at or above the Level B amount but less than the Level C amount, Family 2 pays \$0.20 for each unit of child care service that the child receives.
3. Family 3 has three members, monthly income of \$1,650, and two children in care. The younger child receives ten units of child care service per week. The older child is school-aged and receives only five units of service per week. Since the income is at or above the Level B amount but less than the Level C amount, Family 3 pays \$0.45 for each unit of child care service that the younger child receives.

*b. Collection.* The provider shall collect fees from clients.

(1) The provider shall maintain records of fees collected. These records shall be available for audit by the department or its representative.

(2) When a client does not pay the fee, the provider shall demonstrate that a reasonable effort has been made to collect the fee. "Reasonable effort to collect" means an original billing and two follow-up notices of nonpayment.

*c. Inability of client to pay fees.* Child care assistance may be continued without a fee, or with a reduced fee, when a client reports in writing the inability to pay the assessed fee due to the existence of one or more of the conditions set forth below. Before reducing the fee, the worker shall assess the case to verify that the condition exists and to determine whether a reduced fee can be charged. The reduced fee shall then be charged until the condition justifying the reduced fee no longer exists. Reduced fees may be justified by:

(1) Extensive medical bills for which there is no payment through insurance coverage or other assistance.

(2) Shelter costs that exceed 30 percent of the household income.

(3) Utility costs not including the cost of a telephone that exceed 15 percent of the household income.

(4) Additional expenses for food resulting from diets prescribed by a physician.

**170.4(3) Method of provision.** Parents shall be allowed to exercise their choice for in-home care, except when the parent meets the need for service under subparagraph 170.2(2)"b"(3), as long as the conditions in paragraph 170.4(7)"d" are met. When the child meets the need for service under 170.2(2)"b"(3), parents shall be allowed to exercise their choice of licensed, registered, or nonregistered child care provider except when the department service worker determines it is not in the best interest of the child.

The provider must meet one of the applicable requirements set forth below.

*a. Licensed child care center.* A child care center shall be licensed by the department to meet the requirements set forth in 441—Chapter 109 and shall have a current Certificate of License, Form 470-0618.

*b. Registered child development home.* A child development home shall meet the requirements for registration set forth in 441—Chapter 110 and shall have a current Certificate of Registration, Form 470-3498.

*c. Registered family child care home.* Rescinded IAB 1/7/04, effective 3/1/04.

*d. Relative care.* Rescinded IAB 2/6/02, effective 4/1/02.

*e. In-home care.* The adult caretaker selected by the parent to provide care in the child's own home shall be sent the pamphlet Comm. 95 or Comm. 95(S), Minimum Health and Safety Requirements for Nonregistered Child Care Home Providers, and Form 470-2890 or 470-2890(S), Payment Application for Nonregistered Providers. The provider shall complete and sign Form 470-2890 or 470-2890(S) and return the form to the department before payment may be made. An identifiable application is an application that contains a legible name and address and that has been signed. Signature on the form certifies the provider's understanding of and compliance with the conditions and requirements for nonregistered providers that include:

(1) Minimum health and safety requirements;

(2) Limits on the number of children for whom care may be provided;

(3) Unlimited parental access to the child or children during hours when care is provided, unless prohibited by court order; and

(4) Conditions that warrant nonpayment.

*f. Nonregistered family child care home.* The adult caretaker selected by the parent to provide care in a nonregistered family child care home shall be sent the pamphlet Comm. 95 or Comm. 95(S), Minimum Health and Safety Requirements for Nonregistered Child Care Home Providers, and Form 470-2890 or 470-2890(S), Payment Application for Nonregistered Providers. The provider shall complete and sign Form 470-2890 or 470-2890(S) and return the form to the department before payment may be made. An identifiable application is an application that contains a legible name and address and

that has been signed. Signature on the form certifies the provider's understanding of and compliance with the conditions and requirements for nonregistered providers that include:

- (1) Minimum health and safety requirements;
- (2) Limits on the number of children for whom care may be provided;
- (3) Unlimited parental access to the child or children during hours when care is provided, unless prohibited by court order; and
- (4) Conditions that warrant nonpayment.

*g. Exempt facilities.* Child care facilities operated by or under contract to a public or nonpublic school accredited by the department of education that are exempt from licensing or registration may receive payment for child care services when selected by a parent.

*h. Iowa records checks for nonregistered child care homes and in-home care.* If a nonregistered child care provider or a person who provides in-home care applies to receive public funds as reimbursement for providing child care for eligible clients, the provider shall complete and submit to the department Form 470-5143, Iowa Department of Human Services Record Check Authorization Form, for the provider, for anyone having access to a child when the child is alone, and for anyone 14 years of age or older living in the home. The department shall use this form to conduct Iowa criminal history record and child abuse record checks.

(1) The purpose of these checks is to determine whether the person has committed a transgression that prohibits or limits the person's involvement with child care.

(2) The department may also conduct criminal and child abuse record checks in other states and may conduct dependent adult abuse, sex offender registry, and other public or civil offense record checks in Iowa or in other states.

(3) Records checks shall be repeated for each person subject to the check every two years and when the department or provider becomes aware of any new transgressions committed by that person.

*i. National criminal history record checks for nonregistered child care homes and in-home care.* If a nonregistered child care provider or a person who provides in-home care applies to receive public funds as reimbursement for providing child care for eligible clients, the provider shall complete Form DCI-45, Waiver Agreement, and Form FD-258, Federal Fingerprint Card, for the provider, for anyone 18 years of age or older who is living in the home, or for anyone having access to a child when the child is alone.

(1) The provider or other person subject to this check shall submit any other forms required by the department of public safety to authorize the release of records.

(2) The provider or other person subject to this check is responsible for any costs associated with obtaining the fingerprints and for submitting the prints to the department.

(3) Fingerprints may be taken (rolled) by law enforcement agencies or by agencies or companies that specialize in taking fingerprints.

(4) The national criminal history record check shall be repeated for each person subject to the check every four years and when the department or provider becomes aware of any new transgressions committed by that person in another state.

(5) The department may rely on the results of previously conducted national criminal history record checks when a person subject to a record check in one child development home or child care home submits a request for involvement with child care in another child care home, so long as the person's national criminal history record check is within the allowable four-year time frame. All initial or new applications shall require a new national criminal history record check.

*j. Transgressions.* If any person subject to the record checks in paragraph 170.4(3) "h" or 170.4(3) "i" has a record of founded child abuse, dependent adult abuse, a criminal conviction, or placement on the sex offender registry, the department shall follow the process for prohibition or evaluation defined at 441—subrule 110.7(3).

(1) If any person would be prohibited from registration, employment, or residence, the person shall not provide child care and is not eligible to receive public funds to do so. The department's designee shall notify the applicant.

(2) A person who continues to provide child care in violation of this rule is subject to penalty and injunction under Iowa Code chapter 237A.

**170.4(4) Components of service program.** Every child eligible for child care services shall receive supervision, food services, and program and activities, and may receive transportation.

**170.4(5) Levels of service according to age.** Rescinded IAB 9/30/92, effective 10/1/92.

**170.4(6) Provider's individual program plan.** Rescinded IAB 2/10/10, effective 3/1/10.

**170.4(7) Payment.** The department shall make payment for child care provided to an eligible family when the family reports their choice of provider to the department and the provider has a completed Form 470-3871 or 470-3871(S), Child Care Assistance Provider Agreement, on file with the department. Both the child care provider and the department worker shall sign this form.

*a. Rate of payment.* The rate of payment for child care services, except for in-home care which shall be paid in accordance with 170.4(7)“d,” shall be the actual rate charged by the provider for a private individual, not to exceed the maximum rates shown below. When a provider does not have a half-day rate in effect, a rate is established by dividing the provider's declared full-day rate by 2. When a provider has neither a half-day nor a full-day rate, a rate is established by multiplying the provider's declared hourly rate by 4.5. Payment shall not exceed the rate applicable to the provider and age group in Table I, except for special needs care which shall not exceed the rate applicable to the provider and age group in Table II. To be eligible for the special needs rate, the provider must submit documentation to the child's service worker that the child needing services has been assessed by a qualified professional and meets the definition for “child with special needs,” and a description of the child's special needs, including, but not limited to, adaptive equipment, more careful supervision, or special staff training.

Age Group	Child Care Center	Child Development Home Category A or B	Child Development Home Category C	Nonregistered Family Home
Infant and Toddler	\$16.78	\$12.98	\$12.44	\$8.19
Preschool	\$13.53	\$12.18	\$12.18	\$7.19
School Age	\$12.18	\$10.82	\$10.82	\$7.36

Age Group	Child Care Center	Child Development Home Category A or B	Child Development Home Category C	Nonregistered Family Home
Infant and Toddler	\$51.94	\$17.05	\$13.40	\$10.24
Preschool	\$30.43	\$15.83	\$13.40	\$ 8.99
School Age	\$30.34	\$14.61	\$12.18	\$ 9.20

The following definitions apply in the use of the rate tables:

(1) “Child care center” shall mean those providers as defined in 170.4(3)“a” and “g.” “Registered child development home” shall mean those providers as defined in 170.4(3)“b.” “Nonregistered family child care home” shall mean those providers as defined in 170.4(3)“f.”

(2) Under age group, “infant and toddler” shall mean age two weeks to two years; “preschool” shall mean two years to school age; “school age” shall mean a child in attendance in full-day or half-day classes.

*b. Payment for days of absence.* Payment may be made to a child care provider defined in subrule 170.4(3) for an individual child not in attendance at a child care facility not to exceed four days per calendar month providing that the child is regularly scheduled on those days and the provider also charges a private individual for days of absence.

*c. Payment for multiple children in a family.* When a provider reduces the charges for the second and any subsequent children in a family with multiple children whose care is unsubsidized, the rate of payment made by the department for a family with multiple children shall be similarly reduced.

*d. Payment for in-home care.* Payment may be made for in-home care when there are three or more children in a family who require child care services. The rate of payment for in-home care shall be the minimum wage amount.

*e. Limitations on payment.* Payment shall not be made for therapeutic services that are provided in the care setting and include, but are not limited to, services such as speech, hearing, physical and other therapies, individual or group counseling, therapeutic recreation, and crisis intervention.

*f. Review of the calculation of the rate of payment.* Maximum rate ceilings are not appealable. A provider who is in disagreement with the calculation of the half-day rate as set forth in 170.4(7) "a" may request a review. The procedure for review is as follows:

(1) Within 15 calendar days of notification of the rate in question, the provider shall send a written request for review to the service area manager. The request shall identify the specific rate in question and the methodology used to calculate the rate. The service manager shall provide a written response within 15 calendar days of receipt of the request for review.

(2) When dissatisfied with the response, the provider may, within 15 calendar days of the response, request a review by the chief of the bureau of financial support. The provider shall submit to the bureau chief the original request, the response received, and any additional information desired. The bureau chief shall render a decision in writing within 15 calendar days of receipt of the request.

(3) The provider may appeal the decision to the director of the department or the director's designee within 15 calendar days of the decision. The director or director's designee shall issue the final department decision within 15 calendar days of receipt of the request.

*g. Submission of claims.* The department shall issue payment when the provider submits correctly completed documentation of attendance and charges. The department shall pay for no more than the number of units of service authorized in the notice of decision issued pursuant to subrule 170.3(3). Providers shall submit a claim in one of the following ways:

(1) Using Form 470-4534, Child Care Assistance Billing/Attendance; or

(2) Using an electronic request for payment submitted through the KinderTrack system. Providers using this method shall print Form 470-4535, Child Care Assistance Billing/Attendance Provider Record, to be signed by the provider and the parent. The provider shall keep the signed Form 470-4535 for a period of five years after the billing date.

[ARC 7837B, IAB 6/3/09, effective 7/1/09; ARC 8506B, IAB 2/10/10, effective 3/1/10; ARC 9490B, IAB 5/4/11, effective 7/1/11; ARC 9651B, IAB 8/10/11, effective 10/1/11; ARC 0152C, IAB 6/13/12, effective 7/18/12; ARC 0546C, IAB 1/9/13, effective 1/1/13; ARC 0715C, IAB 5/1/13, effective 7/1/13; ARC 0825C, IAB 7/10/13, effective 7/1/13; ARC 0854C, IAB 7/24/13, effective 7/1/13; ARC 1063C, IAB 10/2/13, effective 11/6/13]

#### **441—170.5(237A) Adverse actions.**

**170.5(1) Provider agreement.** The department may refuse to enter into or may revoke the Child Care Assistance Provider Agreement, Form 470-3871 or 470-3871(S), if any of the following occur:

*a.* The department finds a hazard to the safety and well-being of a child, and the provider cannot or refuses to correct the hazard.

*b.* The provider has submitted claims for payment for which the provider is not entitled.

*c.* The provider fails to cooperate with an investigation conducted by the department of inspections and appeals to determine whether information the provider supplied to the department regarding payment for child care services is complete and correct. Once the agreement is revoked for failure to cooperate, the department shall not enter into a new agreement with the provider until cooperation occurs.

*d.* The provider does not meet one of the applicable requirements set forth in subrule 170.4(3).

**170.5(2) Denial.** Child care assistance shall be denied when the department determines that:

*a.* The client is not in need of service; or

*b.* The client is not financially eligible; or

*c.* There is another resource available to provide the service or a similar service free of charge that allows parents to select from the full range of eligible providers; or

- d. An application is required and the client or representative refuses or fails to sign the application form; or
- e. Funding is not available; or
- f. The client refuses or fails to supply information or verification requested or to request assistance and authorize the department to secure the required information or verification from other sources (signing a general authorization for release of information to the department does not meet this responsibility); or
- g. The client fails to cooperate with a quality control review or with an investigation conducted by the department of inspections and appeals.

**170.5(3) Termination.** Child care assistance may be terminated when the department determines that:

- a. The client no longer meets the eligibility criteria in subrule 170.2(2); or
- b. The client's income exceeds the financial guidelines; or
- c. The client refuses or fails to supply information or verification requested or to request assistance and authorize the department to secure the required information or verification from other sources (signing a general authorization for release of information to the department does not meet this responsibility); or
- d. No payment or only partial payment of client fees has been received within 30 days following the issuance of the last billing; or
- e. Another resource is available to provide the service or a similar service free of charge that allows parents to select from the full range of eligible providers; or
- f. Funding is not available; or
- g. The client fails to cooperate with a quality control review or with an investigation conducted by the department of inspections and appeals.

**170.5(4) Reduction.** Authorized units of service may be reduced when the department determines that:

- a. Continued provision of service at the current level is not necessary to meet the client's service needs; or
- b. Another resource is available to provide the same or similar service free of charge that will meet the client's needs and allow parents to select from the full range of eligible providers; or
- c. Funding is not available to continue the service at the current level. When funding is not available, the department may limit on a statewide basis the number of units of child care services for which payment will be made.

[ARC 7740B, IAB 5/6/09, effective 6/10/09; ARC 8506B, IAB 2/10/10, effective 3/1/10; ARC 9651B, IAB 8/10/11, effective 10/1/11]

**441—170.6(237A) Appeals.** Notice of adverse actions and the right of appeal shall be given in accordance with 441—Chapter 7.

**441—170.7(237A) Provider fraud.**

**170.7(1) Fraud.** The department shall consider a child care provider to have committed fraud when:

- a. The department of inspections and appeals, in an administrative or judicial proceeding, has found the provider to have obtained by fraudulent means child care assistance payment in an amount in excess of \$1,000; or
- b. The provider has agreed to entry of a civil judgment or judgment by confession that includes a conclusion of law that the provider has obtained by fraudulent means child care assistance payment in an amount in excess of \$1,000.

**170.7(2) Potential sanctions.** Providers found to have committed fraud shall be subject to one or more of the following sanctions, as determined by the department:

- a. Special review of the provider's claims for child care assistance.
- b. Suspension from receipt of child care assistance payment for six months.
- c. Ineligibility to receive payment under child care assistance.

**170.7(3) Factors considered in determining level of sanction.** The department shall evaluate the following factors in determining the sanction to be imposed:

*a. History of prior violations.*

(1) If the provider has no prior violations, the sanction imposed shall be a special review of provider claims.

(2) If the provider has one prior violation, the sanction imposed shall be a suspension from receipt of child care assistance payment for six months as well as a special review of provider claims.

(3) If the provider has more than one prior violation, the sanction imposed shall be ineligibility to receive payment under child care assistance.

*b. Prior imposition of sanctions.*

(1) If the provider has not been sanctioned before, the sanction imposed shall be a special review of the provider's claims for child care assistance.

(2) If the provider has been sanctioned once before, the sanction imposed shall be a suspension from receipt of child care assistance payment for six months as well as a special review of provider claims.

(3) If the provider has been sanctioned more than once before, the sanction imposed shall be ineligibility to receive payment under child care assistance.

*c. Seriousness of the violation.*

(1) If the amount fraudulently received is less than \$5,000, the sanction level shall be determined according to paragraphs "a" and "b."

(2) If the amount fraudulently received is \$5,000 or more, and the sanction determined according to paragraphs "a" and "b" is review of provider claims, the sanction imposed shall be suspension from receipt of child care assistance payment.

(3) If the amount fraudulently received is \$5,000 or more, and the sanction determined according to paragraphs "a" and "b" is suspension from receipt of child care assistance payment, the sanction imposed shall be ineligibility to receive payment under child care assistance.

*d. Extent of the violation.*

(1) If the fraudulent claims involve five invoices or less or five months or less, the sanction level shall be determined according to paragraphs "a" and "b."

(2) If the fraudulent claims involve at least six invoices or six months, and the sanction determined according to paragraphs "a" and "b" is review of provider claims, the sanction imposed shall be suspension from receipt of child care assistance payment.

(3) If the fraudulent claims involve at least six invoices or six months, and the sanction determined according to paragraphs "a" and "b" is suspension from receipt of child care assistance payment, the sanction imposed shall be ineligibility to receive payment under child care assistance.

**170.7(4) Mitigating factors.**

*a.* If the sanction determined according to subrule 170.7(3) is suspension from or ineligibility for receipt of child care assistance payment, the department shall determine whether it is appropriate to reduce the level of a sanction for the particular case, considering:

(1) Prior provision of provider education.

(2) Provider willingness to obey program rules.

*b.* If the sanction determined according to subrule 170.7(3) is ineligibility for receipt of child care assistance payment, but consideration of the two factors in paragraph "a" indicates that a lesser sanction will resolve the violation, the sanction imposed shall be:

(1) Suspension from receipt of child care assistance payment for six months; and

(2) A special review of provider claims.

*c.* If the sanction determined according to subrule 170.7(3) is suspension from receipt of child care assistance payment, but consideration of the two factors in paragraph "a" indicates that a lesser sanction will resolve the violation, the sanction imposed shall be a special review of provider claims.

**441—170.9(237A) Child care assistance overpayments.** All child care assistance overpayments shall be subject to recoupment.

**170.9(1) Notification and appeals.** All clients or providers shall be notified as described at subrule 170.9(6), when it is determined that an overpayment exists. Notification shall include the amount, date and reason for the overpayment. The department shall provide additional information regarding the computation of the overpayment upon the client's or provider's request. The client or provider may appeal the computation of the overpayment and any action to recover the overpayment in accordance with 441—subrule 7.5(9).

**170.9(2) Determination of overpayments.** All overpayments due to client, provider, or agency error or due to benefits or payments issued pending an appeal decision shall be recouped. Overpayments shall be computed as if the information had been acted upon timely.

**170.9(3) Benefits or payments issued pending appeal decision.** Recoupment of overpayments resulting from benefits or payments issued pending a decision on an appeal hearing shall not occur until after a final appeal decision is issued affirming the department.

**170.9(4) Failure to cooperate.** Failure by the client to cooperate in the investigation of alleged overpayments shall result in ineligibility for the months in question and the overpayment shall be the total amount of assistance received during those months. Failure by the provider to cooperate in the investigation of alleged overpayments shall result in payments being recouped for the months in question.

**170.9(5) Payment agreement.** The client or provider may choose to make a lump-sum payment or make periodic installment payments as agreed to on the notification form issued pursuant to subrule 170.9(6). Failure to negotiate an approved payment agreement may result in further collection action as outlined in 441—Chapter 11.

**170.9(6) Procedures for recoupment.**

*a.* When the department determines that an overpayment exists, the department shall refer the case to the department of inspections and appeals for investigation, recoupment, or referral for possible prosecution.

*b.* The department of inspections and appeals shall initiate recoupment by notifying the debtor of the overpayment on Form 470-4530, Notice of Child Care Assistance Overpayment.

*c.* When financial circumstances change, the department of inspections and appeals has the authority to revise the recoupment plan.

*d.* Recoupment for overpayments due to client error or due to an agency error that affected eligibility shall be made from the parent who received child care assistance at the time the overpayment occurred. When two parents were in the home at the time the overpayment occurred, both parents are equally responsible for repayment of the overpayment.

*e.* Recoupment for overpayments due to provider error or due to an agency error that affected benefits shall be made from the provider.

**170.9(7) Suspension and waiver.** Recoupment will be suspended on nonfraud overpayments when the amount of the overpayment is less than \$35. Recoupment will be waived on nonfraud overpayments of less than \$35 which have been held in suspense for three years.

[ARC 9651B, IAB 8/10/11, effective 10/1/11]

These rules are intended to implement Iowa Code sections 237A.13 and 237A.29.

[Filed 7/3/79, Notice 12/27/78—published 7/25/79, effective 9/1/79]

[Filed 7/18/80, Notice 3/5/80—published 8/6/80, effective 9/10/80]

[Filed 12/19/80, Notice 10/29/80—published 1/7/81, effective 2/11/81]

[Filed 1/16/81, Notice 12/10/80—published 2/4/81, effective 4/1/81]

[Filed 4/29/82, Notice 3/3/82—published 5/26/82, effective 7/1/82]

[Filed 5/21/82, Notice 3/31/82—published 6/9/82, effective 8/1/82]

[Filed emergency 9/23/82—published 10/13/82, effective 9/23/82]

[Filed emergency 6/17/83—published 7/6/83, effective 7/1/83]

[Filed emergency 2/10/84—published 2/29/84, effective 2/10/84]

[Filed 1/15/87, Notice 12/3/86—published 2/11/87, effective 4/1/87]

- [Filed 9/21/88, Notice 8/10/88—published 10/19/88, effective 12/1/88]
- [Filed emergency 6/8/89 after Notice of 5/3/89—published 6/28/89, effective 7/1/89]
  - [Filed emergency 6/8/89—published 6/28/89, effective 7/1/89]
- [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 10/10/91—published 10/30/91, effective 11/1/91]
- [Filed 12/11/91, Notice 10/30/91—published 1/8/92, effective 3/1/92]
  - [Filed emergency 9/11/92—published 9/30/92, effective 10/1/92]
- [Filed 11/10/92, Notice 9/30/92—published 12/9/92, effective 2/1/93]
  - [Filed emergency 6/11/93—published 7/7/93, effective 7/1/93]
  - [Filed 8/12/93, Notice 7/7/93—published 9/1/93, effective 11/1/93]
  - [Filed emergency 10/14/93—published 11/10/93, effective 12/1/93]
- [Filed 12/16/93, Notice 11/10/93—published 1/5/94, effective 3/1/94]
  - [Filed emergency 6/16/94—published 7/6/94, effective 7/1/94]
- [Filed 8/12/94, Notice 7/6/94—published 8/31/94, effective 11/1/94]
  - [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 emergency 6/13/96—published 7/3/96, effective 7/1/96]
  - [Filed emergency 7/10/96—published 7/31/96, effective 8/1/96]
- [Filed 9/17/96, Notices 7/3/96, 7/31/96—published 10/9/96, effective 12/1/96]
  - [Filed 4/11/97, Notice 2/26/97—published 5/7/97, effective 7/1/97]
  - [Filed emergency 6/12/97—published 7/2/97, effective 7/1/97]
  - [Filed 8/13/97, Notice 7/2/97—published 9/10/97, effective 11/1/97]
  - [Filed 9/16/97, Notice 7/16/97—published 10/8/97, effective 12/1/97]
  - [Filed 5/13/98, Notice 3/25/98—published 6/3/98, effective 8/1/98]
  - [Filed 8/12/98, Notice 6/17/98—published 9/9/98, effective 11/1/98]
  - [Filed 2/10/99, Notice 12/16/98—published 3/10/99, effective 5/1/99]
    - [Filed emergency 6/10/99—published 6/30/99, effective 7/1/99]
  - [Filed 8/12/99, Notice 6/30/99—published 9/8/99, effective 11/1/99]
  - [Filed 2/9/00, Notice 12/29/99—published 3/8/00, effective 5/1/00]
    - [Filed emergency 6/8/00—published 6/28/00, effective 7/1/00]
  - [Filed 8/9/00, Notice 6/14/00—published 9/6/00, effective 11/1/00]
  - [Filed 2/14/01, Notice 11/29/00—published 3/7/01, effective 5/1/01]
  - [Filed 5/9/01, Notice 3/21/01—published 5/30/01, effective 8/1/01]
  - [Filed 1/9/02, Notice 11/28/01—published 2/6/02, effective 4/1/02]
    - [Filed emergency 6/12/03—published 7/9/03, effective 7/1/03]
  - [Filed 9/22/03, Notice 7/9/03—published 10/15/03, effective 12/1/03]
  - [Filed 12/16/03, Notice 10/29/03—published 1/7/04, effective 3/1/04]
    - [Filed emergency 5/14/04—published 6/9/04, effective 7/1/04]
  - [Filed 8/12/04, Notice 6/9/04—published 9/1/04, effective 10/6/04]
    - [Filed emergency 7/15/05—published 8/3/05, effective 9/1/05]
  - [Filed 10/21/05, Notice 8/3/05—published 11/9/05, effective 12/14/05]
    - [Filed emergency 11/16/05—published 12/7/05, effective 12/1/05]
    - [Filed emergency 5/12/06—published 6/7/06, effective 7/1/06]
  - [Filed 10/20/06, Notice 8/30/06—published 11/8/06, effective 1/1/07]
    - [Filed 4/11/07, Notice 2/14/07—published 5/9/07, effective 7/1/07]
    - [Filed emergency 6/14/07—published 7/4/07, effective 7/1/07]
    - [Filed 6/13/07, Notice 4/11/07—published 7/4/07, effective 9/1/07]
    - [Filed emergency 9/12/07—published 10/10/07, effective 9/12/07]
  - [Filed 9/12/07, Notice 7/4/07—published 10/10/07, effective 11/14/07]
    - [Filed emergency 3/12/08—published 4/9/08, effective 3/12/08]
    - [Filed emergency 5/14/08—published 6/4/08, effective 7/1/08]

- [Filed 5/16/08, Notice 3/26/08—published 6/18/08, effective 8/1/08]
- [Filed 6/11/08, Notice 4/9/08—published 7/2/08, effective 8/6/08]
- [Filed 8/19/08, Notice 7/2/08—published 9/10/08, effective 11/1/08]
- [Filed emergency 9/17/08 after Notice 7/16/08—published 10/8/08, effective 10/1/08]
- [Filed ARC 7740B (Notice ARC 7590B, IAB 2/25/09), IAB 5/6/09, effective 6/10/09]
- [Filed Emergency ARC 7837B, IAB 6/3/09, effective 7/1/09]
- [Filed Emergency After Notice ARC 8506B (Notice ARC 8274B, IAB 11/4/09), IAB 2/10/10, effective 3/1/10]
- [Filed Without Notice ARC 9490B, IAB 5/4/11, effective 7/1/11]
- [Filed ARC 9651B (Notice ARC 9518B, IAB 5/18/11), IAB 8/10/11, effective 10/1/11]
- [Filed Without Notice ARC 0152C, IAB 6/13/12, effective 7/18/12]
- [Filed Emergency After Notice ARC 0546C (Notice ARC 0368C, IAB 10/3/12), IAB 1/9/13, effective 1/1/13]
- [Filed ARC 0715C (Notice ARC 0566C, IAB 1/23/13), IAB 5/1/13, effective 7/1/13]
- [Filed Emergency After Notice ARC 0825C (Notice ARC 0670C, IAB 4/3/13), IAB 7/10/13, effective 7/1/13]
- [Filed Emergency ARC 0854C, IAB 7/24/13, effective 7/1/13]
- [Filed ARC 1063C (Notice ARC 0852C, IAB 7/24/13), IAB 10/2/13, effective 11/6/13]

CHAPTER 187  
AFTERCARE SERVICES AND SUPPORTS

PREAMBLE

These rules define and structure the aftercare services program, which assists youth leaving foster care in their successful transition to adulthood. The aftercare program, including the preparation for adult living (PAL) component, helps former foster care youth to continue preparing for the challenges and opportunities presented by adulthood while receiving services and supports. The program also offers financial benefits to eligible youth up to the age of 21. All services and supports are voluntary.

DIVISION I  
AFTERCARE SERVICES

**441—187.1(234) Purpose.** The purpose of aftercare services is to provide services and supports to youth aged 18, 19 or 20 who were formerly in foster care. The primary goal of the program is for participants to achieve self-sufficiency and to recognize and accept their personal responsibility for the transition from adolescence to adulthood.

**441—187.2(234) Eligibility.** To be eligible for aftercare services, a youth must meet the following requirements:

**187.2(1) Residence.** The youth must reside in Iowa.

**187.2(2) Age.** The youth must be at least 18 years of age but less than 21 years of age.

**187.2(3) Foster care experience.**

a. The youth must leave foster care:

(1) On or after the youth's eighteenth birthday; or

(2) Between the ages of 17½ and 18 after being in foster care continuously for at least six months;

or

(3) For placement in a subsidized guardianship arrangement on or after October 7, 2008, and on or after the youth's sixteenth birthday; or

(4) Due to adoption on or after October 7, 2008, and on or after the youth's sixteenth birthday.

b. For purposes of this division, "foster care" is defined as 24-hour substitute care for a child who is placed away from the child's parents or guardians and for whom the department or juvenile court services has placement and care responsibility through either court order or voluntary agreement.

c. A placement may meet the definition of foster care regardless of whether:

(1) The placement is licensed and the state or a local agency makes payments for the child's care;

(2) Adoption subsidy payments are being made before the finalization of adoption; or

(3) There is federal matching of any payments made.

d. Foster care may include, but is not limited to, placement in:

(1) A foster family home;

(2) A foster home of relatives;

(3) A group home;

(4) An emergency shelter;

(5) A preadoptive home;

(6) A residential facility; or

(7) The home of an unlicensed relative or suitable person.

(8) A psychiatric medical institution for children (PMIC).

e. Foster care does not include placement in:

(1) A detention facility;

(2) A forestry camp;

(3) A training school; or

(4) Any other facility operated primarily for the detention of children who are determined to be delinquent.

**187.2(4) Responsibility.** The youth must:

- a. Actively take part in developing and participating in a self-sufficiency plan; and
- b. Indicate recognition and acceptance of personal responsibility in the transition toward self-sufficiency.

[ARC 8717B, IAB 5/5/10, effective 7/1/10]

**441—187.3(234) Services and supports provided.** The aftercare program shall provide the following services and supports to eligible youth:

**187.3(1) Individual self-sufficiency plan.** Each youth shall have an individual self-sufficiency plan based on an assessment of the youth's strengths and needs. The plan shall identify:

- a. The youth's goals for achieving self-sufficiency;
- b. The target date for reaching the goals; and
- c. The tasks, responsible parties, time frames, and desired outcomes needed to reach the goals.

**187.3(2) Life skills services.** The program shall provide life skills services to enable youth to maintain a safe, healthy, and stable home.

**187.3(3) Vendor payments.** The program shall make vendor payments to meet direct expenses of the participant that are necessary in order to meet goals of the participant's self-sufficiency plan.

a. *Need.* To receive a vendor payment, the youth must demonstrate that there are no other means to meet these needs. Youth receiving a PAL stipend are not eligible for a vendor payment.

b. *Scope.* Vendor payments may include but are not limited to:

- (1) Life skills training;
- (2) Transportation assistance;
- (3) Employment and education assistance;
- (4) Clothing; and
- (5) Room and board.

c. *Maximum payment.* The amount available for a 12-month period of service shall not exceed \$1200 per youth.

**187.3(4) Follow-up.** The program shall maintain individual face-to-face contact with the youth at a frequency as defined in the youth's self-sufficiency plan to ensure that the youth is meeting the goals of the plan.

**187.3(5) Ongoing assessment.** Ongoing assessment activities shall be directed toward:

- a. Monitoring the progress being made in the youth's ability to achieve self-sufficiency; and
- b. Coordination and evaluation of the services and supports being provided to reach the self-sufficiency goal.

**187.3(6) Case management.** Case management activities shall include, but not be limited to:

- a. Community involvement services to enable the youth to access community resources; and
- b. Development of support systems, including services to assist the youth in establishing or reestablishing relationships with significant adults.

**441—187.4(234) Termination.** Aftercare services and supports shall be terminated when any of the following conditions apply:

**187.4(1)** The youth fails to follow self-sufficiency plan components and expectations as determined by the program administrator.

**187.4(2)** The youth voluntarily withdraws from aftercare services.

**187.4(3)** The youth is no longer residing in Iowa.

**187.4(4)** The youth reaches 21 years of age.

**187.4(5)** There are insufficient funds to continue the services.

**441—187.5(234) Waiting list.** The program administrator or designee shall create a waiting list when all funds for the aftercare services program are committed for the fiscal year. Names shall be entered on the waiting list on a first-come, first-served basis once the youth is determined eligible.

**441—187.6(234) Administration.** The department may contract with another state agency or a private organization to perform the administrative and case management functions necessary to administer this program.

**187.6(1)** The contractor and any subcontractors shall meet the standards in 441—subrule 150.5(3) and paragraph 150.3(3)“i.”

**187.6(2)** Agencies providing services or supports shall meet the standards in rules 441—108.2(238) through 441—108.6(238).

**441—187.7 to 187.9** Reserved.

These rules are intended to implement Iowa Code section 234.6 and Public Law 106-169, the Foster Care Independence Act of 1999.

DIVISION II  
PREPARATION FOR ADULT LIVING (PAL) PROGRAM

**441—187.10(234) Purpose.** The purpose of the PAL program is to provide financial support to eligible youth who are receiving aftercare services. Youth receiving a PAL stipend are not eligible to receive aftercare vendor payments.

**441—187.11(234) Eligibility.** A monthly stipend may be provided to a youth receiving aftercare services who left foster care after May 1, 2006, and who meets all of the following criteria:

**187.11(1) *Ineligibility for foster care.*** The youth must be ineligible for voluntary foster care placement under 441—Chapter 202.

**187.11(2) *Foster care experience.*** The youth must:

*a.* Leave foster care paid for by the state under Iowa Code section 234.35 on or after the youth’s eighteenth birthday; and

*b.* Have been in foster care paid for by the state under Iowa Code section 234.35 in at least 6 of the last 12 months before the youth left foster care.

**187.11(3) *Living arrangement.*** The youth must have a living arrangement other than a parent’s home, which may include a former foster family, an apartment, a college dormitory, or another approved arrangement. The program administrator or designee is responsible for approving the living arrangement.

**187.11(4) *Activity.*** The youth must meet one or more of the following criteria:

*a.* Be enrolled in or actively pursuing enrollment in a postsecondary education or training program or work training;

*b.* Be employed for 80 hours per month or be actively seeking that level of employment; or

*c.* Be attending an accredited school full-time pursuing a course of study leading to a high school diploma; or

*d.* Be attending an instructional program leading to a high school equivalency diploma.

**187.11(5) *Financial need.*** Initial and ongoing eligibility shall be based on the youth’s income and need as determined according to rule 441—187.12(234).

[ARC 8717B, IAB 5/5/10, effective 7/1/10]

**441—187.12(234) Payment.** The program administrator or designee shall issue payment to each participant according to the following guidelines:

**187.12(1) *Need.*** The amount of the PAL stipend shall be based on the needs of the youth as documented in the youth’s self-sufficiency plan. Eligibility and the stipend amount shall be based on the best estimate of the youth’s income, as determined at least quarterly.

*a.* All earned and unearned income received by the youth during the 30 days before the determination shall be used to project future income.

(1) If the 30-day period is not indicative of future income, income from a longer period or verification of anticipated income from the income source may be used to project future income.

(2) Nonrecurring lump-sum payments are excluded as income. Nonrecurring lump-sum payments include but are not limited to one-time payments received for such things as income tax refunds, rebates, credits, refunds of security deposits on rental property or utilities, and retroactive payments for past months' benefits such as SSI, unemployment insurance, or public assistance.

*b.* The youth shall timely report the beginning or ending of earned or unearned income. A report shall be considered timely when made within ten days from the receipt of income or the date income ended.

*c.* When the youth timely reports a change in income, prospective eligibility and stipend amount for the following month shall be determined based on the change.

*d.* Recoupment shall be made for any overpayment due to failure to timely report a change in income or for benefits paid during an administrative appeal if the department's action is ultimately upheld. Recoupment shall be done through a reasonable reduction of any future stipends.

*e.* Recoupment shall not be made when a youth timely reports a change in income and the change is timely acted upon, but the timely notice policy in rule 441—7.7(17A) requires that the action be delayed until the second calendar month following the month of change.

**187.12(2) Amount of monthly stipend.** The maximum monthly stipend shall be \$602.70.

*a.* The stipend shall be prorated based on the date of entry.

*b.* Effect of income.

(1) When the monthly unearned income of the youth exceeds the maximum monthly stipend, the youth is not eligible for a stipend.

(2) When the net earnings of the youth exceed the maximum monthly stipend, the stipend shall be reduced the following month by 50 cents for every dollar earned over the maximum monthly stipend.

(3) A youth receiving Supplemental Security Income payments is not eligible for a stipend.

**187.12(3) Payee.** The PAL stipend may be paid to the youth, the foster family, or another payee other than a department employee. The payee shall be agreed upon by the parties involved and specified in the self-sufficiency plan under 187.3(1).

**187.12(4) Start-up allowance.** When a youth is approved for the PAL program, the program administrator or designee may authorize a one-time start-up allowance in addition to the monthly stipend. The start-up allowance:

*a.* Is intended to assist in covering the initial costs of establishing the youth's living arrangement, such as rental and utility deposits, purchase of food, and purchase of necessary household items.

*b.* Shall be based on the youth's income and need as determined according to subrule 187.12(1).

*c.* Shall not exceed the maximum monthly stipend amount.

[ARC 8451B, IAB 1/13/10, effective 1/1/10; ARC 8653B, IAB 4/7/10, effective 5/12/10; ARC 8717B, IAB 5/5/10, effective 7/1/10; ARC 0851C, IAB 7/24/13, effective 7/1/13; ARC 1064C, IAB 10/2/13, effective 11/6/13]

**441—187.13(234) Termination of stipend.** The PAL stipend shall be terminated when any of the following conditions apply:

**187.13(1)** The youth reaches the age of 21.

**187.13(2)** The youth fails to meet work or education eligibility requirements for 30 consecutive days without good cause as determined by the program administrator or designee.

**187.13(3)** The youth fails to follow self-sufficiency plan components and expectations as determined by the program administrator or designee.

**187.13(4)** The youth fails to maintain satisfactory progress as defined by the education or training program in which the youth is enrolled. A youth who is not making satisfactory progress may stay in the PAL program by choosing the work option.

**187.13(5)** The youth chooses to live in a nonapproved setting.

**187.13(6)** The youth no longer resides in Iowa.

**187.13(7)** The youth lives with a parent.

**187.13(8)** There are insufficient funds to continue the stipend.

**441—187.14(234) Waiting list.** The program administrator or designee shall create a waiting list when all funds for the PAL program are committed for the fiscal year. Names shall be entered on the waiting list on a first-come, first-served basis once the youth is determined eligible.

**441—187.15(234) Administration.** The department may contract with another state agency or a private organization to perform the administrative functions necessary to administer the PAL program.

**187.15(1)** The contractor and any subcontractors shall meet the standards in 441—subrule 150.5(3) and paragraph 150.3(3) “i.”

**187.15(2)** Agencies providing support or services shall meet the standards in rules 441—108.2(238) through 441—108.6(238).

These rules are intended to implement Iowa Code section 234.46.

[Filed emergency 6/16/06—published 7/5/06, effective 7/1/06]

[Filed emergency 11/9/06 after Notice 7/5/06—published 12/6/06, effective 12/1/06]

[Filed emergency 3/12/08 after Notice 1/30/08—published 4/9/08, effective 4/1/08]

[Filed Emergency ARC 8451B, IAB 1/13/10, effective 1/1/10]

[Filed ARC 8653B (Notice ARC 8452B, IAB 1/13/10), IAB 4/7/10, effective 5/12/10]

[Filed ARC 8717B (Notice ARC 8536B, IAB 2/24/10), IAB 5/5/10, effective 7/1/10]

[Filed Emergency ARC 0851C, IAB 7/24/13, effective 7/1/13]

[Filed ARC 1064C (Notice ARC 0850C, IAB 7/24/13), IAB 10/2/13, effective 11/6/13]



## INSPECTIONS AND APPEALS DEPARTMENT[481]

### CHAPTER 1 ADMINISTRATION

- 1.1(10A) Organization
- 1.2(10A) Definitions
- 1.3(10A) Administration division
- 1.4(10A) Investigations division
- 1.5(10A) Health facilities division
- 1.6(10A) Administrative hearings division
- 1.7(10A) Administering discretion
- 1.8(10A) Employment appeal board
- 1.9(10A,237) Child advocacy board
- 1.10(10A,13B) State public defender
- 1.11(10A,99D,99F) Racing and gaming commission

### CHAPTER 2 PETITIONS FOR RULE MAKING

- 2.1(17A) Petition for rule making
- 2.2(17A) Briefs
- 2.3(17A) Inquiries
- 2.4(17A) Agency consideration

### CHAPTER 3 DECLARATORY ORDERS (Uniform Rules)

- 3.1(17A) Petition for declaratory order
- 3.2(17A) Notice of petition
- 3.3(17A) Intervention
- 3.4(17A) Briefs
- 3.5(17A) Inquiries
- 3.6(17A) Service and filing of petitions and other papers
- 3.7(17A) Consideration
- 3.8(17A) Action on petition
- 3.9(17A) Refusal to issue order
- 3.12(17A) Effect of a declaratory order

### CHAPTER 4 AGENCY PROCEDURE FOR RULE MAKING (Uniform Rules)

- 4.3(17A) Public rule-making docket
- 4.4(17A) Notice of proposed rule making
- 4.5(17A) Public participation
- 4.6(17A) Regulatory analysis
- 4.10(17A) Exemptions from public rule-making procedures
- 4.11(17A) Concise statement of reasons
- 4.13(17A) Agency rule-making record

### 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 a subject may have additions, dissents, or objections entered into the record
- 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) Authority to release confidential records
- 5.15(17A,22) Personnel files
- 5.16(17A,22) Personally identifiable information

#### CHAPTER 6

##### UNIFORM WAIVER AND VARIANCE RULES

- 6.1(10A,17A,ExecOrd11) Applicability
- 6.2(10A,17A,ExecOrd11) Definitions
- 6.3(10A,17A,ExecOrd11) Interpretive rules
- 6.4(10A,17A,ExecOrd11) Compliance with statute
- 6.5(10A,17A,ExecOrd11) Criteria for waiver or variance
- 6.6(10A,17A,ExecOrd11) Filing of petition
- 6.7(10A,17A,ExecOrd11) Content of petition
- 6.8(10A,17A,ExecOrd11) Additional information
- 6.9(10A,17A,ExecOrd11) Notice
- 6.10(10A,17A,ExecOrd11) Hearing procedures
- 6.11(10A,17A,ExecOrd11) Ruling
- 6.12(10A,17A,ExecOrd11) Public availability
- 6.13(10A,17A,ExecOrd11) Voiding or cancellation
- 6.14(10A,17A,ExecOrd11) Violations
- 6.15(10A,17A,ExecOrd11) Defense
- 6.16(10A,17A,ExecOrd11) Appeals
- 6.17(10A,17A,ExecOrd11) Sample petition for waiver or variance

#### CHAPTER 7

##### CONSENT FOR THE SALE OF GOODS AND SERVICES

- 7.1(68B) General prohibition
- 7.2(68B) Definitions
- 7.3(68B) Conditions of consent for officials
- 7.4(68B) Application for consent
- 7.5(68B) Effect of consent
- 7.6(22,68B) Public information
- 7.7(68B) Appeal

#### CHAPTER 8

##### LICENSING ACTIONS FOR NONPAYMENT OF CHILD SUPPORT AND STUDENT LOAN DEFAULT/NONCOMPLIANCE WITH AGREEMENT FOR PAYMENT OF OBLIGATION

- 8.1(252J) Certificates of noncompliance
- 8.2(261) Student loan default/noncompliance with agreement for payment of obligation
- 8.3(261) Suspension or revocation of a license

CHAPTER 9  
INDIGENT DEFENSE CLAIMS PROCESSING

9.1(232,815)	Definitions
9.2(815)	Claims submitted by a public defender
9.3(815)	Claims submitted by a private attorney
9.4(815)	Claims submitted by a county
9.5(815)	Claims for other professional services
9.6(10A)	Processing and payment
9.7(10A)	Payment errors
9.8(10A)	Availability of records

CHAPTER 10  
CONTESTED CASE HEARINGS

10.1(10A)	Definitions
10.2(10A,17A)	Time requirements
10.3(10A)	Requests for a contested case hearing
10.4(10A)	Transmission of contested cases
10.5(17A)	Notices of hearing
10.6(10A)	Waiver of procedures
10.7(10A,17A)	Telephone proceedings
10.8(10A,17A)	Scheduling
10.9(17A)	Disqualification
10.10(10A,17A)	Consolidation—severance
10.11(10A,17A)	Pleadings
10.12(17A)	Service and filing of pleadings and other papers
10.13(17A)	Discovery
10.14(10A,17A)	Subpoenas
10.15(10A,17A)	Motions
10.16(17A)	Prehearing conference
10.17(10A)	Continuances
10.18(10A,17A)	Withdrawals
10.19(10A,17A)	Intervention
10.20(17A)	Hearing procedures
10.21(17A)	Evidence
10.22(17A)	Default
10.23(17A)	Ex parte communication
10.24(10A,17A)	Decisions
10.25(10A,17A)	DIA appeals
10.26(10A,17A,272C)	Board hearings
10.27(10A)	Transportation hearing fees
10.28(10A)	Recording costs
10.29(10A)	Code of administrative judicial conduct

CHAPTER 11  
PROCEDURE FOR CONTESTED CASES INVOLVING PERMITS  
TO CARRY WEAPONS AND ACQUIRE FIREARMS

11.1(17A,724)	Definitions
11.2(724)	Appeals
11.3(17A,724)	Notice of hearing
11.4(17A,724)	Agency record
11.5(17A)	Contested case hearing
11.6(17A)	Service and filing of documents

11.7(17A)	Witness lists and exhibits
11.8(17A)	Evidence
11.9(17A)	Withdrawals and dismissals
11.10(17A)	Default
11.11(10A)	Costs
11.12(724)	Probable cause
11.13(724)	Clear and convincing evidence

CHAPTERS 12 to 19  
Reserved

*AUDITS DIVISION*

CHAPTERS 20 and 21  
Reserved

CHAPTER 22  
HEALTH CARE FACILITY AUDITS

22.1(10A)	Audit occurrence
22.2(10A)	Confidentiality

CHAPTERS 23 and 24  
Reserved

CHAPTER 25  
IOWA TARGETED SMALL BUSINESS CERTIFICATION PROGRAM

25.1(73)	Definitions
25.2(10A)	Certification
25.3(17A)	Description of application
25.4(10A)	Eligibility standards
25.5(10A)	Special consideration
25.6(10A)	Family-owned business
25.7(10A)	Cottage industry
25.8(10A)	Decertification
25.9(12)	Request for bond waiver
25.10(714)	Fraudulent practices in connection with targeted small business programs
25.11(17A)	Appeal procedure

CHAPTERS 26 to 29  
Reserved

*INSPECTIONS DIVISION*

CHAPTER 30  
FOOD AND CONSUMER SAFETY

30.1(10A)	Food and consumer safety bureau
30.2(10A)	Definitions
30.3(137C,137D,137F,196)	Licensing and postings
30.4(137C,137D,196)	License fees
30.5(137F)	Penalty and delinquent fees
30.6(137C,137D,137F,196)	Returned checks
30.7(137F)	Double licenses
30.8(137C,137D,137F)	Inspection frequency
30.9(137D,137F,196)	Disposal standards
30.10	Reserved

- 30.11(22) Examination of records
- 30.12(137C,137D,137F,196) Denial, suspension or revocation of a license to operate
- 30.13(10A,137F) Formal hearing
- 30.14(137D,137F,196) False label or defacement

#### CHAPTER 31

##### FOOD ESTABLISHMENT AND FOOD PROCESSING PLANT INSPECTIONS

- 31.1(137F) Inspection standards
- 31.2(137F) Food processing plant standards
- 31.3(137F) Trichinae control for pork products prepared at retail
- 31.4(137F) Certified food protection programs
- 31.5(137F) Labeling
- 31.6(137F) Adulterated food and disposal
- 31.7 Reserved
- 31.8(137F) Enforcement
- 31.9(137F) Toilets and lavatories
- 31.10(137F) Warewashing sinks in establishments serving alcoholic beverages
- 31.11(137F) Criminal offense—conviction of license holder
- 31.12(137F) Temporary food establishments and farmers market potentially hazardous food licensees

#### CHAPTERS 32 and 33

Reserved

#### CHAPTER 34

##### HOME FOOD ESTABLISHMENTS

- 34.1(137D) Inspection standards
- 34.2(137D) Enforcement
- 34.3(137D) Labeling requirement
- 34.4(137D) Annual gross sales
- 34.5(137D) Criminal offense—conviction of license holder

#### CHAPTER 35

##### CONTRACTOR REQUIREMENTS

- 35.1(137C,137D,137F) Definitions
- 35.2(137C,137D,137F) Contracts
- 35.3(137C,137D,137F) Contractor
- 35.4(137C,137D,137F) Contractor inspection personnel
- 35.5(137C,137D,137F) Investigation
- 35.6(137C,137D,137F) Inspection standards
- 35.7(137C,137D,137F) Enforcement
- 35.8(137C,137D,137F) Licensing
- 35.9(137C,137D,137F) Records
- 35.10(137C,137D,137F) Reporting requirements
- 35.11(137C,137D,137F) Contract rescinded

#### CHAPTER 36

Reserved

#### CHAPTER 37

##### HOTEL AND MOTEL INSPECTIONS

- 37.1(137C) Building and grounds
- 37.2(137C) Guest rooms

37.3(137C)	Bedding
37.4(137C)	Lavatory facilities
37.5(137C)	Glasses and ice
37.6(137C)	Employees
37.7(137C)	Room rates
37.8(137C)	Inspections
37.9(137C)	Enforcement
37.10(137C)	Criminal offense—conviction of license holder

## CHAPTERS 38 and 39

Reserved

## CHAPTER 40

## FOSTER CARE FACILITY INSPECTIONS

40.1(10A)	License surveys
40.2(10A)	Unannounced inspections
40.3(10A)	Results
40.4(10A)	Ownership of records

## CHAPTER 41

## PSYCHIATRIC MEDICAL INSTITUTIONS FOR CHILDREN (PMIC)

41.1(135H)	Definitions
41.2(135H)	Application for license
41.3(135H)	Renewal application or change of ownership
41.4(135H)	Licenses for distinct parts
41.5(135H)	Variances
41.6(135H)	Notice to the department
41.7(135H)	Inspection of complaints
41.8(135H)	General requirement
41.9(135H)	Certification of need for services
41.10(135H)	Active treatment
41.11(135H)	Individual plan of care
41.12(135H)	Individual written plan of care
41.13(135H)	Plan of care team
41.14(135H)	Required discharge
41.15(135H)	Criminal behavior involving children
41.16(22,135H)	Confidential or open information
41.17(135H)	Additional provisions concerning physical restraint

## CHAPTERS 42 to 49

Reserved

## CHAPTER 50

## HEALTH CARE FACILITIES ADMINISTRATION

50.1(10A)	Inspections
50.2(10A)	Definitions
50.3(135B,135C)	Licensing
50.4(135C)	Fines and citations
50.5(135C)	Denial, suspension or revocation
50.6(10A)	Formal hearing
50.7(10A,135C)	Additional notification
50.8(22,135B,135C)	Records
50.9(135C)	Criminal, dependent adult abuse, and child abuse record checks

50.10(135C)	Inspections, exit interviews, plans of correction, and revisits
50.11(135C)	Complaint and self-reported incident investigation procedure
50.12(135C)	Requirements for service
50.13(135C)	Inspectors' conflicts of interest

CHAPTER 51  
HOSPITALS

51.1(135B)	Definitions
51.2(135B)	Classification, compliance and license
51.3(135B)	Quality improvement program
51.4(135B)	Long-term acute care hospital located within a general hospital
51.5(135B)	Medical staff
51.6(135B)	Patient rights and responsibilities
51.7(135B)	Abuse
51.8(135B)	Organ and tissue—requests and procurement
51.9(135B)	Nursing services
51.10 and 51.11	Reserved
51.12(135B)	Records and reports
51.13	Reserved
51.14(135B)	Pharmaceutical service
51.15	Reserved
51.16(135B)	Radiological services
51.17	Reserved
51.18(135B)	Laboratory service
51.19	Reserved
51.20(135B)	Food and nutrition services
51.21	Reserved
51.22(135B)	Equipment for patient care
51.23	Reserved
51.24(135B)	Infection control
51.25	Reserved
51.26(135B)	Surgical services
51.27	Reserved
51.28(135B)	Anesthesia services
51.29	Reserved
51.30(135B)	Emergency services
51.31	Reserved
51.32(135B)	Obstetric and neonatal services
51.33	Reserved
51.34(135B)	Pediatric services
51.35	Reserved
51.36(135B)	Psychiatric services
51.37	Reserved
51.38(135B)	Long-term care service
51.39(135B)	Penalty and enforcement
51.40(135B)	Validity of rules
51.41 to 51.49	Reserved
51.50(135B)	Minimum standards for construction
51.51 and 51.52	Reserved
51.53(135B)	Critical access hospitals

## CHAPTER 52

## DEPENDENT ADULT ABUSE IN FACILITIES AND PROGRAMS

- 52.1(235E) Definitions
- 52.2(235E) Persons who must report dependent adult abuse and the reporting procedure for those persons
- 52.3(235E) Reports and registry of dependent adult abuse
- 52.4(235E) Financial institution employees and reporting suspected financial exploitation
- 52.5(235E) Evaluation of report
- 52.6(235E) Separation of victim and alleged abuser
- 52.7(235E) Interviews, examination of evidence, and investigation of dependent adult abuse allegations
- 52.8(235E) Notification to subsequent employers

## CHAPTER 53

## HOSPICE LICENSE STANDARDS

- 53.1(135J) Definitions
- 53.2(135J) License
- 53.3(135J) Patient rights
- 53.4(135J) Governing body
- 53.5(135J) Quality assurance and utilization review
- 53.6(135J) Attending physician services
- 53.7(135J) Medical director
- 53.8(135J) Interdisciplinary team (IDT)
- 53.9(135J) Nursing services
- 53.10 Reserved
- 53.11(135J) Coordinator of patient care
- 53.12(135J) Social services
- 53.13(135J) Counseling services
- 53.14(135J) Volunteer services
- 53.15(135J) Spiritual counseling
- 53.16(135J) Optional services
- 53.17(135J) Contracted services
- 53.18(135J) Short-term hospital services
- 53.19(135J) Bereavement services
- 53.20(135J) Records

## CHAPTER 54

## GOVERNOR'S AWARD FOR QUALITY CARE

- 54.1(135C) Purpose
- 54.2(135C) Definitions
- 54.3(135C) Nomination
- 54.4(135C) Applicant eligibility
- 54.5(135C) Nomination information
- 54.6(135C) Evaluation
- 54.7(135C) Selection of finalists
- 54.8(135C) Certificate of recognition

## CHAPTER 55

Reserved

CHAPTER 56  
FINING AND CITATIONS

56.1(135C)	Authority for citations
56.2(135C)	Classification of violations—classes
56.3(135C)	Fines
56.4(135C)	Time for compliance
56.5(135C)	Failure to correct a violation within the time specified—penalty
56.6(135C)	Treble and double fines
56.7(135C)	Notation of classes of violations
56.8(135C)	Notation for more than one class of violation
56.9(135C)	Factors determining selection of class of violation
56.10(135C)	Factors determining imposition of citation and fine
56.11(135C)	Class I violation not specified in the rules
56.12(135C)	Class I violation as a result of multiple lesser violations
56.13(135C)	Form of citations
56.14(135C)	Licensee's response to a citation
56.15(135C)	Procedure for facility after informal conference
56.16	Reserved
56.17(135C)	Formal contest

CHAPTER 57  
RESIDENTIAL CARE FACILITIES

57.1(135C)	Definitions
57.2(135C)	Variances
57.3(135C)	Application for licensure
57.4(135C)	Special categories
57.5(135C)	General requirements
57.6(135C)	Notifications required by the department
57.7	Reserved
57.8(135C)	Licenses for distinct parts
57.9(135C)	Administrator
57.10(135C)	Administration
57.11(135C)	General policies
57.12(135C)	Personnel
57.13(135C)	Admission, transfer, and discharge
57.14(135C)	Contracts
57.15(135C)	Physical examinations
57.16(135C)	Records
57.17(135C)	Resident care and personal services
57.18	Reserved
57.19(135C)	Drugs
57.20(135C)	Dental services
57.21(135C)	Dietary
57.22(135C)	Service plan
57.23(135C)	Resident activities program
57.24(135C)	Resident advocate committee
57.25(135C)	Safety
57.26(135C)	Housekeeping
57.27(135C)	Maintenance
57.28(135C)	Laundry
57.29(135C)	Garbage and waste disposal
57.30(135C)	Buildings, furnishings, and equipment

57.31(135C)	Family and employee accommodations
57.32(135C)	Animals
57.33(135C)	Environment and grounds
57.34(135C)	Supplies
57.35(135C)	Residents' rights in general
57.36(135C)	Involuntary discharge or transfer
57.37(135C)	Residents' rights
57.38(135C)	Financial affairs—management
57.39(135C)	Resident abuse prohibited
57.40(135C)	Resident records
57.41(135C)	Dignity preserved
57.42(135C)	Resident work
57.43(135C)	Communications
57.44(135C)	Resident activities
57.45(135C)	Resident property
57.46(135C)	Family visits
57.47(135C)	Choice of physician
57.48(135C)	Incompetent residents
57.49(135C)	County care facilities
57.50(135C)	Another business or activity in a facility
57.51(135C)	Respite care services

#### CHAPTER 58 NURSING FACILITIES

58.1(135C)	Definitions
58.2(135C)	Variances
58.3(135C)	Application for licensure
58.4(135C)	General requirements
58.5(135C)	Notifications required by the department
58.6	Reserved
58.7(135C)	Licenses for distinct parts
58.8(135C)	Administrator
58.9(135C)	Administration
58.10(135C)	General policies
58.11(135C)	Personnel
58.12(135C)	Admission, transfer, and discharge
58.13(135C)	Contracts
58.14(135C)	Medical services
58.15(135C)	Records
58.16(135C)	Resident care and personal services
58.17	Reserved
58.18(135C)	Nursing care
58.19(135C)	Required nursing services for residents
58.20(135C)	Duties of health service supervisor
58.21(135C)	Drugs, storage, and handling
58.22(135C)	Rehabilitative services
58.23(135C)	Dental, diagnostic, and other services
58.24(135C)	Dietary
58.25(135C)	Social services program
58.26(135C)	Resident activities program
58.27(135C)	Resident advocate committee
58.28(135C)	Safety

58.29(135C)	Resident care
58.30	Reserved
58.31(135C)	Housekeeping
58.32(135C)	Maintenance
58.33(135C)	Laundry
58.34(135C)	Garbage and waste disposal
58.35(135C)	Buildings, furnishings, and equipment
58.36(135C)	Family and employee accommodations
58.37(135C)	Animals
58.38(135C)	Supplies
58.39(135C)	Residents' rights in general
58.40(135C)	Involuntary discharge or transfer
58.41(135C)	Residents' rights
58.42(135C)	Financial affairs—management
58.43(135C)	Resident abuse prohibited
58.44(135C)	Resident records
58.45(135C)	Dignity preserved
58.46(135C)	Resident work
58.47(135C)	Communications
58.48(135C)	Resident activities
58.49(135C)	Resident property
58.50(135C)	Family visits
58.51(135C)	Choice of physician and pharmacy
58.52(135C)	Incompetent resident
58.53(135C)	County care facilities
58.54(73GA,ch 1016)	Special unit or facility dedicated to the care of persons with chronic confusion or a dementing illness (CCDI unit or facility)
58.55(135C)	Another business or activity in a facility
58.56(135C)	Respite care services
58.57(135C)	Training of inspectors

#### CHAPTER 59

##### TUBERCULOSIS (TB) SCREENING

59.1(135B,135C)	Purpose
59.2(135B,135C)	Definitions
59.3(135B,135C)	TB risk assessment
59.4(135B,135C)	Health care facility or hospital risk classification
59.5(135B,135C)	Baseline TB screening procedures for health care facilities and hospitals
59.6(135B,135C)	Serial TB screening procedures for health care facilities and hospitals
59.7(135B,135C)	Screening of HCWs who transfer to other health care facilities or hospitals
59.8(135B,135C)	Baseline TB screening procedures for residents of health care facilities
59.9(135B,135C)	Serial TB screening procedures for residents of health care facilities
59.10(135B,135C)	Performance of screening and testing

#### CHAPTER 60

##### MINIMUM PHYSICAL STANDARDS FOR RESIDENTIAL CARE FACILITIES

60.1(135C)	Definitions
60.2(135C)	Variances
60.3(135C)	General requirements
60.4(135C)	Typical construction
60.5(135C)	Supervised care unit

60.6(135C)	Support area
60.7(135C)	Service area
60.8(135C)	Administration and staff area
60.9(135C)	Definition of public area
60.10(135C)	Elevator requirements
60.11(135C)	Mechanical requirements
60.12(135C)	Electrical requirement
60.13(135C)	Codes and standards

#### CHAPTER 61

##### MINIMUM PHYSICAL STANDARDS FOR NURSING FACILITIES

61.1(135C)	Definitions
61.2(135C)	General requirements
61.3(135C)	Submission of construction documents
61.4(135C)	Variances
61.5(135C)	Additional notification requirements
61.6(135C)	Construction requirements
61.7(135C)	Nursing care unit
61.8(135C)	Dietetic and other service areas
61.9(135C)	Specialized unit or facility for persons with chronic confusion or a dementing illness (CCDI unit or facility)

#### CHAPTER 62

##### RESIDENTIAL CARE FACILITIES

##### FOR PERSONS WITH MENTAL ILLNESS (RCF/PMI)

62.1(135C)	Definitions
62.2(135C)	Application for license
62.3(135C)	Licenses for distinct parts
62.4(135C)	Variances
62.5(135C)	General requirements
62.6(135C)	Notification required by the department
62.7(135C)	Administrator
62.8(135C)	Administration
62.9(135C)	Personnel
62.10(135C)	General admission policies
62.11(135C)	Evaluation services
62.12(135C)	Programming
62.13(135C)	Crisis intervention
62.14(135C)	Discharge or transfer
62.15(135C)	Medication management
62.16(135C)	Resident property
62.17(135C)	Financial affairs
62.18(135C)	Records
62.19(135C)	Health and safety
62.20(135C)	Nutrition
62.21(135C)	Physical facilities and maintenance
62.22(135C)	Care review committee
62.23(135C)	Residents' rights in general
62.24(135C)	County care facilities
62.25(135C)	Another business or activity in a facility
62.26(135C)	Respite care services

CHAPTER 63  
RESIDENTIAL CARE FACILITIES FOR THE  
INTELLECTUALLY DISABLED

63.1(135C)	Definitions
63.2(135C)	Variances
63.3(135C)	Application for licensure
63.4(135C)	General requirements
63.5(135C)	Notifications required by the department
63.6	Reserved
63.7(135C)	Licenses for distinct parts
63.8(135C)	Administrator
63.9(135C)	General policies
63.10	Reserved
63.11(135C)	Personnel
63.12(135C)	Resident care and personal services
63.13(135C)	Admission, transfer, and discharge
63.14(135C)	Contracts
63.15(135C)	Physical examinations
63.16(135C)	Dental services
63.17(135C)	Records
63.18(135C)	Drugs
63.19(135C)	Dietary
63.20(135C)	Orientation program
63.21(135C)	Individualized program of care
63.22(135C)	Care review committee
63.23(135C)	Safety
63.24(135C)	Housekeeping
63.25(135C)	Maintenance
63.26(135C)	Laundry
63.27(135C)	Garbage and waste disposal
63.28(135C)	Buildings, furnishings, and equipment
63.29(135C)	Family and employee accommodations
63.30(135C)	Animals
63.31(135C)	Environment and grounds
63.32(135C)	Supplies
63.33(135C)	Residents' rights in general
63.34(135C)	Involuntary discharge or transfer
63.35(135C)	Resident rights
63.36(135C)	Financial affairs—management
63.37(135C)	Resident abuse prohibited
63.38(135C)	Resident records
63.39(135C)	Dignity preserved
63.40(135C)	Resident work
63.41(135C)	Communications
63.42(135C)	Resident activities
63.43(135C)	Resident property
63.44(135C)	Family visits
63.45(135C)	Choice of physician
63.46(135C)	Incompetent resident
63.47(135C)	Specialized license for three- to five-bed facilities
63.48	Reserved

63.49(135C) Another business or activity in a facility  
 63.50(135C) Respite care services

CHAPTER 64  
 INTERMEDIATE CARE FACILITIES FOR THE  
 INTELLECTUALLY DISABLED

64.1 Reserved  
 64.2(135C) Variances  
 64.3(135C) Application for license  
 64.4(135C) General requirements  
 64.5(135C) Notifications required by the department  
 64.6(135C) Veteran eligibility  
 64.7(135C) Licenses for distinct parts  
 64.8 to 64.16 Reserved  
 64.17(135C) Contracts  
 64.18(135C) Records  
 64.19 to 64.32 Reserved  
 64.33(235B) Separation of accused abuser and victim  
 64.34(135C) Employee criminal record checks, child abuse checks and dependent adult abuse checks and employment of individuals who have committed a crime or have a founded abuse  
 64.35(135C) Care review committee  
 64.36(135C) Involuntary discharge or transfer  
 64.37 to 64.59 Reserved  
 64.60(135C) Federal regulations adopted—conditions of participation  
 64.61(135C) Federal regulations adopted—rights  
 64.62(135C) Another business or activity in a facility  
 64.63(135C) Respite care services

CHAPTER 65  
 INTERMEDIATE CARE FACILITIES  
 FOR PERSONS WITH MENTAL ILLNESS (ICF/PMI)

65.1(135C) Definitions  
 65.2(135C) Application for license  
 65.3(135C) Licenses for distinct parts  
 65.4(135C) Variances  
 65.5(135C) General requirements  
 65.6(135C) Notification required by the department  
 65.7(135C) Administrator  
 65.8(135C) Administration  
 65.9(135C) Personnel  
 65.10(135C) General admission policies  
 65.11(135C) Evaluation services  
 65.12(135C) Individual program plan (IPP)  
 65.13(135C) Activity program  
 65.14(135C) Crisis intervention  
 65.15(135C) Restraint or seclusion  
 65.16(135C) Discharge or transfer  
 65.17(135C) Medication management  
 65.18(135C) Resident property and personal affairs  
 65.19(135C) Financial affairs  
 65.20(135C) Records

65.21(135C)	Health and safety
65.22(135C)	Nutrition
65.23(135C)	Physical facilities and maintenance
65.24(135C)	Care review committee
65.25(135C)	Residents' rights in general
65.26(135C)	Incompetent residents
65.27(135C)	County care facilities
65.28(135C)	Violations
65.29(135C)	Another business or activity in a facility
65.30(135C)	Respite care services

#### CHAPTER 66 BOARDING HOMES

66.1(83GA,SF484)	Definitions
66.2(83GA,SF484)	Registration of boarding homes
66.3(83GA,SF484)	Occupancy reports
66.4(83GA,SF484)	Complaints
66.5(83GA,SF484)	Investigations
66.6(83GA,SF484)	Penalties
66.7(83GA,SF484)	Public and confidential information

#### CHAPTER 67 GENERAL PROVISIONS FOR ELDER GROUP HOMES, ASSISTED LIVING PROGRAMS, AND ADULT DAY SERVICES

67.1(231B,231C,231D)	Definitions
67.2(231B,231C,231D)	Program policies and procedures, including those for incident reports
67.3(231B,231C,231D)	Tenant rights
67.4(231B,231C,231D)	Program notification to the department
67.5(231B,231C,231D)	Medications
67.6(231B,231C,231D)	Another business or activity located in a program
67.7(231B,231C,231D)	Waiver of criteria for retention of a tenant in the program
67.8(231B,231C,231D)	All other waiver requests
67.9(231B,231C,231D)	Staffing
67.10(17A,231B,231C,231D)	Monitoring
67.11(231B,231C,231D)	Complaint and program-reported incident report investigation procedure
67.12(17A,231B,231D)	Adult day services and elder group homes—preliminary report, plan of correction and request for reconsideration
67.13(17A,231C,85GA,SF394)	Assisted living programs—exit interview, final report, plan of correction
67.14(17A,231C,85GA,SF394)	Assisted living programs—response to final report
67.15(17A,231B,231C,231D)	Denial, suspension or revocation of a certificate
67.16(17A,231B,231C,231D)	Conditional certification
67.17(17A,231B,231C,231D)	Civil penalties
67.18(17A,231B,231C,231D)	Judicial review
67.19(135C,231B,231C,231D)	Criminal, dependent adult abuse, and child abuse record checks
67.20(17A,231C,231D)	Emergency removal of tenants
67.21(231C)	Nursing assistant work credit
67.22(231B,231C,231D)	Public or confidential information
67.23(231B,231C,231D)	Training related to Alzheimer's disease and similar forms of irreversible dementia

CHAPTER 68  
ELDER GROUP HOMES

68.1(231B)	Definitions
68.2(231B)	Program certification and posting requirements
68.3(231B)	Certification—application process
68.4(231B)	Certification—application content
68.5(231B)	Initial certification process
68.6(231B)	Expiration of program certification
68.7(231B)	Recertification process
68.8(231B)	Notification of recertification
68.9(231B)	Listing of all certified programs
68.10(231B)	Transfer of certification
68.11(231B)	Cessation of program operation
68.12(231B)	Occupancy agreement
68.13(231B)	Evaluation of tenant
68.14(231B)	Criteria for admission and retention of tenants
68.15(231B)	Involuntary transfer from the program
68.16(231B)	Tenant documents
68.17(231B)	Service plans
68.18(231B)	Nurse review
68.19(231B)	Staffing
68.20(231B)	Managed risk policy and managed risk consensus agreements
68.21(231B)	Transportation
68.22(231B)	Identification of veteran's benefit eligibility
68.23(231B)	Resident advocate committees
68.24(231B)	Life safety—emergency policies and procedures and structural safety requirements
68.25(231B)	Structural standards
68.26(231B)	Landlord and tenant Act

CHAPTER 69  
ASSISTED LIVING PROGRAMS

69.1(231C)	Definitions
69.2(231C)	Program certification
69.3(231C)	Certification of a nonaccredited program—application process
69.4(231C)	Nonaccredited program—application content
69.5(231C)	Initial certification process for a nonaccredited program
69.6(231C)	Expiration of the certification of a nonaccredited program
69.7(231C)	Recertification process for a nonaccredited program
69.8(231C)	Notification of recertification for a nonaccredited program
69.9(231C)	Certification or recertification of an accredited program—application process
69.10(231C)	Certification or recertification of an accredited program—application content
69.11(231C)	Initial certification process for an accredited program
69.12(231C)	Recertification process for an accredited program
69.13(231C)	Listing of all certified programs
69.14(231C)	Recognized accrediting entity
69.15(231C)	Requirements for an accredited program
69.16(231C)	Maintenance of program accreditation
69.17(231C)	Transfer of certification
69.18(231C)	Structural and life safety reviews of a building for a new program
69.19(231C)	Structural and life safety review prior to the remodeling of a building for a certified program
69.20(231C)	Cessation of program operation

69.21(231C)	Occupancy agreement
69.22(231C)	Evaluation of tenant
69.23(231C)	Criteria for admission and retention of tenants
69.24(231C)	Involuntary transfer from the program
69.25(231C)	Tenant documents
69.26(231C)	Service plans
69.27(231C)	Nurse review
69.28(231C)	Food service
69.29(231C)	Staffing
69.30(231C)	Dementia-specific education for program personnel
69.31(231C)	Managed risk policy and managed risk consensus agreements
69.32(231C)	Life safety—emergency policies and procedures and structural safety requirements
69.33(231C)	Transportation
69.34(231C)	Activities
69.35(231C)	Structural requirements
69.36(231C)	Dwelling units in dementia-specific programs
69.37(231C)	Landlord and tenant Act
69.38(83GA,SF203)	Identification of veteran's benefit eligibility

#### CHAPTER 70 ADULT DAY SERVICES

70.1(231D)	Definitions
70.2(231D)	Program certification
70.3(231D)	Certification of a nonaccredited program—application process
70.4(231D)	Nonaccredited program—application content
70.5(231D)	Initial certification process for a nonaccredited program
70.6(231D)	Expiration of the certification of a nonaccredited program
70.7(231D)	Recertification process for a nonaccredited program
70.8(231D)	Notification of recertification for a nonaccredited program
70.9(231D)	Certification or recertification of an accredited program—application process
70.10(231D)	Certification or recertification of an accredited program—application content
70.11(231D)	Initial certification process for an accredited program
70.12(231D)	Recertification process for an accredited program
70.13(231D)	Listing of all certified programs
70.14(231D)	Recognized accrediting entity
70.15(231D)	Requirements for an accredited program
70.16(231D)	Maintenance of program accreditation
70.17(231D)	Transfer of certification
70.18(231D)	Structural and life safety reviews of a building for a new program
70.19(231D)	Structural and life safety review prior to the remodeling of a building for a certified program
70.20(231D)	Cessation of program operation
70.21(231D)	Contractual agreement
70.22(231D)	Evaluation of participant
70.23(231D)	Criteria for admission and retention of participants
70.24(231D)	Involuntary discharge from the program
70.25(231D)	Participant documents
70.26(231D)	Service plans
70.27(231D)	Nurse review
70.28(231D)	Food service
70.29(231D)	Staffing
70.30(231D)	Dementia-specific education for program personnel

70.31(231D)	Managed risk policy and managed risk consensus agreements
70.32(231D)	Life safety—emergency policies and procedures and structural safety requirements
70.33(231D)	Transportation
70.34(231D)	Activities
70.35(231D)	Structural requirements
70.36(231D)	Identification of veteran’s benefit eligibility

## CHAPTER 71

Reserved

## CHAPTER 72

PUBLIC ASSISTANCE  
FRONT END INVESTIGATIONS

72.1(10A)	Definitions
72.2(10A)	Referrals
72.3(10A)	Investigation procedures
72.4(10A)	Findings

## CHAPTER 73

## MEDICAID FRAUD CONTROL BUREAU

73.1(10A)	Definitions
73.2(10A)	Complaints
73.3(10A)	Investigative procedures
73.4(10A)	Audit of clinical and fiscal records by the department
73.5(10A)	Who shall be reviewed, audited, or investigated
73.6(10A)	Auditing and investigative procedures
73.7(10A)	Actions based on audit or investigative findings
73.8(10A)	Confidentiality
73.9(10A)	Appeal by provider of care

## CHAPTER 74

## ECONOMIC ASSISTANCE FRAUD BUREAU

74.1(10A)	Definitions
74.2(10A)	Responsibilities
74.3(10A)	Procedures
74.4(10A)	Investigations
74.5(10A)	Executive branch investigations

## CHAPTER 75

## DIVESTITURE UNIT

## PREAMBLE

75.1(10A)	Definitions
75.2(10A)	Referral process
75.3(10A)	Referral review
75.4(10A)	Investigation
75.5(10A)	Organizing information
75.6(10A)	Computation of debt
75.7(10A)	Issuing notices
75.8(10A)	Conducting informal conferences
75.9(10A)	Failure to timely request hearing
75.10(10A)	District court hearing
75.11(10A)	Filing and docketing of the order
75.12(10A,22)	Confidentiality

## CHAPTERS 76 to 89

Reserved

## CHAPTER 90

## PUBLIC ASSISTANCE DEBT RECOVERY UNIT

90.1(10A)	Definitions
90.2(10A)	Recovery process
90.3(10A)	Records
90.4(10A)	Review
90.5(10A)	Debt repayment
90.6(10A)	Further collection action
90.7(10A)	Appeal rights
90.8(10A)	Data processing systems matches
90.9(10A)	Confidentiality

## CHAPTERS 91 to 99

Reserved

*GAMES OF SKILL, CHANCE, BINGO  
AND RAFFLES*

## CHAPTER 100

## ADMINISTRATION

100.1(10A,99B)	Definitions
100.2(99B)	Licensing
100.3(99B)	License requirements
100.4(99B)	Participation
100.5(99B)	Posted rules
100.6(99B)	Prizes
100.7(10A,99B)	Records
100.8(10A,99B)	Inspections
100.9(99B)	Reports
100.10(99B)	Extension of time to file quarterly report
100.11(10A,422)	State and local option sales tax
100.12(10A,17A,99B)	Appeal rights
100.13(99B)	Penalties
100.14 to 100.29	Reserved

## QUALIFIED ORGANIZATION

100.30(99B)	License requirements
100.31	Reserved
100.32(99B)	Raffles
100.33(99B)	Expenses
100.34(99B)	Nature and dedication of net receipts
100.35(99B)	Extension of time to dedicate net receipts
100.36(10A,22)	Confidentiality
100.37 to 100.49	Reserved

## RAFFLES CONDUCTED AT A FAIR

100.50(99B)	Raffles conducted at a fair
100.51(99B)	Raffle prizes at a fair
100.52(99B)	Exceptions for an annual raffle
100.53 to 100.79	Reserved

ANNUAL GAME NIGHT  
BINGO MANUFACTURERS AND DISTRIBUTORS

- 100.80(99B) Bingo manufacturers and distributors
- 100.81(99B) Bingo manufacturer and distributor licenses
- 100.82(99B) Bingo supplies and equipment

CHAPTER 101  
AMUSEMENT CONCESSIONS

- 101.1(99B) License requirements
- 101.2(99B) Prizes
- 101.3(99B) Conducting games
- 101.4(99B) Posted rules

CHAPTER 102  
SOCIAL GAMBLING

- 102.1(99B) License requirements
- 102.2(99B) Participation allowed
- 102.3(99B) Permissible games

CHAPTER 103  
BINGO

- 103.1(10A,99B) Definitions
- 103.2(10A,99B) License
- 103.3(99B) Bingo occasion
- 103.4(99B) Game of bingo
- 103.5(99B) State and house rules
- 103.6(99B) Prizes
- 103.7(10A,99B) Workers
- 103.8(99B) Expenses
- 103.9(99B) Location
- 103.10 Reserved
- 103.11(10A,725) Advertising
- 103.12(10A,99B) Equipment
- 103.13(99B) Records
- 103.14(10A,99B) Bingo checking account
- 103.15(10A,99B) Bingo savings account
- 103.16(10A,99B) Reports
- 103.17(10A,99B) Inspections and audits
- 103.18(10A,99B) Penalties

CHAPTER 104  
GENERAL PROVISIONS FOR ALL AMUSEMENT DEVICES

- 104.1(10A,99B) Definitions
- 104.2(99B) Device restrictions
- 104.3(99B) Prohibited games/devices
- 104.4(99B) Prizes
- 104.5(99B) Registration
- 104.6(99B) Violations

CHAPTER 105  
REGISTERED AMUSEMENT DEVICES

- 105.1(10A,99B) Definitions
- 105.2(99B) Registered amusement device restrictions
- 105.3(99B) Prohibited registered amusement devices

- 105.4(99B) Prizes
- 105.5(99B) Registration by a manufacturer, manufacturer's representative, distributor, or an owner that operates for profit
- 105.6(99B) Registration of registered amusement devices
- 105.7(99B) Violations
- 105.8(10A,99B) Appeal rights
- 105.9(10A,99B,82GA,SF510) Procedure for denial, revocation, or suspension of a registration
- 105.10(99B) Reports
- 105.11(99B) Criteria for approval or denial of a registration
- 105.12(10A,99B) Suspension or revocation of a registration

#### CHAPTER 106

##### CARD GAME TOURNAMENTS BY VETERANS ORGANIZATIONS

- 106.1(10A,99B) Definitions
- 106.2(99B) Licensing
- 106.3(99B) Card game tournament
- 106.4(99B) Required postings
- 106.5(99B) Prizes and cost to participate
- 106.6(99B) Restrictions
- 106.7(99B) Qualified expenses limitation
- 106.8(99B) Records
- 106.9(99B) State and local option sales tax
- 106.10(99B) Inspections
- 106.11(99B) Quarterly reports
- 106.12(99B) Penalties
- 106.13(99B) Revocation, suspension, or denial of license

#### CHAPTER 107

##### GAME NIGHTS

- 107.1(10A,99B) Definitions
- 107.2(99B) Restrictions on game nights
- 107.3(99B) Applications
- 107.4(99B) Games
- 107.5(99B) Sponsors
- 107.6(99B) Reports and dedication of funds for qualified and eligible qualified organizations
- 107.7(422) State and local option sales tax



CHAPTER 56  
FINING AND CITATIONS  
[Prior to 7/15/87, Health Department[470] Ch 56]

**481—56.1(135C) Authority for citations.** Pursuant to the authority vested in the director of the department of inspections and appeals to issue citations and assess penalties for violations of the statutes or departmental rules relating to the health care facilities, the following rules indicate the method by which citations may be issued when a particular statute or departmental rule is violated by a facility.

**481—56.2(135C) Classification of violations—classes.** There are three classifications for violations of statutes or departmental rules which may result in the issuance of a citation by the director of inspections and appeals and the assessment of a penalty therefor.

**56.2(1) Class I.** A class I violation is one which presents an imminent danger or a substantial probability of resultant death or physical harm to the residents of the facility in which the violation occurs. A physical condition or one or more practices in a facility may constitute a class I violation;

**56.2(2) Class II.** A class II violation is one that has a direct or immediate relationship to the health, safety, or security of residents of a health care facility, but which presents no imminent danger nor substantial probability of death or physical harm to them. A physical condition or one or more practices within a facility, including either physical abuse of any resident or failure to treat any resident with consideration, respect, and full recognition of the resident's dignity and individuality, in violation of a specific rule adopted by the department, may constitute a class II violation;

**56.2(3) Class III.** A class III violation is one which is not classifiable in the department's rules nor classifiable under the criteria stated in those rules as a class I or class II violation.

**481—56.3(135C) Fines.** Citations which are issued by the director of the department of inspections and appeals for violations of the statutes or rules relating to health care facilities will subject the facility to the following penalties.

**56.3(1) Citation for a class I violation.** The penalty shall not be less than \$2,000 nor more than \$10,000. The penalty for a class I violation shall be doubled when the violation is due to an intentional act by the facility in violation of a provision of Iowa Code chapter 135C or a rule adopted pursuant thereto.

**56.3(2) Citation for a class II violation.** The penalty shall not be less than \$100 nor more than \$500. Using the criteria established in paragraph 56.3(2) "a," the director of the department of inspections and appeals may, upon written request, waive the penalty if the class II violation is corrected within the time specified in the citation. The director shall not waive penalties related to the items listed in subrule 56.3(4).

*a. Criteria for waiving the penalty for a class II violation.* The director shall consider the following criteria, among others, when deciding whether to grant a waiver of a class II penalty.

(1) The past history of the facility within the last 24 months of the violation as it relates to the nature of the violation;

(2) The rights of residents to make informed decisions with their doctor(s) and family/legal representative(s); and

(3) The financial hardship the fine will cause the facility.

*b. Process for requesting a waiver of the penalty for a class II violation.*

(1) A facility shall submit documentation that supports the waiver request.

(2) If the facility has requested a waiver based on financial hardship, the facility must provide proof of the hardship for the individual facility, along with the parent corporation, if any. Supporting documentation shall, at minimum, include the facility's, and the parent corporation's, if any, most recent profit and loss statement and balance sheet.

(3) Requests for a waiver shall be submitted within ten working days of receipt by the facility of the notice that the violation has been corrected.

(4) The department shall make a decision on the waiver request or request additional information, if necessary, within ten working days of receipt of a waiver request and shall notify the facility in writing of the department's determination by personal service, by electronic mail, or by certified mail. If additional information is requested, such information shall be provided by the facility within five working days. If additional information is necessary, the department shall make a decision on the waiver request within ten working days of receipt of the additional information requested by the department.

(5) If the waiver request is granted and the facility has paid the penalty, the facility shall be refunded the amount of the penalty paid that was subject to the approved waiver request.

*c. Denial of penalty waiver request for a class II violation.* The director's decision to deny a waiver request is not subject to appeal. The underlying citation or state statement of deficiencies is eligible for appeal.

**56.3(3)** *Citation for a class III violation.* No penalty shall be assessed for a class III violation except as provided in rule 481—56.5(135C).

**56.3(4)** *Self-identification and correction of a class II or class III violation prior to the on-site inspection.* If a facility self-identifies a deficient practice prior to the on-site visit inspection, there has been no complaint filed with the department related to that specific deficient practice, and the facility corrects such practice prior to an inspection, no citation shall be issued or fine assessed for class II or III violations except for those penalties arising pursuant to paragraphs "a" to "f":

*a. Abuse.*

- (1) Rule 481—57.39(135C);
- (2) Rule 481—58.43(135C);
- (3) 481—subrules 62.23(23) to 62.23(25);
- (4) Rule 481—63.37(135C);
- (5) Rule 481—64.33(235B);
- (6) Rule 481—65.15(135C);
- (7) 481—subrules 65.25(3) to 65.25(5); and
- (8) 42 CFR Section 483.420(d).

*b. Personnel histories.*

- (1) Iowa Code section 135C.33;
- (2) 481—subrule 57.12(3);
- (3) 481—subrule 58.11(3);
- (4) 481—subrule 62.9(5);
- (5) 481—subrule 63.11(3);
- (6) Rule 481—64.34(135C); and
- (7) 481—subrule 65.9(5).

*c. Failure to implement physician's orders as required.*

- (1) 481—paragraph 57.12(2) "d";
- (2) 481—paragraph 58.19(2) "h";
- (3) 481—paragraph 62.15(1) "a";
- (4) 481—paragraph 63.11(2) "d"; and
- (5) 42 CFR Section 483.460(c)(4).

*d. Failure to notify the physician of any accident, injury, or adverse change in a resident's condition.*

- (1) 481—subrule 57.15(5);
- (2) 481—subrule 58.14(5); and
- (3) 481—paragraph 62.19(2) "c."

*e. Failure to administer all medications as ordered by the resident's physician.*

- (1) 481—paragraph 57.12(2) "d";
- (2) 481—paragraph 58.19(2) "a";
- (3) 481—paragraph 63.11(2) "d";
- (4) 481—subrule 64.4(9); and
- (5) 42 CFR Section 483.460(c)(4).

*f.* Failure to meet the fire safety rules and regulations promulgated by the state fire marshal.

- (1) 481—paragraph 58.28(1) “a”;
- (2) 481—subrule 62.19(7);
- (3) 481—paragraph 63.23(1) “a”; and
- (4) 42 CFR Section 483.470(j).

*g.* Process for documenting self-identification. If, during the inspection, an area of concern is identified to the facility that was self-identified and corrected by the facility prior to the inspection, no complaint has been filed, and the violation does not fall in the exemptions listed in 481—paragraphs 56.3(4) “a” to “f,” the facility shall complete a “Self-Identification and Correction Form” and submit it to the inspector(s) prior to the conclusion of the inspection, or to the department within two working days of the exit interview via E-mail, facsimile, or overnight courier. The documentation shall include:

- (1) The nature of the problem;
- (2) The date the problem was identified;
- (3) Who identified the problem, i.e., family, resident, staff, physician, pharmacist;
- (4) Action steps taken to correct the problem;
- (5) Date the facility determined correction was completed; and
- (6) All documentation that substantiates the above information.

**56.3(5)** *State penalty dismissed if the corresponding federal deficiency or citation is dismissed or removed.* Any state penalty, including a fine or citation, issued as a result of a joint state and federal survey and certification process shall be dismissed if the corresponding federal deficiency or citation is dismissed or removed.

*a.* If the federal deficiency is dismissed or removed during the federal informal dispute resolution process, the department shall remove any corresponding state fine, citation or deficiency within 20 working days of issuance of the decision.

*b.* If the federal deficiency is dismissed or removed at the conclusion of the federal administrative hearing process, the facility shall submit to the department a copy of the decision, along with a written request for the removal of the corresponding state fine, citation, or deficiency.

**56.3(6)** *Reduction of fine amount by 35 percent.* If a facility has been assessed a penalty, does not request a formal hearing pursuant to Iowa Code section 135C.43 and rule 481—56.17(135C), or withdraws its request for a formal hearing within 30 days of the date that the penalty was assessed, and the penalty is paid within 30 days of receipt of notice or service, the amount of the civil penalty shall be reduced by 35 percent.

[ARC 8433B, IAB 12/30/09, effective 2/3/10]

**481—56.4(135C) Time for compliance.** Citations which are issued by the director of the department of inspections and appeals for violations of the statutes or rules related to health care facilities shall specify the length of time permitted for the violation to be abated or eliminated, as follows:

**56.4(1)** *Citation for a class I violation:* The violation shall be abated or eliminated immediately, unless the department determines that a stated period of time, specified in the citation, is required to correct the violation;

**56.4(2)** *Citation for a class II violation:* The violation shall be corrected within a stated period of time determined by the department and specified in the citation. The stated period of time specified in the citation may subsequently be modified by the department for good cause shown;

**56.4(3)** *Citation for a class III violation:* The violation shall be corrected within a reasonable time specified by the department in the citation.

**481—56.5(135C) Failure to correct a violation within the time specified—penalty.** Failure to correct any class of violation within the time specified in the citation, unless the licensee shows that the failure was due to circumstances beyond the licensee’s control, shall subject the facility to a further penalty of \$50 for each day that the violation continues after the time specified for correction.

**481—56.6(135C) Treble and double fines.**

**56.6(1) *Treble fines for repeated violations.*** The director of the department of inspections and appeals shall treble the penalties specified in rule 481—56.3(135C) for any second or subsequent class I or class II violation occurring within any 12-month period, if a citation was issued for the same class I or class II violation occurring within that period and a penalty was assessed therefor.

**56.6(2) *Double fines for intentional class I violations.*** The director of the department of inspections and appeals shall double the penalties specified in subrule 56.3(1) when the violation is due to an intentional act by the facility in violation of a provision of Iowa Code chapter 135C or rule adopted pursuant thereto.

*a.* For purposes of this subrule, “intentional” means doing an act voluntarily, not by mistake or accident, and doing the act with a specific purpose in mind.

*b.* The facts and circumstances surrounding the act shall be considered when determining whether the act was done intentionally.

*c.* It is assumed that a person intends the natural results of the person’s act(s).

[ARC 8433B, IAB 12/30/09, effective 2/3/10]

**481—56.7(135C) Notation of classes of violations.** All rules relating to health care facilities, other than those which are informational in character, shall be followed by a notation at the end of each rule, or pertinent part thereof. This notation shall consist of a Roman numeral or numerals in parentheses. These Roman numerals refer to the class (either class I, class II, or class III) of violation which may be cited by the commissioner when that rule, or part of a rule carrying the notation is violated by the facility.

**481—56.8(135C) Notation for more than one class of violation.** In those instances where a particular rule, or part of a rule is followed by a notation consisting of more than one Roman numeral in parentheses, at the discretion of the director of the department of inspections and appeals, the director may issue a citation for a violation of that rule, or part thereof, designating any one of the multiple classes of violations specified in the notation.

**481—56.9(135C) Factors determining selection of class of violation.** In determining which class of violation will be designated in the citation, where more than one class is specified in the notation following the rule, the director of the department of inspections and appeals shall consider evidence of the circumstances surrounding the violation, including, but not limited to, the following factors:

**56.9(1)** The frequency and length of time the violation occurred, i.e., whether the violation was an isolated or a widespread occurrence, practice, or condition;

**56.9(2)** The past history of the facility within 24 months of the violation as it relates to the nature of the violation;

**56.9(3)** The culpability of the facility as it relates to the reasons the violation occurred;

**56.9(4)** The extent of any harm to the residents or the effect on the health, safety, or security of the residents which resulted from the violation;

**56.9(5)** The relationship of the violation to any other types of violations which have occurred in the facility;

**56.9(6)** The actions of the facility after the occurrence of the violation, including when corrective measures, if any, were implemented and whether the facility notified the director as required;

**56.9(7)** The accuracy and extent of records kept by the facility which relate to the violation, and the availability of such records to the department;

**56.9(8)** The rights of residents to make informed decisions with their doctor(s) and family/legal representative(s); and

**56.9(9)** Whether the facility made a good-faith effort to address a high-risk resident’s specific needs, and whether the evidence substantiates this effort.

**481—56.10(135C) Factors determining imposition of citation and fine.** The director of the department of inspections and appeals may consider evidence of the circumstances surrounding the violation including, but not limited to, those factors set out in rule 481—56.9(135C) when:

1. Determining whether a violation will be subject to a fine or citation; and
2. Determining the monetary amount of the penalty to be specified in the citation, when such a fine is authorized to be levied for a particular class of violation.

**481—56.11(135C) Class I violation not specified in the rules.** The director of the department of inspections and appeals may issue a citation for a class I violation when a physical condition or one or more practices exist in a facility which are not in violation of a specific statute or rule, but which constitute an imminent danger or a substantial probability of resultant death or physical harm to the residents of the facility.

**481—56.12(135C) Class I violation as a result of multiple lesser violations.** The director of the department of inspections and appeals may issue a citation for a class I violation when a physical condition or one or more practices exist in a facility which are a result of multiple lesser violations of the statutes or rules, but which taken as a whole constitute an imminent danger or a substantial probability of resultant death or physical harm to the residents of the facility.

**481—56.13(135C) Form of citations.** Each citation issued by the director of the department of inspections and appeals shall contain the following information:

**56.13(1)** A description of the nature of the violation;

**56.13(2)** A statement of the Code section or subsection or the rule or standard violated. (In the case of class I violations as described in 481—56.11(135C), a statement of the specific physical condition or one or more practices may be made in lieu of this statement.);

**56.13(3)** A statement of the classification of the violation, as specified in 481—56.2(135C);

**56.13(4)** When appropriate, a statement of the period of time allowed for correction of the violation, which shall in each case be the shortest period of time the department deems feasible; and

**56.13(5)** A statement that the fine may be reduced by 35 percent pursuant to Iowa Code section 135C.43A and subrule 56.3(6).

[ARC 8433B, IAB 12/30/09, effective 2/3/10]

**481—56.14(135C) Licensee's response to a citation.** Within 20 business days after service of a citation, the facility shall respond in the following manner, according to the type of citation issued.

**56.14(1)** If the facility does not desire to seek an informal conference or contest the citation, the facility shall remit to the department of inspections and appeals the amount specified by the department of inspections and appeals in the citation unless:

*a.* The violation was issued in conjunction with a federal civil money penalty, and the department holds the fine issued pursuant to this chapter in abeyance pursuant to Iowa Code section 249A.19, or

*b.* The class II violation for which the penalty was imposed has been waived pursuant to subrule 56.3(2).

**56.14(2)** For each class II or class III violation, the facility shall send a written response to the department of inspections and appeals, acknowledging that the citation has been received and stating that the violation will be corrected within the specified period of time allowed by the citation.

**56.14(3) Informal conference.** If the facility desires to contest a citation for a class I, class II or class III violation, the facility shall notify the department of inspections and appeals in writing that it desires to contest such citation and request in writing an informal conference with an independent reviewer. The informal conference will be held concurrently with any informal dispute resolution held pursuant to 42 CFR Section 488.331 for those health care facilities certified under Medicare or the medical assistance program.

*a. Definition.* For purposes of this subrule, "independent reviewer" means an attorney licensed in the state of Iowa who is not currently and has not been employed by the department in the past eight years, or has not appeared in front of the department on behalf of a health care facility in the past eight years. Preference shall be given to an attorney with background knowledge, experience or training in long-term care.

*b. Request for informal conference.* The request for an informal conference must be in writing, addressed to the compliance officer and include the following:

- (1) Identification of the citation(s) being disputed;
- (2) The type of informal conference requested: face-to-face or telephone conference; and
- (3) A request for surveyor worksheets for the citation(s) being disputed, if desired.

*c. Submission of documentation.* Within the same ten-day period required for submission of a plan of correction pursuant to 481—subrule 50.10(7), the facility shall submit the following:

- (1) The names of those who will be attending the informal conference, including legal counsel; and
- (2) Documentation supporting the facility's position. The facility must highlight or use some other means to identify written information pertinent to the disputed deficiency(ies). Supporting documentation that is not submitted within the required time frame will not be considered, except as otherwise permitted by the independent reviewer upon good cause shown. "Good cause" means substantial or adequate grounds for failing to submit documentation in a timely manner. In determining whether the facility has shown good cause, the independent reviewer shall consider what circumstances kept the facility from submitting the supporting documentation within the required time frame.

*d. Face-to-face or telephone conference.* A face-to-face or telephone conference, if requested, will be scheduled to occur within ten business days of the receipt of the written request, all supporting documentation, and the plan of correction required by 481—subrule 50.10(7).

- (1) Failure to submit supporting documentation will not delay scheduling.
- (2) The conference will be scheduled for one hour to allow the facility to informally present information and explanation concerning the contested deficiencies. Due to the confidential nature of the conference, attendance may be limited.

(3) If additional information is requested during the informal conference, the facility will have two business days to deliver the additional materials to the department.

(4) When extenuating circumstances preclude a face-to-face conference, a telephone conference will be held or the facility may be given one opportunity to reschedule the face-to-face conference.

*e. Results.* The results of the informal conference will generally be sent within ten business days after the date of the informal conference, or within ten business days after the receipt of additional information, if requested.

(1) The independent reviewer may affirm or may modify or dismiss the citation. The independent reviewer shall state in writing the specific reasons for the affirmation, modification or dismissal of the citation.

(2) The department will issue an amended (changes in factual content) or corrected (changes in typographical/data errors) citation if changes result from the informal conference.

(3) The facility must submit to the department a new plan of correction for the amended or corrected citation within ten calendar days from the date of the letter conveying the results of the informal conference.

[ARC 8433B, IAB 12/30/09, effective 2/3/10; ARC 1047C, IAB 10/2/13, effective 1/1/14]

**481—56.15(135C) Procedure for facility after informal conference.** After the conclusion of an informal conference requested by the licensee and provided pursuant to 56.14(3):

**56.15(1)** If the facility does not desire to further contest an affirmed or modified citation for a class I, class II or class III violation, the facility shall, within five business days after the informal conference, or within five business days after receipt of the written decision and explanation of the independent reviewer, whichever occurs later, comply with the provisions of subrule 56.14(1).

**56.15(2)** If the facility does desire to further contest an affirmed or modified citation for a class I, class II or class III violation, the facility shall, within five business days after the informal conference, or within five business days after receipt of the written decision and explanation of the independent reviewer, whichever occurs later, notify the department of inspections and appeals in writing of the facility's intent to formally contest the citation.

[ARC 8433B, IAB 12/30/09, effective 2/3/10; ARC 1047C, IAB 10/2/13, effective 1/1/14]

**481—56.16(135C) Contesting a citation for a class I violation.** Rescinded IAB 12/30/09, effective 2/3/10.

**481—56.17(135C) Formal contest.** The procedures for contested cases, as set out in Iowa Code chapter 17A, and the rules adopted by the department of inspections and appeals shall be followed in all cases where proper notice has been made to the department of inspections and appeals of the intent to formally contest any citation.

These rules are intended to implement Iowa Code chapters 10A and 135C.

[Filed 8/6/76, Notice 4/19/76—published 8/23/76, effective 9/27/76]<sup>1</sup>

[Filed emergency 7/1/86—published 7/16/86, effective 7/1/86]<sup>2</sup>

[Filed emergency 9/19/86—published 10/8/86, effective 9/19/86]

[Filed emergency 6/25/87—published 7/15/87, effective 7/1/87]

[Filed 3/14/91, Notice 9/19/90—published 4/3/91, effective 5/8/91]

[Filed 7/11/97, Notice 4/23/97—published 7/30/97, effective 9/3/97]

[Filed 7/24/08, Notice 4/9/08—published 8/13/08, effective 9/17/08]

[Filed ARC 8433B (Notice ARC 8190B, IAB 10/7/09), IAB 12/30/09, effective 2/3/10]

[Filed ARC 1047C (Notice ARC 0922C, IAB 8/7/13), IAB 10/2/13, effective 1/1/14]

<sup>1</sup> Effective date of Ch 56 delayed by the Administrative Rules Review Committee until 12/6/76, pursuant to Iowa Code section 17A.4 as amended by 66 GA, SF 1288, section 2, to allow further time to study and examine the rules.

<sup>2</sup> See IAB Inspections and Appeals Department.



CHAPTER 57  
RESIDENTIAL CARE FACILITIES  
[Prior to 7/15/87, Health Department[470] Ch 57]

**481—57.1(135C) Definitions.** For the purpose of these rules, the following terms shall have the meaning indicated in this chapter. The definitions set out in Iowa Code section 135C.1 shall be considered to be incorporated verbatim in the rules. The use of the words “shall” and “must” indicate those standards are mandatory. The use of the words “should” and “could” indicate those standards are recommended.

**57.1(1)** “*Accommodation*” means the provision of lodging, including sleeping, dining, and living areas.

**57.1(2)** “*Administrator*” means a person approved and certified by the department who administers, manages, supervises, and is in general administrative charge of a residential care facility, whether or not such individual has an ownership interest in such facility, and whether or not the functions and duties are shared with one or more individuals.

**57.1(3)** “*Alcoholic*” means a person in a state of dependency resulting from excessive or prolonged consumption of alcoholic beverages as defined in Iowa Code section 125.2.

**57.1(4)** “*Ambulatory*” means the condition of a person who immediately and without aid of another is physically and mentally capable of traveling a normal path to safety, including the ascent and descent of stairs.

**57.1(5)** “*Basement*” means that part of a building where the finish floor is more than 30 inches below the finish grade of the building.

**57.1(6)** “*Board*” means the regular provision of meals.

**57.1(7)** “*Communicable disease*” means a disease caused by the presence of viruses or microbial agents within a person’s body, which agents may be transmitted either directly or indirectly to other persons.

**57.1(8)** “*Department*” means the state department of inspections and appeals.

**57.1(9)** “*Distinct part*” means a clearly identifiable area or section within a health care facility, consisting of at least a residential unit, wing, floor, or building containing contiguous rooms.

**57.1(10)** “*Drug addiction*” means a state of dependency, as medically determined, resulting from excessive or prolonged use of drugs as defined in Iowa Code chapter 204.

**57.1(11)** “*Medication*” means any drug including over-the-counter substances ordered and administered under the direction of the physician.

**57.1(12)** “*Nonambulatory*” means the condition of a person who immediately and without aid of another is not physically and mentally capable of traveling a normal path to safety, including the ascent and descent of stairs.

**57.1(13)** “*Personal care*” means assistance with the activities of daily living which the recipient can perform only with difficulty. Examples are help in getting in and out of bed, assistance with personal hygiene and bathing, help with dressing and feeding, and supervision over medications which can be self-administered.

**57.1(14)** “*Program of care*” means all services being provided for a resident in a health care facility.

**57.1(15)** “*Qualified intellectual disabilities professional*” means a psychologist, physician, registered nurse, educator, social worker, physical or occupational therapist, speech therapist or audiologist who meets the educational requirements for the profession, as required in the state of Iowa, and having one year’s experience working with persons with an intellectual disability.

**57.1(16)** “*Rate*” means that daily fee charged for all residents equally and shall include the cost of all minimum services required in these rules and regulations.

**57.1(17)** “*Responsible party*” means the person who signs or cosigns the admission agreement required in 481—57.14(135C) or the resident’s guardian or conservator if one has been appointed. In the event that a resident has neither a guardian, conservator nor person who signed or cosigned the resident’s admission agreement, the term “responsible party” shall include the resident’s sponsoring agency, e.g., the department of social services, veteran’s administration, religious groups, fraternal

organizations, or foundations that assume responsibility and advocate for their client patients and pay for their health care.

**57.1(18)** “*Restraints*” means the measures taken to control a resident’s physical activity for the resident’s own protection or for the protection of others.

[ARC 0766C, IAB 5/29/13, effective 7/3/13]

**481—57.2(135C) Variances.** Variances from these rules may be granted by the director of the department of inspections and appeals for good and sufficient reason when the need for variance has been established; no danger to the health, safety, or welfare of any resident results; alternate means are employed or compensating circumstances exist and the variance will apply only to an individual residential care facility. Variances will be reviewed at the discretion of the director of the department of inspections and appeals.

**57.2(1)** To request a variance, the licensee must:

- a. Apply for variance in writing on a form provided by the department of inspections and appeals;
- b. Cite the rule or rules from which a variance is desired;
- c. State why compliance with the rule or rules cannot be accomplished;
- d. Explain alternate arrangements or compensating circumstances which justify the variance;
- e. Demonstrate that the requested variance will not endanger the health, safety, or welfare of any resident.

**57.2(2)** Upon receipt of a request for variance, the director of the department of inspections and appeals will:

- a. Examine the rule from which variance is requested to determine that the request is necessary and reasonable;
- b. If the request meets the above criteria, evaluate the alternate arrangements of compensating circumstances against the requirement of the rules;
- c. Examine the effect of the requested variance on the health, safety, or welfare of the residents;
- d. Consult with the applicant if additional information is required.

**57.2(3)** Based upon these studies, approval of the variance will be either granted or denied within 120 days of receipt.

**481—57.3(135C) Application for licensure.**

**57.3(1)** Initial application and licensing. In order to obtain an initial residential care facility license for a residential care facility which is currently licensed the applicant must:

- a. Meet all of the rules, regulations, and standards contained in 481—Chapters 57 and 60;
- b. Submit a letter of intent and a written résumé of the resident care program and other services provided for departmental review and approval;
- c. Make application at least 30 days prior to the change of ownership of the facility on forms provided by the department;
- d. Submit a floor plan of each floor of the facility drawn on 8½- × 11-inch paper showing room areas in proportion, room dimensions, room numbers for all rooms, including bathrooms, and designation of the use to which room will be put and window and door location;
- e. Submit a photograph of the front and side elevation of the facility;
- f. Submit the statutory fee for a residential care facility license;
- g. Comply with all other local statutes and ordinances in existence at the time of licensure;
- h. Have a certificate signed by the state fire marshal or deputy state fire marshal as to compliance with fire safety rules and regulations.

**57.3(2)** In order to obtain an initial residential care facility license for a facility not currently licensed as a residential care facility, the applicant must:

- a. Meet all of the rules, regulations, and standards contained in 481—Chapters 57 and 60. Exceptions noted in 481—subrule 60.3(2) shall not apply;
- b. Submit a letter of intent and a written résumé of the resident care program and other services provided for departmental review and approval;

- c. Make application at least 30 days prior to the proposed opening date of the facility on forms provided by the department;
- d. Submit a floor plan of each floor of the residential care facility, drawn on 8½- × 11-inch paper showing room areas in proportion, room dimensions, room numbers for all rooms, including bathrooms, and designation of the use to which room will be put and window and door locations;
- e. Submit a photograph of the front and side of the residential care facility;
- f. Submit the statutory fee for a residential care facility license;
- g. Comply with all other local statutes and ordinances in existence at the time of licensure;
- h. Have a certificate signed by the state fire marshal or deputy state fire marshal as to compliance with fire safety rules and regulations.

**57.3(3) Renewal application.** In order to obtain a renewal of the residential care facility license, the applicant must:

- a. Submit the completed application form 30 days prior to annual license renewal date of residential care facility license;
- b. Submit the statutory license fee for a residential care facility with the application for renewal;
- c. Have an approved current certificate signed by the state fire marshal or deputy state fire marshal as to compliance with fire safety rules and regulations;
- d. Submit appropriate changes in the résumé to reflect any changes in the resident care program or other services.

**57.3(4) Licenses are issued to the person or governmental unit which has responsibility for the operation of the facility and authority to comply with all applicable statutes, rules or regulations.**

The person or governmental unit must be the owner of the facility or, if the facility is leased, the lessee.

**481—57.4(135C) Special categories.** Special variations and considerations may be granted a residential care facility which is operated for people who have special problems such as intellectual disabilities, physical disabilities, have a physical or mental disability or a condition in common which can best be treated in a specialized environment under an approved program of care commensurate with the needs of the residents of the facility. Criteria for these specialized programs shall be established by the department based on the résumé of programs and services furnished by the facility and the numbers and qualifications of the administrator and staff providing these services in the facility.

**57.4(1)** Such a facility shall be provided with the kind of equipment, numbers of qualified staff, and operated in such fashion as to meet the requirements of the department.

**57.4(2)** On approval of the department, the state fire marshal, the department of human services, or other appropriate agencies, other variations from the established rules and regulations and standards for a licensed health care facility of that category may be made as is necessary to successfully implement the specialized program, providing that it does not endanger the health, safety, or welfare of any resident and that alternate means to effect the same degree of protection shall be used when such variances are permitted.

[ARC 0766C, IAB 5/29/13, effective 7/3/13]

**481—57.5(135C) General requirements.**

**57.5(1)** The license shall be displayed in a conspicuous place in the facility which is viewed by the public. (III)

**57.5(2)** The license shall be valid only in the possession of the licensee to whom it is issued.

**57.5(3)** The posted license shall accurately reflect the current status of the residential care facility. (III)

**57.5(4)** Licenses expire one year after the date of issuance or as indicated on the license.

**57.5(5)** Each citation or a copy of each citation issued by the department for a class I or class II violation shall be prominently posted by the facility in plain view of the residents, visitors, and persons inquiring about placement in the facility. The citation or copy of the citation shall remain posted until the violation is corrected to the satisfaction of the department. (III)

**481—57.6(135C) Notifications required by the department.** The department shall be notified:

**57.6(1)** Within 48 hours, by letter, of any reduction or loss of personal care or dietary staff lasting more than seven days which places the staffing ratio below that required for licensing. No additional residents may be admitted until the minimum staffing requirements are achieved; (III)

**57.6(2)** Of any proposed change in the residential care facility's functional operation or addition or deletion of required services; (III)

**57.6(3)** Thirty days before addition, alteration, or new construction is begun in the residential care facility or on the premises; (III)

**57.6(4)** Thirty days in advance of closure of the residential care facility; (III)

**57.6(5)** Within two weeks of any change in administrator; (III)

**57.6(6)** When any change in the category of license is sought; (III)

**57.6(7)** Prior to the purchase, transfer, assignment, or lease of a residential care facility, the licensee shall:

*a.* Inform the department of the pending sale, transfer, assignment, or lease of the facility; (III)

*b.* Inform the department of the name and address of the prospective purchaser, transferee, assignee, or lessee at least 30 days before the sale, transfer, assignment, or lease if completed; (III)

*c.* Submit a written authorization to the department permitting the department to release all information of whatever kind from the department's files concerning the licensee's residential care facility to the named prospective purchaser, transferee, assignee, or lessee. (III)

**57.6(8)** Pursuant to the authorization submitted to the department by the licensee prior to the purchase, transfer, assignment, or lease of a residential care facility, the department shall upon request send or give copies of all recent licensure surveys and of any other pertinent information relating to the facility's licensure status to the prospective purchaser, transferee, assignee, or lessee; costs for such copies shall be paid by the prospective purchaser.

**481—57.7(135C) Witness fees.** Rescinded IAB 3/30/94, effective 5/4/94. See 481—subrule 50.6(4).

**481—57.8(135C) Licenses for distinct parts.**

**57.8(1)** Separate licenses may be issued for distinct parts of a health care facility which are clearly identifiable, containing contiguous rooms in a separate wing or building or on a separate floor of the facility and which provide care and services of separate categories.

**57.8(2)** The following requirements shall be met for a separate licensing of a distinct part:

*a.* The distinct part shall serve only residents who require the category of care and services immediately available to them within that part; (III)

*b.* The distinct part shall meet all the standards, rules, and regulations pertaining to the category for which a license is being sought;

*c.* The distinct part must be operationally and financially feasible;

*d.* A separate personal care staff with qualifications appropriate to the care and services being rendered must be regularly assigned and working in the distinct part under responsible management; (III)

*e.* Separately licensed distinct parts may have certain services such as management, building maintenance, laundry and dietary in common with each other.

**481—57.9(135C) Administrator.** Each residential care facility shall have one person in charge, duly approved by the department or acting in a provisional capacity in accordance with these regulations. (III)

**57.9(1)** The administrator shall be at least 18 years of age and shall have a high school diploma or equivalent. (III) In addition, this person shall meet at least one of the following conditions:

*a.* Be a licensed nursing home administrator; or (III)

*b.* Have completed a one-year educational training program approved by the department for residential care facility administrators; or (III)

*c.* Have two years of supervised experience in a residential care facility, at least six months of which was in an administrative capacity. (III)

**57.9(2)** The administrator may act as an administrator for not more than two residential care facilities. (II)

*a.* The distance between the two facilities shall be no greater than 50 miles. (II)

*b.* The administrator shall spend the equivalent of three full eight-hour days per week in each facility. (II)

*c.* The administrator may be responsible for no more than 150 beds in total if the administrator is an administrator of more than one facility. (II)

**57.9(3)** The licensee may be the approved administrator providing the licensee meets the requirements set forth in these regulations and devotes the required time to administrative duties. Residency in the facility does not in itself meet the requirement. (III)

**57.9(4)** A provisional administrator may be appointed on a temporary basis by the residential care facility licensee to assume the administrative responsibilities for a residential care facility for a period not to exceed six months when, through no fault of its own, the home has lost its administrator and has not been able to replace the administrator provided the department has been notified prior to the date of the administrator's appointment. (III)

**57.9(5)** In the absence of the administrator, a responsible person shall be designated in writing to the department to be in charge of the facility. (III) The person designated shall:

*a.* Be knowledgeable of the operation of the facility; (III)

*b.* Have access to records concerned with the operation of the facility; (III)

*c.* Be capable of carrying out administrative duties and of assuming administrative responsibilities; (III)

*d.* Be at least 18 years of age; (III)

*e.* Be empowered to act on behalf of the licensee during the administrator's absence concerning the health, safety, and welfare of the residents; (III)

*f.* Have had training to carry out assignments and take care of emergencies and sudden illnesses of residents. (III)

**57.9(6)** An administrator of only one facility shall be considered as a full-time employee. Full-time employment is defined as 40 hours per week. (III)

#### **481—57.10(135C) Administration.**

**57.10(1)** The licensee shall:

*a.* Assume the responsibility for the overall operation of the residential care facility; (III)

*b.* Be responsible for compliance with all applicable laws and with the rules of the department; (III)

*c.* Establish written policies, which shall be available for review, for the operation of the residential care facility. (III)

**57.10(2)** The administrator shall:

*a.* Be responsible for the selection and direction of competent personnel who provide services for the resident care program; (III)

*b.* Be responsible for the arrangement for all department heads to annually attend a minimum of ten contact hours of educational programs to increase skills and knowledge needed for the position; (III)

*c.* Be responsible for a monthly in-service educational program for all employees and to maintain records of programs and participants; (III)

*d.* Make available the residential care facility payroll records for departmental review as needed. (III)

#### **481—57.11(135C) General policies.**

**57.11(1)** There shall be written personnel policies in facilities of more than 15 beds to include hours of work and attendance at educational programs. (III)

**57.11(2)** There shall be a written job description developed for each category of worker in facilities of more than 15 beds. The job description shall include title of job, job summary, age range, qualifications (formal education and experience), skills needed, physical requirements, and responsibilities. (III)

**57.11(3)** There shall be written personnel policies for each facility. Personnel policies shall include the following requirements:

- a. Employees shall have a physical examination before employment. (I, II, III)
- b. Employees shall have a physical examination at least every four years. (I, II, III)
- c. Screening and testing for tuberculosis shall be conducted pursuant to 481—Chapter 59. (I, II, III)

**57.11(4)** Health certificates for all employees shall be available for review. (III)

**57.11(5)** Rescinded IAB 10/19/88, effective 11/23/88.

**57.11(6)** There shall be written policies for emergency medical care for employees and residents in case of sudden illness or accident, which includes the individuals to be contacted in case of emergency. (III)

**57.11(7)** The facility shall have a written agreement with a hospital for the timely admission of a resident who, in the opinion of the attending physician, requires hospitalization. (III)

**57.11(8)** The residential care facility shall have established policies concerning the control, investigation, and prevention of infections within the facility. (III)

**57.11(9)** Each facility licensed as a residential care facility shall provide an organized continuous 24-hour program of care commensurate with the needs of the residents of the home and under the direction of an administrator whose combined training and supervisory experience is such as to ensure adequate and competent care. (III)

**57.11(10)** Prior to the removal of a deceased resident/patient from a facility, the funeral director or person responsible for transporting the body shall be notified by the facility staff of any special precautions that were followed by the facility having to do with the mode of transmission of a known or suspected communicable disease. (III)

**57.11(11)** Each facility shall have a written and implemented infection control program addressing the following:

a. Techniques for hand washing consistent with Guidelines for Handwashing and Hospital Control, 1985, Centers for Disease Control, U.S. Department of Health and Human Services, PB85-923404; (I, II, III)

b. Techniques for handling of blood, body fluids, and body wastes consistent with Guideline for Isolation Precautions in Hospitals, Centers for Disease Control, U.S. Department of Health and Human Services, PB96-138102; (I, II, III)

c. Dressings, soaks, or packs; (I, II, III)

d. Infection identification; (I, II, III)

e. Resident care procedures to be used when there is an infection present consistent with Guideline for Isolation Precautions in Hospitals, Centers for Disease Control, U.S. Department of Health and Human Services, PB96-138102; (I, II, III)

f. Sanitation techniques for resident care equipment; (I, II, III)

g. Techniques for sanitary use and reuse of feeding syringes and single-resident use and reuse of urine collection bags; (I, II, III)

h. Techniques for use and disposal of needles, syringes, and other sharp instruments consistent with Guideline for Isolation Precautions in Hospitals, Centers for Disease Control, U.S. Department of Health and Human Services, PB96-138102; (I, II, III)

CDC Guidelines may be obtained from the U.S. Department of Commerce, Technology Administration, National Technical Information Service, 5285 Port Royal Rd., Springfield, Virginia 22161 (1-800-553-6847).

**57.11(12)** Aseptic techniques. If a resident needs any of the treatment or devices on the list below, written and implemented procedures regarding aseptic techniques shall be followed.

- a. Intravenous or central line catheter consistent with Guideline for Prevention of Intravascular Device Related Infections, Centers for Disease Control, U.S. Department of Health and Human Services, PB97-130074, (I, II, III)
- b. Urinary catheter, (I, II, III)
- c. Respiratory suction, oxygen or humidification, (I, II, III)
- d. Decubitus care, (I, II, III)
- e. Tracheostomy, (I, II, III)
- f. Nasogastric or gastrostomy tubes, (I, II, III)
- g. Sanitary use and reuse of feeding syringes and single-resident use and reuse of urine collection bags. (I, II, III)

[ARC 0663C, IAB 4/3/13, effective 5/8/13]

#### **481—57.12(135C) Personnel.**

##### **57.12(1) General qualifications.**

- a. No person with a current record of habitual alcohol intoxication or addiction to the use of drugs shall serve in a managerial role of a residential care facility. (II)
- b. No person under the influence of alcohol or intoxicating drugs shall be permitted to provide services in a residential care facility. (II)
- c. No person shall be allowed to provide services in a facility if the person has a disease;
  - (1) Which is transmissible through required workplace contact, (I, II, III)
  - (2) Which presents a significant risk of infecting others, (I, II, III)
  - (3) Which presents a substantial possibility of harming others, and (I, II, III)
  - (4) For which no reasonable accommodation can eliminate the risk. (I, II, III)

Refer to Guidelines for Infection Control in Hospital Personnel, Centers for Disease Control, U.S. Department of Health and Human Services, PB85-923402 to determine (1), (2), (3) and (4).

- d. Reserved.
- e. Individuals with either physical or mental disabilities may be employed for specific duties, but only if that disability is unrelated to that individual's ability to perform the duties of the job. (III)

##### **57.12(2) Supervision and staffing.**

- a. Staffing.
  - (1) In a facility that is licensed for more than one level of care, where the facility consists of a single building or of contiguous buildings, the department shall establish on an individual facility basis the numbers and qualifications of the staff required in a residential care facility, based on the needs of the residents in that facility.
  - (2) In a facility licensed only for residential care the facility shall provide the following minimum staffing ratios of personal care staff:
    - Days—1:25 or less (II, III)
    - Evenings—1:35 or less (II, III)
    - Nights—1:45 or less (II, III)
 Additional staffing above the minimum ratio may be required by the department commensurate with the needs of individual residents.
- b. Personnel in a residential care facility shall provide 24-hour coverage for residential care services. Personnel shall be up and dressed at all times in facilities over 15 beds. (II, III)
- c. Direct care staff shall be present in the facility unless all residents are involved in activities away from the facility. (II, III)
- d. Physician's orders shall be implemented by qualified personnel. (II, III)

**57.12(3) Employee criminal record checks, child abuse checks and dependent adult abuse checks and employment of individuals who have committed a crime or have a founded abuse.** The facility shall comply with the requirements found in Iowa Code section 135C.33 as amended by 2013 Iowa Acts, Senate File 347, and rule 481—50.9(135C) related to completion of criminal record checks, child abuse

checks, and dependent adult abuse checks and to employment of individuals who have committed a crime or have a founded abuse. (I, II, III)  
[ARC 0903C, IAB 8/7/13, effective 9/11/13]

**481—57.13(135C) Admission, transfer, and discharge.**

**57.13(1) General admission policies.**

a. No resident shall be admitted to or retained in a residential care facility who is in need of greater services than the facility can provide. (II, III)

b. No residential care facility shall admit more residents than the number of beds for which it is licensed. (II, III)

c. There shall be no more beds erected than is stipulated on the license. (II, III)

d. There shall be no more beds erected in a room than its size and other characteristics will permit. (II, III)

e. The admission of a resident to a residential care facility shall not give the facility or any employee of the facility the right to manage, use, or dispose of any property of the resident except with the written authorization of the resident or the resident's legal representative. (III)

f. The admission of a resident shall not grant the residential care facility the authority or responsibility to manage the personal affairs of the resident except as may be necessary for the safety of the resident and safe and orderly management of the residential care facility as required by these rules. (III)

g. A residential care facility shall provide for the safekeeping of personal effects, funds, and other property of its residents. The facility may require that items of exceptional value or which would convey unreasonable responsibilities to the licensee be removed from the premises of the facility for safekeeping. (III)

h. Rescinded, effective 7/14/82.

i. Funds or properties received by the residential care facility, belonging to or due a resident, expendable for the resident's account, shall be trust funds. (III)

j. Infants and children under the age of 16 shall not be admitted to health care facilities for adults unless given prior written approval by the department. A distinct part of a health care facility, segregated from the adult section, may be established based on a program of care submitted by the licensee or applicant which is commensurate with the needs of the residents of the health care facility and has received the department's review and approval. (III)

k. No health care facility, and no owner, administrator, employee or representative thereof shall act as guardian, trustee, or conservator for any resident's property, unless such resident is related to the person acting as guardian within the third degree of consanguinity. (III)

l. Upon the verified petition of the county board of supervisors, the district court may appoint the administrator of a county care facility as conservator or guardian or both of a resident of such county care facility. Such administrator shall serve as conservator or guardian or both without fee. The administrator may establish either separate or common bank accounts for cash funds of such resident wards. (III)

**57.13(2) Discharge or transfer.**

a. Prior notification shall be made to the next of kin, legal representative, attending physician, and sponsoring agency, if any, prior to transfer or discharge of any resident. (III)

b. Proper arrangements shall be made by the residential care facility for the welfare of the resident prior to the transfer or discharge in the event of an emergency or inability to reach the next of kin or legal representative. (III)

c. The licensee shall not refuse to discharge or transfer a resident when the physician, family, resident, or legal representative requests such transfer or discharge. (II, III)

d. Advance notification by telephone will be made to the receiving facility prior to the transfer of any resident. (III)

e. When a resident is transferred or discharged, the appropriate record as set forth in 57.16(1) will accompany the resident. (II, III)

*f.* Prior to the transfer or discharge of a resident to another health care facility, arrangements to provide for continuity of care shall be made with the facility to which the resident is being sent. (II, III)

**481—57.14(135C) Contracts.** Each contract shall:

**57.14(1)** State the base rate or scale per day or per month, the services included, and the method of payment; (III)

**57.14(2)** Contain a complete schedule of all offered services for which a fee may be charged in addition to the base rate. (III) Furthermore, the contract shall:

*a.* Stipulate that no further additional fees shall be charged for items not contained in complete schedule of services as set forth in subsection 2; (III)

*b.* State the method of payment of additional charges; (III)

*c.* Contain an explanation of the method of assessment of such additional charges and an explanation of the method of periodic reassessment, if any, resulting in changing such additional charges; (III)

*d.* State that additional fees may be charged to the resident for nonprescription drugs, other personal supplies, and services by a barber, beautician, etc. (III)

**57.14(3)** Contain an itemized list of those services, with the specific fee the resident will be charged and method of payment, as related to the resident's current condition, based on the program assessment at the time of admission, which is determined in consultation with the administrator; (III)

**57.14(4)** Include the total fee to be charged initially to the specific resident; (III)

**57.14(5)** State the conditions whereby the facility may make adjustments to its overall fees for resident care as a result of changing costs. (III) Furthermore, the contract shall provide that the facility shall give:

*a.* Written notification to the resident, or the responsible party when appropriate, of changes in the overall rates of both base and additional charges at least 30 days prior to the effective date of such changes; (III)

*b.* Notification to the resident, or responsible party when appropriate, of changes in additional charges, based on a change in the resident's condition. Notification must occur prior to the date such revised additional charges begin. If notification is given orally, subsequent written notification must be also given within a reasonable time, not to exceed one week, listing specifically the adjustments made. (III)

**57.14(6)** State the terms of agreement in regard to refund of all advance payments, in the event of transfer, death, voluntary, or involuntary discharge; (III)

**57.14(7)** State the terms of agreement concerning the holding and charging for a bed when a resident is hospitalized or leaves the facility temporarily for recreational or therapeutic reasons. The terms shall contain a provision that the bed will be held at the request of the resident or the resident's responsible party.

*a.* The facility shall ask the resident or responsible party if they want the bed held. This request shall be made before the resident leaves or within 48 hours after the resident leaves. The inquiry and the response shall be documented. (II)

*b.* The facility shall reserve the bed when requested for as long as payments are made in accordance with the contract. (II)

**57.14(8)** State the conditions under which the involuntary discharge or transfer of a resident would be effected; (III)

**57.14(9)** State the conditions of voluntary discharge or transfer; (III)

**57.14(10)** Set forth any other matters deemed appropriate by the parties to the contract. No contract or any provision thereof shall be drawn or construed so as to relieve any health care facility of any requirement or obligation imposed upon it by this chapter or any standards or rules in force pursuant to this chapter; (III)

**57.14(11)** Each party shall receive a copy of the signed contract. (III)

**481—57.15(135C) Physical examinations.**

**57.15(1)** Each resident in a residential care facility shall have a designated licensed physician, who may be called when needed. (III)

**57.15(2)** Each resident admitted to a residential care facility shall have had a physical examination prior to admission. (II, III)

*a.* If the resident is admitted directly from a hospital, a copy of the hospital admission physical and discharge summary may be a part of the record in lieu of an additional physical examination. A record of the examination, signed by the physician, shall be a part of the resident's record. (II, III)

*b.* The record of the admission physical examination and medical history shall portray the current medical status of the resident and shall include the resident's name, sex, age, medical history, physical examination, diagnosis, statement of chief complaints, and results of any diagnostic procedures. (II, III)

*c.* Screening and testing for tuberculosis shall be conducted pursuant to 481—Chapter 59. (I, II, III)

**57.15(3)** Arrangements shall be made to have a physician available to furnish medical care in case of emergency. (II, III)

**57.15(4)** Rescinded, effective 7/14/82.

**57.15(5)** The person in charge shall immediately notify the physician of any accident, injury, or adverse change in the resident's condition. (I, II, III)

**57.15(6)** Each resident shall be visited by or shall visit the resident's physician at least once each year. The year period shall be measured from the date of admission and is not to include preadmission physicals. Any required physician task or visit in a residential care facility may also be performed by an advanced registered nurse practitioner, clinical nurse specialist, or physician assistant who is working in collaboration with the physician. (III)

**57.15(7)** Residents shall be admitted to a residential care facility only on a written order signed by a physician certifying that the individual being admitted requires no more than personal care and supervision but does not require nursing care. (III)

This rule is intended to implement Iowa Code section 135C.23(2).  
[ARC 0663C, IAB 4/3/13, effective 5/8/13]

**481—57.16(135C) Records.**

**57.16(1)** *Resident record.* The licensee shall keep a permanent record on all residents admitted to a residential care facility with all entries current, dated, and signed. (III) The record shall include:

- a.* Name and previous address of resident; (III)
- b.* Birth date, sex, and marital status of resident; (III)
- c.* Church affiliation; (III)
- d.* Physician's name, telephone number, and address; (III)
- e.* Dentist's name, telephone number, and address; (III)
- f.* Name, address, and telephone number of next of kin or legal representative; (III)
- g.* Name, address, and telephone number of person to be notified in case of emergency; (III)
- h.* Mortician's name, telephone number, and address; (III)
- i.* Pharmacist's name, telephone number, and address; (III)
- j.* Physical examination and medical history; (III)
- k.* Certification by the physician that the resident requires no more than personal care and supervision, but does not require nursing care; (III)
- l.* Physician's orders for medication, treatments, and diet in writing and signed by the physician quarterly; (III)
- m.* A notation of yearly or other visits to physician or other professional services; (III)
- n.* Any change in the resident's condition; (II, III)
- o.* If the physician has certified that the resident is capable of taking prescribed medications, the resident shall be required to keep the administrator advised of current medications, treatments, and diet. The administrator shall keep a listing of medications, treatments, and diet prescribed by the physician for each resident; (III)

*p.* If the physician has certified that the resident is not capable of taking prescribed medication, it must be administered by a qualified person of the facility. A qualified person shall be defined as either a registered or licensed practical nurse or an individual who has completed the state-approved training course in medication administration; (II)

*q.* Medications administered by an employee of the facility shall be recorded on a medication record by the individual who administers the medication; (II, III)

*r.* A notation describing condition on admission, transfer, and discharge; (III)

*s.* In the event of a resident's death, notations in the resident's record shall include the date and time of the resident's death, the circumstances of the resident's death, the disposition of the resident's body, and the date and time that the resident's family and physician were notified of the resident's death; (III)

*t.* A copy of instructions given to the resident, legal representative, or facility in the event of discharge or transfer; (III)

*u.* Disposition of valuables. (III)

**57.16(2) Incident record.**

*a.* Each residential care facility shall maintain an incident record report and shall have available incident report forms. (III)

*b.* Report of incidents shall be in detail on a printed incident report form. (III)

*c.* The person in charge at the time of the incident shall oversee the preparation and sign the incident report. (III)

*d.* The report shall cover all accidents whether there is apparent injury or where hidden injury may have occurred. (III)

*e.* The report shall cover all accidents or unusual occurrences within the facility or on the premises affecting residents, visitors, or employees. (III)

*f.* A copy of the incident report shall be kept on file in the facility. (III)

**57.16(3) Retention of records.**

*a.* Records shall be retained in the facility for five years following termination of services. (III)

*b.* Records shall be retained within the facility upon change of ownership. (III)

*c.* Rescinded, effective 7/14/82.

*d.* When the facility ceases to operate, the resident's record shall be released to the facility to which the resident is transferred. If no transfer occurs, the record shall be released to the individual's physician. (III)

**57.16(4) Reports to the department.** The licensee shall furnish statistical information concerning the operation of the facility to the department on request. (III)

**57.16(5) Personnel record.**

*a.* An employment record shall be kept for each employee consisting of the following information: Name and address of employee, social security number of employee, date of birth of employee, date of employment, experience and education, references, position in the home, date and reason for discharge or resignation. (III)

*b.* The personnel records shall be made available for review upon request by the department. (III)

**481—57.17(135C) Resident care and personal services.**

**57.17(1)** Beds shall be made daily and adjusted as necessary. A complete change of linen shall be made at least once a week and more often if necessary. (III)

**57.17(2)** Residents shall receive sufficient supervision so that their personal cleanliness is maintained. (II, III)

**57.17(3)** Residents shall have clean clothing as needed to present a neat appearance, be free of odors, and to be comfortable. Clothing shall be appropriate to their activities and to the weather. (III)

**57.17(4)** Rescinded, effective 7/14/82.

**57.17(5)** Residents shall be encouraged to leave their rooms and make use of the recreational room or living room of the facility. (III)

**57.17(6)** Residents shall not be required to pass through another's bedroom to reach a bathroom, living room, dining room, corridor, or other common areas of the facility. (III)

**57.17(7)** Rescinded, effective 7/14/82.

**57.17(8)** Uncontrollable residents shall be transferred or discharged from the facility in accordance with contract arrangements and requirements of Iowa Code chapter 135C. (II, III)

**57.17(9)** Residents shall be required to bathe at least twice a week. (II, III)

**57.17(10)** Nonambulatory residents.

*a.* All nonambulatory residents shall be housed on the grade level floor. (II)

*b.* These provisions in paragraph "a" above relating to nonambulatory residents are not applicable if the facility has a suitably sized elevator.

**481—57.18** Rescinded, effective 7/14/82.

**481—57.19(135C) Drugs.**

**57.19(1)** *Drug storage.*

*a.* Residents who have been certified in writing by the physician as capable of taking their own medications, may retain these medications in their bedroom but locked storage must be provided. (III)

*b.* Drug storage for residents who are unable to take their own medications and require supervision shall meet the following requirements:

(1) A cabinet with a lock shall be provided which can be used for storage of drugs, solutions, and prescriptions; (III)

(2) A bathroom shall not be used for drug storage; (III)

(3) The drug storage cabinet shall be kept locked when not in use; (III)

(4) The drug storage cabinet key shall be in the possession of the employee charged with the responsibility of administering medications; (II)

(5) Schedule II drugs, as defined by Iowa Code chapter 204, shall be kept in a locked box within the locked medication cabinet; (II, III)

(6) Medications requiring refrigeration shall be kept in a refrigerator and separated from food and other items; (III)

(7) Drugs for external use shall be stored separately from drugs for internal use; (III)

(8) All potent, poisonous, or caustic materials shall be stored separately from drugs. They shall be plainly labeled and stored in a specific, well-illuminated cabinet, closet, or storeroom and made accessible only to authorized persons; (I, II)

(9) The drug cabinet shall have a work counter. Both the counter and cabinet shall be well-lighted; (III)

(10) Running water shall be available in the room in which the medicine cabinet is located or in an adjacent room; (III)

(11) Inspection of drug storage condition shall be made by the administrator and a registered pharmacist not less than once every three months. The inspection shall be verified by a report signed by the administrator and the pharmacist and filed with the administrator. The report shall include, but not be limited to, certifying absence of the following: expired drugs, deteriorated drugs, improper labeling, drugs for which there is no current physician's order, and drugs improperly stored. (III)

(12) Double-locked storage of Schedule II drugs shall not be required under single-unit package drug distribution systems in which the quantity stored does not exceed a three-day supply and a missing dose can be readily detected. (II)

*c.* Bulk supplies of prescription drugs shall not be kept in a residential care facility unless a licensed pharmacy is established in the facility under the direct supervision and control of a pharmacist. (III)

**57.19(2)** *Drug safeguards.*

*a.* All prescribed medications shall be clearly labeled indicating the resident's full name, physician's name, prescription number, name and strength of drug, dosage, directions for use, date of issue, and name and address and telephone number of pharmacy or physician issuing the drug.

Where unit dose is used, prescribed medications shall, as a minimum, indicate the resident's full name, physician's name, name and strength of drug, and directions for use. Standard containers shall be utilized for dispensing drugs. Paper envelopes shall not be considered standard containers. (III)

*b.* Medication containers having soiled, damaged, illegible, or makeshift labels shall be returned to the issuing pharmacist, pharmacy, or physician for relabeling or disposal. (III)

*c.* The medication for each resident shall be kept or stored in the original containers. (II, III)

*d.* When a resident is discharged or leaves the facility, the unused prescription shall be sent with the resident or with a legal representative only upon the written order of a physician. (III)

*e.* Unused prescription drugs prescribed for residents who have died shall be destroyed by the person in charge with a witness and notation made on the resident's record, or, if a unit dose system is used, such drugs shall be returned to the supplying pharmacist. (III)

*f.* Prescriptions shall be refilled only with the permission of the attending physician. (II, III)

*g.* No medications prescribed for one resident may be administered to or allowed in the possession of another resident. (II)

*h.* Instructions shall be requested of the Iowa board of pharmacy examiners concerning disposal of unused Schedule II drugs prescribed for residents who have died or for whom the Schedule II drug was discontinued. (III)

*i.* There shall be a formal routine for the proper disposal of discontinued medications within a reasonable but specified time. These medications shall not be retained with the resident's current medications. Discontinued drugs shall be destroyed by a responsible person with a witness and notation made to that effect or returned to the pharmacist for destruction or resident credit. Drugs listed under the Schedule II drugs shall be disposed of in accordance with the provisions of the Iowa board of pharmacy examiners. (II, III)

*j.* All medication orders which do not specifically indicate the number of doses to be administered or the length of time the drug is to be administered shall be stopped automatically after a given time period. The automatic stop order may vary for different types of drugs. The personal physician of the resident, in conjunction with the pharmacist, shall institute these policies and provide procedures for review and endorsement. (II, III)

*k.* No resident shall be allowed to keep possession of any medications unless the attending physician has certified in writing on the resident's medical record that the resident is mentally and physically capable of doing so. (II)

*l.* No medications or prescription drugs shall be administered to a resident without a written order signed by the attending physician. (II)

*m.* Each facility shall establish a policy in conjunction with a licensed pharmacist to govern distributing prescribed medication to residents who are on leave from a facility. (III)

(1) Medication may be issued to residents who will be on leave from a facility for less than 24 hours. Notwithstanding the prohibition against paper envelopes in 57.19(2) "a," non-child-resistant containers may be used. Each container may hold only one medication. A label on each container shall indicate the date, the resident's name, the facility, the medication, its strength, dose, and time of administration.

(2) Medication for residents on leave from a facility longer than 24 hours shall be obtained in accordance with requirements established by the Iowa board of pharmacy examiners.

(3) Medication distributed as above may be issued only by facility personnel responsible for administering medication.

**57.19(3) Drug administration.**

*a.* A properly trained person shall be charged with the responsibility of administering nonparenteral medications.

*b.* The individual shall have knowledge of the purpose of the drugs, their dangers, and contraindications.

*c.* This person shall be a licensed nurse or physician or shall have successfully completed a department-approved medication aide course or passed a department-approved medication aide challenge examination administered by an area community college.

*d.* Prior to taking a department-approved medication aide course, the individual shall:

(1) Successfully complete an approved residential aide course, nurse aide course, nurse aide training and testing program or nurse aide competency examination;

(2) Be employed in the same facility for at least six consecutive months prior to the start of the medication aide course. This requirement is not subject to waiver.

(3) Have a letter of recommendation for admission to the medication aide course from the employing facility.

*e.* A person who is a nursing student or a graduate nurse may take the challenge examination in place of taking a medication aide course. This individual shall do all of the following before taking the medication aide challenge examination:

(1) Complete a clinical or nursing theory course within six months before taking the challenge examination;

(2) Successfully complete a nursing program pharmacology course within one year before taking the challenge examination;

(3) Provide to the community college a written statement from the nursing program's pharmacology or clinical instructor indicating the individual is competent in medication administration.

*f.* A person who has written documentation of certification as a medication aide in another state may become a medication aide in Iowa by successfully completing a department-approved nurse aide competency examination and a medication aide challenge examination.

The requirements of paragraph "d" of this subrule do not apply to this individual.

*g.* Unless the unit dose system is used, the person assigned the responsibility of medication administration must complete the procedure by personally preparing the dose, observing the actual act of swallowing the oral medication, and charting the medication. (II) In facilities where the unit dose system is used, the person assigned the responsibility must complete the procedure by observing the actual act of swallowing the medication and charting the medication. Medications shall be prepared on the same shift of the same day that they are administered, (II) unless the unit dose system is used.

*h.* Injectable medications shall be administered as permitted by Iowa law by a qualified nurse, physician, pharmacist, or physician assistant (PA).

*i.* Residents certified by their physician as capable of injecting their own insulin may do so. Insulin may be administered pursuant to "h" above or as otherwise authorized by the resident's physician. Authorization by the physician shall:

(1) Be in writing,

(2) Be maintained in the resident's record,

(3) Be renewed quarterly,

(4) Include the name of the individual authorized to administer the insulin,

(5) Include documentation by the physician that the authorized person is qualified to administer insulin to that resident.

*j.* An individual inventory record shall be maintained for each Schedule II drug prescribed for each resident. (II)

*k.* The unit dose system may be used by the facility.

*l.* In a freestanding residential care facility licensed for 15 or fewer beds, a person who has successfully completed a state-approved medication manager course may administer medications.

[ARC 1050C, IAB 10/2/13, effective 11/6/13]

#### **481—57.20(135C) Dental services.**

**57.20(1)** The residential care facility personnel shall assist residents to obtain regular and emergency dental services. (III)

**57.20(2)** Transportation arrangements shall be made when necessary for the resident to be transported to the dentist's office. (III)

**57.20(3)** Dental services shall be performed only on the request of the resident, responsible relative, or legal representative. The resident's physician shall be advised of the resident's dental problems. (III)

**57.20(4)** All dental reports or progress notes shall be included in the clinical record. (III)

**57.20(5)** Personal care staff shall assist the resident in carrying out dentist's recommendations. (III)

**57.20(6)** Dentists shall be asked to participate in the in-service program of the facility. (III)

**481—57.21(135C) Dietary.**

**57.21(1) *Dietary staffing.***

*a.* In facilities licensed for over 15 beds, persons in charge of meal planning and food preparation shall complete the home study course on sanitation and food preparation offered by the department. (III)

*b.* In facilities licensed for over 15 beds, food service personnel shall be on duty during a 12-hour span extending from the preparation of breakfast through supper. (III)

*c.* There shall be written work schedules and time schedules covering each type of job in the food service department. These work and time schedules shall be posted or kept in a notebook which is available for use in the food service area in facilities over 15 beds. (III)

**57.21(2) *Nutrition and menu planning.***

*a.* Menus shall be planned and followed to meet nutritional needs of residents in accordance with the physician's orders. (II)

*b.* Menus shall be planned and served to include foods and amounts necessary to meet the recommended daily dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences. (II) Recommended daily dietary allowances are:

(1) Milk - two or more cups served as beverage or used in cooking;

(2) Meat group - two or more servings of meat, fish, poultry, eggs, cheese or equivalent; at least four to five ounces edible portion per day;

(3) Vegetable and fruit group - four or more servings (two cups). This shall include a citrus fruit or other fruit and vegetable important for vitamin C daily, a dark green or deep yellow vegetable for vitamin A at least every other day, and other fruits and vegetables, including potatoes;

(4) Bread and cereal group - four or more servings of whole-grain, enriched or restored;

(5) Foods other than those listed will usually be included to meet daily energy requirements (calories) to add to the total nutrients and variety of meals.

*c.* At least three meals or their equivalent shall be served daily, at regular hours. (II)

(1) There shall be no more than a 14-hour span between substantial evening meal and breakfast. (II, III)

(2) To the extent medically possible, bedtime nourishments shall be offered routinely to all residents. Special nourishments shall be available when ordered by physician. (II, III)

*d.* Menus shall include a variety of foods prepared in various ways. The same menu shall not be repeated on the same day of the following week. (III)

*e.* Menus shall be written at least one week in advance. The current menu shall be located in an accessible place in the dietetic service department for easy use by persons purchasing, preparing, and serving food. (III)

*f.* Records of menus as served shall be filed and maintained for 30 days and shall be available for review by departmental personnel. When substitutions are necessary, they shall be of similar nutritive value and recorded on the menu or in a notebook. (III)

*g.* A file of tested recipes adjusted to the number of people to be fed in the facility shall be maintained. (III)

**57.21(3) *Dietary storage, food preparation, and service.***

*a.* All food and drink shall be clean, wholesome, free from spoilage, and safe for human consumption. (II, III)

*b.* The use of foods from salvaged, damaged, or unlabeled containers shall be prohibited. (III)

*c.* All perishable or potentially hazardous food shall be stored at safe temperatures of 45°F (7°C) or below, or 140°F (60°C) or above. (III)

*d.* No perishable food shall be allowed to stand at room temperature any longer than is required to prepare and serve. (III)

*e.* Supplies of staple foods for a minimum of a one-week period and of perishable foods for a minimum of a two-day period shall be maintained on the premises. Minimum food portion requirements

for a low-cost plan shall conform to information supplied by the nutrition section of the department of health. (II, III)

*f.* Table service shall be attractive. Dishes shall be free of cracks, chips, and stains. (III)

*g.* If family-style service is used, all leftover prepared food that has been on the table shall be properly handled. (III)

*h.* Poisonous compounds shall not be kept in food storage or preparation areas. (II)

**57.21(4) Sanitation in food preparation area.**

*a.* "Food Service Sanitation Manual", revised 1976, U.S. Department of Health, Education, and Welfare, Public Health Service, U.S. Government Printing Office, Washington, D.C., shall be used as the established, nationally recognized reference for establishing and determining satisfactory compliance with food service sanitation.

*b.* Residents shall not be allowed in the food preparation area. (III)

*c.* In facilities licensed for over 15 beds, the kitchen shall not be used for serving meals to residents, food service personnel, or other staff. (III)

*d.* All foods, while being stored, prepared, displayed, served, or transported shall be protected against contamination from dust, flies, rodents, and other vermin. (II, III)

*e.* Food shall be protected from unclean utensils and worn surfaces, unnecessary handling, coughs and sneezes, flooding, drainage, and overhead leakage. (II, III)

*f.* All appliances and work areas shall be kept clean. (III)

*g.* There shall be written procedures established for cleaning all work and serving areas in facilities over 15 beds. (III)

*h.* A schedule for duties to be performed daily shall be posted in each food area. (III)

*i.* All cooking equipment in facilities of 15 or more beds shall be provided with a properly sized exhaust system and hood to eliminate excess heat, moisture, and odors from the kitchen. (III)

*j.* Spillage and breakage shall be cleaned up immediately. (III)

*k.* All garbage not mechanically disposed of shall be kept in nonabsorbent, cleanable containers pending disposal. All filled containers shall be covered and stored in a sanitary manner. (III)

*l.* The food service area shall be located so it will not be used as a passageway by residents, guests, or nonfood service staff. (III)

*m.* The walls, ceilings, and floors of all rooms in which food is prepared and served shall be in good repair, smooth, washable, and shall be kept clean. (III)

*n.* There shall be no washing, ironing, sorting or folding of laundry in the food service area. Dirty linen shall not be carried through the food service area unless it is in sealed, leakproof containers. (III)

*o.* Ice shall be stored and handled in such a manner as to prevent contamination. Ice scoops should be sanitized daily and kept in a clean container. (III)

*p.* There shall be no animals or birds in the food preparation area. (III)

*q.* No dishes or cooking utensils shall be towel dried. (III)

*r.* In facilities over 15 beds, a mechanical dishwasher is required. (III)

*s.* If there is a dishwashing machine, it must provide a wash temperature of 140°F (60°C) to 160°F (71°C) and a rinse temperature of 170°F (76°C) to 180°F (82°C). In a freestanding residential care facility licensed for 15 or fewer beds, a wash and rinse temperature of 140°F (60°C) to 160°F (71°C) shall be acceptable. (III)

*t.* A three-compartment pot and pan sink with 110°F (43°C) to 115°F (46°C) water for washing, a compartment for rinsing with water at 170°F (76°C) to 180°F (82°C) for sanitizing with space for air drying, or a two-compartment sink with access to a mechanical dishwasher for sanitizing all utensils shall be provided. (III)

*u.* All dishes, silverware, and cooking utensils shall be stored above the floor in a sanitary manner, in a clean, dry place protected from flies, splashes, dust, and other contaminants. (III)

*v.* Procedures for washing and handling dishes shall be followed in order to protect the welfare of the residents and employees. Persons handling dirty dishes shall not handle clean dishes without washing their hands. (III)

w. Dishes, silverware, and cooking utensils shall be properly cleaned by prerinsing or scraping, washing, sanitizing, and air-drying. (III)

**57.21(5) Hygiene of food service personnel.**

a. Food service personnel shall be free of communicable diseases and practice hygienic food-handling techniques. In the event food service employees are assigned duties outside the dietetic service, these duties shall not interfere with sanitation, safety, or time required for dietetic work assignments. Personnel recovering from a diagnosed intestinal infection shall submit a report from their physician showing freedom from infection before returning to work in the food service department. (II, III)

b. Employees shall wear clean, washable uniforms that are not used for duties outside the food service area. (III)

c. Hairnets shall be worn by all food service personnel. Individuals with beards shall provide for total enclosure of facial hair. (III)

d. Clean aprons and hairnets shall be available for use by other personnel in emergency situations. (III)

e. Persons handling food shall be knowledgeable of good hand-washing techniques. A hand-wash sink shall be provided in or adjacent to the food service area. Continuous on-the-job training on sanitation shall be encouraged. (III)

f. The use of tobacco shall be prohibited in the kitchen. (III)

**57.21(6) Food and drink.** All food and drink consumed within the facility shall be clean and wholesome and comply with local ordinances and applicable provisions of state and federal laws. (II, III)

**481—57.22(135C) Service plan.**

**57.22(1)** Prior to admission of a resident, the administrator or the administrator's designee shall develop a written and organized orientation plan. The plan shall be designed to assist the resident in adapting to the facility and to assist the facility staff in becoming knowledgeable of the resident and the resident's needs. (III)

**57.22(2)** Within 30 days of admission, the administrator or the administrator's designee shall, in conjunction with the resident, other facility staff or any organization that works with or serves the resident, develop a written, individualized, and integrated program of ongoing services for the resident. (III)

a. The program shall be planned and implemented to address the resident's priorities and assessed needs, such as living, rehabilitation, activity, behavioral, emotional, mental health and social, and shall take into consideration the resident's personal goals and preferences, including the resident's preferred living situation. (III)

b. The service plan shall include specific goals and objectives with regular documentation of each. (III)

c. The service plan shall be reviewed at least quarterly, or more often as necessary. (III)

**57.22(3)** Communications related to service plan changes or changes in the resident's condition shall occur within five working days of the change, and shall be conveyed to all individuals inside and outside the residential care facility who work with the resident, as well as to the resident's family members or responsible party. (III)

**481—57.23(135C) Resident activities program.**

**57.23(1)** Each residential care facility shall provide an organized resident activity program for the group and for the individual resident which shall include suitable activities for evenings and weekends. (III)

a. The activity program shall be designed to meet the needs and interests of each resident and to assist residents in continuing normal activities within limitations set by the resident's physician. This shall include helping residents continue in their individual interests or hobbies. (III)

b. The program shall include individual goals for each resident. (III)

c. The activity program shall include both group and individual activities. (III)

d. No resident shall be forced to participate in the activity program. (III)

**57.23(2) Coordination of activities program.**

a. Each residential care facility with over 15 beds shall employ a person to direct the activities program. (III)

<sup>1</sup>b. <sup>2</sup> Staffing for the activity program shall be provided on the minimum basis of 45 minutes per licensed bed per week. (II, III)

c. The activity coordinator shall have completed the activity coordinators' orientation course offered through the department within six months of employment or have comparable training and experience as approved by the department. (III)

d. The activity coordinator shall attend workshops or educational programs which relate to activity programming. These shall total a minimum of ten contact hours per year. These programs shall be approved by the department. (III)

e. There shall be a written plan for personnel coverage when the activity coordinator is absent during scheduled working hours. (III)

**57.23(3) Duties of activity coordinator.** The activity coordinator shall:

a. Have access to all residents' records excluding financial records; (III)

b. Coordinate all activities, including volunteer or auxiliary activities and religious services; (III)

c. Keep all necessary records including:

(1) Attendance; (III)

(2) Record individual resident progress notes at least every three months; (III)

(3) Monthly calendars, prepared in advance. (III)

d. Coordinate the activity program with all other services in the facility; (III)

e. Participate in the in-service training program in the facility. This shall include attending as well as presenting sessions. (III)

**57.23(4) Supplies, equipment, and storage.**

a. Each facility shall provide a variety of supplies and equipment of a nature calculated to fit the needs and interests of the residents. These may include: books (standard and large print), magazines, newspapers, radio, television, and bulletin boards. Also appropriate would be box games, game equipment, songbooks, cards, craft supplies, record player, movie projector, piano, outdoor equipment, etc. (III)

b. Storage shall be provided for recreational equipment and supplies. (III)

c. Locked storage should be available for potentially dangerous items such as scissors, knives, and toxic materials. (III)

<sup>1</sup> Emergency, pursuant to Iowa Code section 17A.5(2)"b"(2).

<sup>2</sup> Objection filed 2/14/79, see insert IAC 3/7/79.

**481—57.24(135C) Resident advocate committee.** Each facility shall have a resident advocate committee in accordance with Iowa Code section 135C.25, which shall operate within the scope of the rules for resident advocate committees promulgated by the department on aging. (II)

**57.24(1) Role of committee in complaint investigations.**

a. The department shall notify the facility's resident advocate committee of a complaint from the public. The department shall not disclose the name of a complainant.

b. The department may refer complaints to the resident advocate committee for initial evaluation or investigation by the committee pursuant to rules promulgated by the department on aging. Within ten days of completion of the investigation, the committee shall report to the department in writing the results of the evaluation or the investigation.

c. When the department investigates a complaint, upon conclusion of its investigation, it shall notify the resident advocate committee and the department on aging of its findings, including any citations and fines issued.

d. Results of all complaint investigations addressed by the resident advocate committee shall be forwarded to the department within ten days of completion of the investigation.

**57.24(2)** The resident advocate committee shall, upon department request, be responsible for monitoring correction of substantiated complaints.

**57.24(3)** When requested, names, addresses and telephone numbers of family members shall be given to the resident advocate committee, unless the family refuses. The facility shall provide a form on which a family member may refuse to have the family member's name, address or telephone number given to the resident advocate committee.

This rule is intended to implement Iowa Code section 135C.25.

**481—57.25(135C) Safety.** The licensee of a residential care facility shall be responsible for the provision and maintenance of a safe environment for residents and personnel. (III)

**57.25(1) Fire safety.**

a. All residential care facilities shall meet the fire safety rules and regulations as promulgated by the state fire marshal. (I, II)

b. The size of the facility and needs of the residents shall be taken into consideration in evaluating safety precautions and practices.

**57.25(2) Safety duties of administrator.** The administrator shall have a written emergency plan to be followed in the event of fire, tornado, explosion, or other emergency. (III)

a. The plan shall be posted. (III)

b. In-service shall be provided to ensure that all employees are knowledgeable of the emergency plan. (III)

**57.25(3) Resident safety.**

a. Residents shall be permitted to smoke only where proper facilities are provided. Smoking shall not be permitted in bedrooms. Smoking by residents considered to be careless shall be prohibited except when under direct supervision. (II, III)

b. Smoking is prohibited in all rooms where oxygen is being administered or in rooms where oxygen is stored. (II, III)

c. Whenever full or empty tanks of oxygen are being used or stored, they shall be securely supported in an upright position. (II, III)

d. Smoking shall be permitted only in posted areas. (II, III)

e. Residents shall receive adequate supervision to ensure against hazard from themselves, others, or elements in the environment. (II, III)

**57.25(4) Restraints.**

a. Rescinded, effective 7/14/82.

b. Residents shall not be kept behind locked doors;

c. Temporary seclusion of residents shall be used only in an emergency to prevent injury to the resident or to others pending transfer to appropriate placement;

d. A divided door equipped with a securing device that may be readily opened by personnel shall be considered an appropriate means of temporarily confining a resident in the resident's room;

e. Divided doors shall be of such type that when the upper half is closed the lower section shall close.

**481—57.26(135C) Housekeeping.**

**57.26(1)** Written procedures shall be established and implemented for daily and weekly cleaning schedules. (III)

**57.26(2)** Each resident unit shall be cleaned on a routine schedule. (III)

**57.26(3)** All rooms, corridors, storage areas, linen closets, attics, and basements shall be kept in a clean, orderly condition, free of unserviceable furniture and equipment and accumulations of refuse. (III)

**57.26(4)** A hallway or corridor shall not be used for storage of equipment. (III)

**57.26(5)** All odors shall be kept under control by cleanliness and proper ventilation. (III)

**57.26(6)** Clothing worn by personnel shall be clean and washable. (III)

**57.26(7)** Housekeeping and maintenance personnel shall be provided with well-constructed and properly maintained equipment appropriate to the function for which it is to be used. (III)

**57.26(8)** All furniture, bedding, linens, and equipment shall be cleaned periodically and before use by another resident. (III)

**57.26(9)** Polishes used on floors shall provide a nonslip finish. (III)

**57.26(10)** Throw or scatter rugs shall not be permitted. (III)

**57.26(11)** Entrances, exits, steps, and outside walkways shall be kept free from ice, snow, and other hazards. (II, III)

**57.26(12)** Residents shall not have access to storage areas for all cleaning agents, bleaches, insecticides, or any other poisonous, dangerous, or flammable materials. (II, III)

**57.26(13)** Sufficient numbers of noncombustible trash containers, which have covers, shall be available. (III)

**57.26(14)** Personal possessions of residents which may constitute hazards to themselves or to others shall be removed and stored. (III)

#### **481—57.27(135C) Maintenance.**

**57.27(1)** Each facility shall establish a maintenance program to ensure the continued maintenance of the facility, to promote good housekeeping procedures, and ensure sanitary practices throughout the facility. In facilities over 15 beds, this program shall be established in writing and available for review by the department. (III)

**57.27(2)** The building, grounds, and other buildings shall be maintained in a clean, orderly condition and in good repair. (III)

**57.27(3)** Draperies and furniture shall be clean and in good repair. (III)

**57.27(4)** Cracks in plaster, peeling wallpaper or paint, and tears or splits in floor coverings shall be promptly repaired or replaced in a professional manner. (III)

**57.27(5)** The electrical systems, including appliances, cords, and switches, shall be maintained to guarantee safe functioning and comply with the national electric code. (III)

**57.27(6)** All plumbing fixtures shall function properly and comply with the state plumbing code. (III)

**57.27(7)** Yearly inspections of the heating and cooling systems shall be made to guarantee safe operation. (III)

**57.27(8)** The building, grounds, and other buildings shall be kept free of breeding areas for flies, other insects, and rodents. (III)

**57.27(9)** The facility shall be kept free of flies, other insects, and rodents. (III)

**57.27(10)** Janitor closet.

*a.* Facilities shall be provided with storage for cleaning equipment, supplies, and utensils. (III)

*b.* Mops, scrub pails, and other cleaning equipment used in the resident areas shall not be stored or used in the dietary area. (III)

*c.* In facilities licensed for over 15 beds, a janitor's closet shall be provided. It shall be equipped with water for filling scrub pails and a janitor's sink for emptying scrub pails. (III)

#### **481—57.28(135C) Laundry.**

**57.28(1)** All soiled linens shall be collected in and transported to the laundry room in closed, leakproof laundry bags or covered, impermeable containers. (III)

**57.28(2)** Except for related activities, the laundry room shall not be used for other purposes. (III)

**57.28(3)** Procedures shall be written for the proper handling of wet, soiled, and contaminated linens. (III)

**57.28(4)** Residents' personal laundry shall be marked with an identification. (III)

**57.28(5)** Bed linens, towels, and washcloths shall be clean and stain-free. (III)

**57.28(6)** If laundry is done in the facility, the following shall be provided:

*a.* A clean, dry, well-lighted area to accommodate a washer and dryer of adequate size to serve the needs of the facility. (III)

b. In facilities of over 15 beds, the laundry room shall be divided into separate areas, one for sorting soiled linen and one for sorting and folding clean linen. (III)

**481—57.29(135C) Garbage and waste disposal.**

**57.29(1)** All garbage shall be gathered, stored, and disposed of in a manner that will not permit transmission of disease, create a nuisance, or provide a breeding or feeding place for vermin or insects. (III)

**57.29(2)** All containers for refuse shall be watertight, rodent-proof, and have tight-fitting covers. (III)

**57.29(3)** All containers shall be thoroughly cleaned each time the containers are emptied. (III)

**57.29(4)** All wastes shall be properly disposed of in compliance with local ordinances and state codes. (III)

**57.29(5)** Special provision shall be made for the disposal of soiled dressings and similar items in a safe, sanitary manner. (III)

**481—57.30(135C) Buildings, furnishings, and equipment.**

**57.30(1) Buildings—general requirements.**

a. For purposes of computation of usable floor space in bedrooms and other living areas of the facility, that part of the room having no less than seven feet of ceiling height shall be used. Usable floor space may include irregularities in the rooms such as alcoves and offsets with approval of the department. Usable floor space shall not include space needed for corridor door swings or wardrobes being used as a substitute for closet space. (III)

b. Battery-operated, portable emergency lights in good working condition shall be available at all times, at a ratio of one light per one employee on duty from 6 p.m. to 6 a.m. (III)

c. All windows shall be supplied with curtains and shades or drapes which are kept clean and in good repair. (III)

d. Light fixtures shall be so equipped to prevent glare and to prevent hazards to the residents. (III)

e. Exposed heating pipes, hot water pipes, or radiators in rooms and areas used by residents and within reach of residents shall be covered or protected to prevent injury or burns to residents. (II, III)

f. All fans located within seven feet of the floor shall be protected by screen guards of not more than one-fourth inch mesh. (III)

g. Whenever glass sliding doors or transparent panels are used, they shall be marked conspicuously. (III)

h. The facility shall meet the equivalent requirements of the appropriate group occupancy of the state building code. (III)

i. No part of any room shall be enclosed, subdivided, or partitioned unless such part is separately lighted and ventilated and meets such other requirements as its usage and occupancy dictates except closets used for the storage of residents' clothing. (III)

j. All stairways in resident-occupied areas shall have substantial handrails on both sides. (III)

k. Each open stairway shall have protective barriers. (III)

l. Screens of 16 mesh per square inch shall be provided at all openings. (III)

m. Screen doors shall swing outward and be self-closing. At the discretion of the state fire marshal, screens for fire doors may swing in. (III)

n. All resident rooms shall have a door. (III)

o. All rooms in resident-occupied areas shall have general lighting switched at the entrance to each room. (III)

**57.30(2) Furnishings and equipment.**

a. All furnishings and equipment shall be durable, cleanable, and appropriate to its function and in accordance with the department's approved program of care. (III)

b. All resident areas shall be decorated, painted, and furnished to provide a home-like atmosphere. (III)

c. Upholstery materials shall be moisture- and soil-resistant, except on furniture provided by the resident and the property of the resident. (III)

d. Night lights shall be provided in corridors, at stairways, attendant's stations and residents' bedrooms, and hazardous areas with no less than one foot-candle throughout the area at all times. (III)

**57.30(3) Dining and living rooms.**

a. Every facility shall have a dining room and a living room easily accessible to all residents. (III)

b. Dining rooms and living rooms shall at no time be used as bedrooms. (III)

c. Dining rooms and living rooms shall be available for use by residents at appropriate times to provide periods of social and diversional individual and group activities. (III)

d. A combination dining room and living room may be permitted if the space requirements of a multipurpose room as provided in 57.30(3) "e" are met. (III)

e. Multipurpose rooms. When space is provided for multipurpose dining and activities and recreational purposes, the area shall total at least 30 square feet per licensed bed for the first 100 beds and 27 square feet per licensed bed for all beds in excess of 100. An open area of sufficient size shall be provided to permit group activities such as religious meetings or presentation of demonstrations or entertainment.

f. Living rooms.

(1) Living rooms shall be maintained for the use of residents and their visitors and may be used for recreational activities. (III)

(2) Living rooms shall be suitably furnished. (III)

(3) When space is provided to be used only for activities and recreational purposes, the area shall be at least 15 square feet per licensed bed. At least 50 percent of the required area must be in one room. (III)

g. Dining rooms.

(1) Dining rooms shall be furnished with dining tables and chairs appropriate to the size and function of the facility. These rooms and furnishings shall be kept clean and sanitary. (III)

(2) When space is provided to be used only for dining, the area shall total at least 15 square feet per licensed bed. (III)

**57.30(4) Bedrooms.**

a. Each resident shall be provided with a standard, single, or twin bed, substantially constructed and in good repair. Rollaway beds, metal cots, or folding beds are not acceptable. (III)

b. Each bed shall be equipped with the following: casters or glides; clean springs in good repair; a clean, comfortable, well-constructed mattress approximately five inches thick and standard in size for the bed; and clean, comfortable pillows of average bed size. (III)

c. Each resident shall have a bedside table with a drawer to accommodate personal possessions. (III)

d. There shall be a comfortable chair, either a rocking chair or arm chair, per resident bed. The resident's personal wishes shall be considered. (III)

e. There shall be drawer space for each resident's clothing. In a multiple bedroom, drawer space shall be assigned each resident. (III)

f. Walls, ceilings, and floors shall have easily cleanable surfaces and shall be kept clean and in good repair. (III)

g. Beds and other furnishings shall not obstruct free passage to and through doorways. (III)

h. There shall be a wardrobe or closet in each resident's room. Minimum clear dimensions shall be 1' 10" deep by 1' 8" wide with full hanging space and provide a clothes rod and shelf. In a multiple bedroom, closet or wardrobe space shall be assigned each resident sufficient for the resident's needs. (III)

i. Beds shall not be placed with the head of the bed in front of a window or radiator. (III)

j. Beds shall not be placed in such a manner that the side of the bed is against the radiator or in close proximity to it unless it is covered so as to protect the resident from contact with it or from excessive heat. (III)

k. Reading lamps shall be provided each resident in the resident's room. (III)

- l.* Each room shall have sufficient accessible mirrors to serve residents' needs. (III)
- m.* Usable floor space of a room shall be no less than eight feet in any major dimension. (III)
- n.* Bedrooms shall have a minimum of 80 square feet of usable floor space per bed. (III)
- o.* There shall be no more than four residents per room. (III)
- p.* Each resident room shall be provided with light and ventilation by means of a window or windows with an area equal to one-eighth of the total floor area. The windows shall be openable. (III)

**57.30(5) Bath and toilet facilities.**

- a.* Provision shall be made for bars to hold individual towels and washcloths. (III)
- b.* All lavatories shall have paper towel dispensers and an available supply of soap. (III)
- c.* Minimum numbers of toilet and bath facilities shall be one lavatory, one toilet for each 10 residents, and one tub or shower for each 15 residents or fraction thereof. (III)
- d.* There shall be a minimum of one bathroom with tub or shower, toilet stool and lavatory on each floor in multistory buildings for facilities licensed for over 15 beds. Separate toilets for the sexes shall be provided. (III)
- e.* Grab bars shall be provided at all toilet stools, tubs, and showers. Grab bars, accessories, and anchorage shall have sufficient strength to sustain a deadweight of 250 pounds for five minutes. (III)
- f.* Each toilet room shall have a door. (III)
- g.* All toilet, bath, and shower facilities shall be supplied with adequate safety devices appropriate to the needs of the individual residents. Raised toilet seats shall be available for residents who are aged or infirm. (III)
- h.* Toilet and bath facilities shall have an aggregate outside window area of at least four square feet. Facilities having a system of mechanical ventilation are exempt from this regulation. (III)
- i.* Every facility shall provide a toilet and lavatory with grab bars for the public and staff. (III)

**57.30(6) Heating.** A centralized heating system capable of maintaining a minimum temperature of 78°F (26°C) shall be provided. Portable units or space heaters are prohibited from being used in the facility except in an emergency. (III)

**57.30(7) Water supply.**

- a.* Every facility shall have an adequate water supply from an approved source. A municipal source of supply shall be considered as meeting this requirement. (III)
- b.* Private sources of supply shall be tested annually and the report submitted with the annual application for license. (III)
- c.* A bacterially unsafe source of supply shall be grounds for denial, suspension, or revocation of license. (III)
- d.* The department may require testing of private sources of supply at its discretion in addition to the annual test. The facility shall supply reports of such tests as directed by the department. (III)
- e.* Hot and cold running water under pressure shall be available in the facility. (III)
- f.* Prior to construction of a new facility or new water source, private sources of supply shall be surveyed and shall comply with the requirements of the department. (III)

**57.30(8) Sewage system.**

- a.* Sewage shall be collected and disposed of in a manner approved by the department. Disposal into a municipal system will be considered as meeting this requirement. (III)
- b.* Private sewage systems shall conform to the rules and regulations of the department of environmental quality, state health department, and the natural resources council. (III)
- c.* Every facility shall have an interior plumbing system complete with flushing device. (III)

**57.30(9) Attendant's station.** In facilities over 15 beds, an attendant's station with a minimum of 40 square feet shall be provided which is centrally located in the resident area and shall have a well-lighted desk with the necessary equipment for the keeping of required records and supplies. (III)

**481—57.31(135C) Family and employee accommodations.**

**57.31(1)** Children under 14 years of age shall not be allowed into the service areas. (III)

**57.31(2)** The residents' bedrooms shall not be occupied by employees, family members of employees, or family members of the licensee. (III)

**57.31(3)** In facilities where the total occupancy of family, employees, and residents is five or less, one toilet and one tub or shower shall be the minimum requirement. (III)

**57.31(4)** In facilities where the total occupancy of family, employees, and residents is more than five, separate bathing and toilet facilities shall be required for the family or employees distinct from such areas provided for residents. (III)

**57.31(5)** In all health care facilities, if the family or employees live within the facility, separate living quarters and recreation facilities shall be required for the family or employees distinct from such areas provided for residents. (III)

**481—57.32(135C) Animals.** No animals shall be allowed within the facility except with written approval of the department and under controlled conditions. (III)

**481—57.33(135C) Environment and grounds.**

**57.33(1)** A residential care facility shall be constructed in a neighborhood free from excessive noise, dirt, polluted, or odorous air, or similar disturbances. (III)

**57.33(2)** There shall be an area available for outdoor activities calculated at 25 square feet per licensed bed. Open air porches may be included in meeting such requirements. (III)

**481—57.34(135C) Supplies.**

**57.34(1) Linen supplies.**

*a.* There shall be an adequate supply of linen so that each resident shall have at least three washcloths, hand towels, and bath towels per week. (III)

*b.* A complete change of bed linens shall be available in the linen storage area for each bed. (III)

*c.* Sufficient lightweight, clean, serviceable blankets shall be available. All blankets shall be laundered as often as necessary for cleanliness and freedom of odors. (III)

*d.* Each bed shall be provided with clean, washable bedspreads. There shall be a supply available when changes are necessary. (III)

*e.* Uncrowded and convenient storage shall be provided for linens, pillows, and bedding. (III)

**57.34(2) First aid kit.** A first aid emergency kit shall be available on each floor in every facility. (II, III)

**57.34(3) General supplies.**

*a.* All equipment shall be properly cleaned and sanitized before use by another resident. (III)

*b.* Clean and sanitary storage shall be provided for equipment and supplies. (III)

**481—57.35(135C) Residents' rights in general.**

**57.35(1)** Each facility shall ensure that policies and procedures are written and implemented which include, at a minimum, all of the following provisions (subrules 57.35(2) to 57.35(6)) and which govern all areas of service provided by the facility. These policies and procedures shall be available to staff, residents, their families or legal representatives and the public and shall be reviewed annually. (II)

**57.35(2)** Policies and procedures regarding the admission, transfer, and discharge of residents shall ensure that:

*a.* Only those persons are accepted whose needs can be met by the facility directly or in cooperation with community resources or other providers of care with which it is affiliated or has contracts. (II)

*b.* As changes occur in residents' physical or mental condition, necessitating services or care which cannot be adequately provided by the facility, they are transferred promptly to other appropriate facilities. (II)

**57.35(3)** Policies and procedures regarding the use of chemical and physical restraints shall define the use of restraints and identify the individual who may authorize the application of physical restraints in emergencies, and describe the mechanism for monitoring and controlling their use. (II)

**57.35(4)** Policies and procedures shall include a method for submitting complaints and recommendations by residents or their responsible party and for ensuring a response and disposition by the facility. (II)

**57.35(5)** Policies and procedures shall include provisions governing access to, duplication of, and dissemination of information from the residents' records. (II)

**57.35(6)** Policies and procedures shall include a provision that each resident shall be fully informed of the resident's rights and responsibilities as a resident and of all rules governing resident conduct and responsibilities. This information must be provided upon admission, or in the case of residents already in the facility, upon the facility's adoption or amendment of residents' rights policies. (II)

*a.* The facility shall make known to residents what they may expect from the facility and its staff, and what is expected from them. The facility shall communicate these expectations during the period of not more than two weeks before or five days after admission. The communication shall be in writing, e.g., in a separate handout or brochure describing the facility, and interpreted verbally, e.g., as part of a preadmission interview, resident counseling, or in individual or group orientation sessions following admission. (II)

*b.* Residents' rights and responsibilities shall be presented in language understandable to the resident. If the facility serves residents who are non-English speaking or deaf, steps shall be taken to translate the information into a foreign or sign language. In the case of blind residents, either Braille or a recording shall be provided. Residents shall be encouraged to ask questions about their rights and responsibilities and these questions shall be answered. (II)

*c.* A statement shall be signed by the resident, or the resident's responsible party, if applicable, indicating an understanding of these rights and responsibilities, and shall be maintained in the record. The statement shall be signed no later than five days after admission, and a copy of the signed statement shall be given to the resident or responsible party. In the case of an intellectually disabled resident, the signature shall be witnessed by a person not associated with or employed by the facility. The witness may be a parent, guardian, Medicaid agency representative, etc. (II)

*d.* In order to ensure that residents continue to be aware of these rights and responsibilities during their stay, a written copy shall be prominently posted in a location that is available to all residents. (II)

*e.* All residents shall be advised within 30 days following changes made in the statement of residents' rights and responsibilities. Appropriate means shall be utilized to inform non-English speaking, deaf or blind residents of changes. (II)

**57.35(7)** Each resident or responsible party shall be fully informed in a contract as required in rule 57.14(135C), prior to or at the time of admission and during the resident's stay, of services available in the facility, and of related charges not covered by the facility's basic per diem rate. (II)

**57.35(8)** Each resident or responsible party shall be fully informed by a physician of the resident's health and medical condition unless medically contraindicated (as documented by a physician in the resident's record). Each resident shall be afforded the opportunity to participate in the planning of the resident's total care and medical treatment, which may include, but is not limited to, nursing care, nutritional care, rehabilitation, restorative therapies, activities, and social work services. Each resident only participates in experimental research conducted under the U.S. Department of Health and Human Services protection from research risks policy and then only upon the resident's informed written consent. Each resident has the right to refuse treatment except as provided by Iowa Code chapter 229. In the case of a confused or intellectually disabled individual, the responsible party shall be informed by the physician of the resident's medical condition and be afforded the opportunity to participate in the planning of the resident's total care and medical treatment, to be informed of the medical condition, and to refuse to participate in experimental research. (II)

*a.* The requirement that residents shall be informed of their conditions, involved in the planning of their care, and advised of any significant changes in either shall be communicated to every physician responsible for the medical care of residents in the facility. (II)

*b.* The administrator or designee shall be responsible for working with attending physicians in the implementation of this requirement. (II)

*c.* If the physician determines or in the case of a confused or intellectually disabled resident the responsible party determines that informing the resident of the resident's condition is contraindicated, this decision and reasons for it shall be documented in the resident's record by the physician. (II)

*d.* Any clinical investigation involving residents must be under the sponsorship of an institution with a human subjects review board functioning in accordance with the requirements of Public Law 93-348, as implemented by Part 46 of Title 45 of the Code of Federal Regulations, as amended to December 1, 1981 (45 CFR 46). A resident being considered for participation in experimental research must be fully informed of the nature of the experiment, e.g., medication, treatment, and understand the possible consequences of participating or not participating. The resident's (or responsible party's) written informed consent must be received prior to participation. (II)

**57.35(9)** In residential care facilities which are also county care facilities, policies and procedures shall address the admission and retention of persons with histories of dangerous and disturbing behavior. For the purpose of this subrule, persons with histories of dangerous or disturbing behavior are those persons who have been committed for evaluation and found to be seriously mentally impaired pursuant to Iowa Code section 229.13 or 812.1 within six months of the request for admission to the facility. In addition to establishing the criteria for admission and retention of persons so defined, the policies and procedures shall provide for:

*a.* Reasonable precautions to prevent the resident from harming self, other residents, or employees of the facility.

*b.* Treatment of persons with mental illness as defined in Iowa Code section 229.1(1) which is provided in accordance with the individualized health care plan.

*c.* Ongoing and documented staff training on individualized health care planning for persons with mental illness.

[ARC 0766C, IAB 5/29/13, effective 7/3/13]

**481—57.36(135C) Involuntary discharge or transfer.**

**57.36(1)** A facility shall not involuntarily discharge or transfer a resident from a facility except: for medical reasons; for the resident's welfare or that of other residents; for nonpayment for the resident's stay (as contained in the contract for the resident's stay), except as prohibited by Title XIX of the Social Security Act, 42 U.S.C. 1396 to 1396k and by reason of action pursuant to Iowa Code chapter 229. (I, II)

*a.* "Medical reasons" for transfer or discharge are based on the resident's needs and are determined and documented in the resident's record by the attending physician. Transfer or discharge may be required to provide a different level of care. (II)

*b.* "Welfare" of a resident or that of other residents refers to their social, emotional, or physical well-being. A resident might be transferred or discharged because the resident's behavior poses a continuing threat to the resident (e.g., suicidal) or to the well-being of other residents or staff (e.g., the resident's behavior is incompatible with other residents' needs and rights). Evidence that the resident's continued presence in the facility would adversely affect the resident's own welfare or that of other residents shall be made by the administrator or designee and shall be in writing and shall include specific information to support this determination. (II)

*c.* Involuntary transfer or discharge of a resident from a facility shall be preceded by a written notice to the resident or responsible party at least 30 days in advance of the proposed transfer or discharge. The 30-day requirement shall not apply in any of the following instances:

(1) If an emergency transfer or discharge is mandated by the resident's health care needs and is in accord with the written orders and medical justification of the attending physician. Emergency transfers or discharges may also be mandated to protect the health, safety, or well-being of other residents and staff from the resident being transferred. (II)

(2) If the transfer or discharge is subsequently agreed to by the resident or the resident's responsible party, and notification is given to the responsible party, physician, and the person or agency responsible for the resident's placement, maintenance, and care in the facility. (II)

*d.* The notice required by paragraph "c" shall contain all of the following information:

(1) The stated reason for the proposed transfer or discharge. (II)

(2) The effective date of the proposed transfer or discharge. (II)

(3) A statement in not less than 12-point type (elite), which reads: “You have a right to appeal the facility’s decision to transfer or discharge you. If you think you should not have to leave this facility, you may request a hearing in writing or verbally with the Iowa state department of inspections and appeals (hereinafter referred to as “department”) within seven days after receiving this notice. You have a right to be represented at the hearing by an attorney or any other individual of your choice. If you request a hearing, it will be held no later than 14 days after receipt of your request by the department and you will not be transferred prior to a final decision. Provision may be made for extension of the 14-day requirement upon request to the department of inspections and appeals designee in emergency circumstances. If you lose the hearing, you will not be transferred before the expiration of 30 days following receipt of the original notice of the discharge or transfer, or no sooner than 5 days following final decision of such hearing. To request a hearing or receive further information, call the department at (515)281-4115 or you may write to the department to the attention of: Administrator, Division of Health Facilities, Department of Inspections and Appeals, Lucas State Office Building, Des Moines, Iowa 50319-0083.” (II)

*e.* A request for a hearing made under 57.36(1) “d”(3) shall stay a transfer or discharge pending a hearing or appeal decision. (II)

*f.* The type of hearing shall be determined by a representative of the department. Notice of the date, time, and place of the hearing shall be sent by certified mail or delivered in person to the licensee, resident, responsible party, and Iowa department on aging long-term care ombudsman of record, not later than five full business days after receipt of the request. This notice shall also inform the licensee, resident or responsible party that they have a right to appear at the hearing in person or be represented by their attorneys or other individual. The hearing shall be dismissed if neither party is present or represented at the hearing. If only one party appears or is represented, the hearing shall proceed with one party present. The Iowa department on aging long-term care ombudsman shall have the right to appear at the hearing.

*g.* The hearing shall be heard by a department of inspections and appeals designee pursuant to Iowa Code chapter 17A. (The hearing shall be public unless the resident or representative requests in writing that it be closed.) The licensee or designee shall have the opportunity to present to the representative of the department any oral testimony or written materials to show by a preponderance of the evidence just cause why a transfer or discharge may be made. The resident and responsible party shall also have an opportunity to present to the representative of the department any oral testimony or written material to show just cause why a transfer or discharge should not be made. In a determination as to whether a transfer or discharge is authorized, the burden of proof rests on the party requesting the transfer or discharge.

*h.* Based upon all testimony and material submitted to the representative of the department, the representative shall issue, in accordance with Iowa Code chapter 17A, written findings of fact and conclusions of law and issue a decision and order in respect to the adverse action. This decision shall be mailed by certified mail to the licensee, resident, responsible party, and department on aging long-term care ombudsman within 10 working days after the hearing has been concluded. The representative shall have the power to issue fines and citations against the facility in appropriate circumstances.

A request for review of a proposed decision in which the department is the final decision maker shall be made within 15 days of issuance of the proposed decision, unless otherwise provided by statute. Requests shall be mailed or delivered by either party to the Director, Department of Inspections and Appeals, Lucas State Office Building, Des Moines, Iowa 50319-0083. Failure to request review will preclude judicial review unless the department reviews a proposed decision upon its own motion within 15 days of the issuance of the decision.

*i.* A copy of the notice required by paragraph “c” shall be personally delivered to the resident and a copy placed in the resident’s record. A copy shall also be transmitted to the department, the resident’s responsible party, physician, the person or agency responsible for the resident’s placement, maintenance, and care in the facility, and the department on aging long-term care ombudsman.

*j.* If nonpayment is the basis for involuntary transfer or discharge, the resident shall have the right to make full payment up to the date that the discharge or transfer is to be made and then shall have the right to remain in the facility. (II)

*k.* The involuntary transfer or discharge shall be discussed with the resident, the resident's responsible party, and the person or agency responsible for the resident's placement, maintenance, and care in the facility within 48 hours after notice of discharge has been received. The explanation and discussion of the reasons for involuntary transfer or discharge shall be given by the facility administrator or other appropriate facility representative as the administrator's designee. The content of the discussion and explanation shall be summarized in writing and shall include the names of the individuals involved in the discussions and made a part of the resident's record. (II)

*l.* The resident shall receive counseling services before (by the sending facility) and after (by the receiving facility) the involuntary transfer to minimize the possible adverse effects of the involuntary transfer. Counseling shall be documented in the resident's record. (II)

(1) Counseling shall be provided by a qualified individual who meets one of the following criteria:

1. Has a bachelor's or master's degree in social work from an accredited college. (II)
2. Is a graduate of an accredited four-year college and has had at least one year of full-time paid employment in a social work capacity with a public or private agency. (II)
3. Has been employed in a social work capacity for a minimum of four years in a public or private agency. (II)
4. Is a licensed psychologist or psychiatrist. (II)
5. Is any other person of the resident's choice. (II)

(2) The facility shall develop a plan to provide for the orderly and safe transfer or discharge of each resident to be discharged or transferred. (II)

(3) The receiving health care facility of a resident involuntarily discharged or transferred shall immediately formulate and implement a plan of care which takes into account possible adverse effects the transfer may cause. (II)

*m.* In the case of an emergency transfer or discharge as outlined in 57.36(1) "c"(1), the resident must still be given a written notice prior to or within 48 hours following transfer or discharge. A copy of this notice must be placed in the resident's file and it must contain all the information required by subparagraphs (1) and (2) of 57.36(1) "d." In addition, the notice must contain a statement in not less than 12-point type (elite), which reads: "You have a right to appeal the facility's decision to transfer or discharge you on an emergency basis. If you think you should not have to leave this facility, you may request a hearing in writing or verbally with the Iowa state department of inspections and appeals within 7 days after receiving this notice. If you request a hearing, it will be held no later than 14 days after receipt of your request by the department. You may be transferred or discharged before the hearing is held or before a final decision is rendered. If you win the hearing, you have the right to be transferred back into the facility. To request a hearing or receive further information, call the department at (515)281-4115 or you may write to the department to the attention of: Administrator, Division of Health Facilities, Department of Inspections and Appeals, Lucas State Office Building, Des Moines, Iowa 50319-0083." A hearing requested pursuant to this subrule shall be held in accordance with paragraphs "f," "g," and "h." (II)

*n.* Residents shall not have the right to a hearing to contest an involuntary discharge or transfer resulting from the revocation of the facility's license by the department of inspections and appeals. In the case of a facility voluntarily closing, a period of 30 days must be allowed for an orderly transfer of residents to other facilities.

**57.36(2) Intrafacility transfer:**

*a.* Residents shall not be relocated from room to room within a licensed health care facility arbitrarily. (I, II) Involuntary relocation may occur only in the following situations, and the situation shall be documented in the resident's record.

- (1) Incompatibility with or disturbing to other roommates, as documented in the resident's record.
- (2) For the welfare of the resident or other residents of the facility.

(3) For medical, nursing or psychosocial reasons, as documented in the resident's record, as judged by the attending physician, nurse or social worker in the case of a facility which groups residents by medical, nursing or psychosocial needs.

(4) To allow a new admission to the facility which would otherwise not be possible due to separation of roommates by sex.

(5) In the case of a resident whose source of payment was previously private, but who now is eligible for Title XIX assistance, the resident may be transferred from a private room to a semiprivate room or from one semiprivate room to another.

(6) Reasonable and necessary administrative decisions regarding the use and functioning of the building.

*b.* Unreasonable and unjustified reasons for changing a resident's room without the concurrence of the resident or responsible party include:

(1) Change from private pay status to Title XIX, except as outlined in 57.36(2) "a"(5). (II)

(2) As punishment or behavior modification (except as specified in 57.36(2) "a"(1)). (II)

(3) Discrimination on the basis of race or religion. (II)

*c.* If intrafacility relocation is necessary for reasons outlined in paragraph "a," the resident shall be notified at least 48 hours prior to the transfer and the reason therefor shall be explained. The responsible party shall be notified as soon as possible. The notification shall be documented in the resident's record and signed by the resident or responsible party. (II)

*d.* If emergency relocation is required to protect the safety or health of the resident or other residents, the notification requirements may be waived. The conditions of the emergency shall be documented. The family or responsible party shall be notified immediately, or as soon as possible, of the condition requiring emergency relocation and the notification shall be documented. (II)

**481—57.37(135C) Residents' rights.** Each resident shall be encouraged and assisted throughout the resident's period of stay, to exercise the resident's rights as a resident and as a citizen and may voice grievances and recommend changes in policies and services to administrative staff or to outside representatives of the resident's choice, free from interference, coercion, discrimination, or reprisal. (II)

**57.37(1)** The facility shall provide ongoing opportunities for residents to be aware of and to exercise their rights as residents. Residents shall be kept informed of issues or pending decisions of the facility that affect them and their views shall be solicited prior to action. (II)

**57.37(2)** The facility shall implement a written procedure for registering and resolving grievances and recommendations by residents or their responsible party. The procedure shall ensure protection of the resident from any form of reprisal or intimidation. The written procedure shall include:

*a.* Designation of an employee responsible for handling grievances and recommendations. (II)

*b.* A method of investigating and assessing the validity of a grievance or recommendation. (II)

*c.* Methods of resolving grievances. (II)

*d.* Methods of recording grievances and actions taken. (II)

**57.37(3)** The facility shall post in a prominent area the name, telephone number, and address of the ombudsman, survey agency, local law enforcement agency, and resident advocate committee members and the text of Iowa Code section 135C.46 to provide to residents a further course of redress. (II)

**481—57.38(135C) Financial affairs—management.** Each resident, who has not been assigned a guardian or conservator by the court, may manage the resident's own personal financial affairs, and to the extent, under written authorization by the resident that the facility assists in management, the management shall be carried out in accordance with Iowa Code section 135C.24. (II)

**57.38(1)** The facility shall maintain a written account of all residents' funds received by or deposited with the facility. (II)

**57.38(2)** An employee shall be designated in writing to be responsible for resident accounts. (II)

**57.38(3)** The facility shall keep on deposit personal funds over which the resident has control in accordance with Iowa Code subsection 135C.24(2). Should the resident request these funds, they shall be given to the resident on request with receipts maintained by the facility and a copy to the resident. In

the case of a confused or intellectually disabled resident, the resident's responsible party shall designate a method of disbursing the resident's funds. (II)

**57.38(4)** If the facility makes financial transactions on a resident's behalf, the resident must receive or acknowledge having seen an itemized accounting of disbursements and current balances at least quarterly. A copy of this statement shall be maintained in the resident's financial or business record. (II)

**57.38(5)** A resident's personal funds shall not be used without the written consent of the resident or the resident's guardian. (II)

**57.38(6)** A resident's personal funds shall be returned to the resident when the funds have been used without the written consent of the resident or the resident's guardian. The department may report findings that resident funds have been used without written consent to the audits division or the local law enforcement agency, as appropriate. (II)

[ARC 0766C, IAB 5/29/13, effective 7/3/13]

**481—57.39(135C) Resident abuse prohibited.** Each resident shall receive kind and considerate care at all times and shall be free from mental and physical abuse. Each resident shall be free from chemical and physical restraints, except in an emergency for the shortest amount of time necessary to protect the resident from injury to the resident or to others, pending the immediate transfer to an appropriate facility. The decision to use restraints on an emergency basis shall be made by the designated charge person who shall promptly report the action taken to the physician and the reasons for using restraints shall be documented in the resident's record. Mechanical supports used in normative situations to achieve proper body position and balance shall not be considered to be a restraint. (II)

**57.39(1)** Mental abuse includes, but is not limited to, humiliation, harassment, and threats of punishment or deprivation. (II)

**57.39(2)** Physical abuse includes, but is not limited to, corporal punishment and the use of restraints as punishment. (II)

**57.39(3)** Drugs such as tranquilizers may not be used as chemical restraints to limit or control resident behavior for the convenience of staff. (II)

**57.39(4)** Upon a claim of dependent adult abuse of a resident being reported, the administrator of the facility shall separate the victim and accused abuser immediately and maintain that separation until the abuse investigation is completed. (I, II)

**57.39(5)** Suspected abuse reports. The department shall investigate all complaints of dependent adult abuse which are alleged to have happened in a health care facility. The department shall inform the department of human services of the results of all evaluations and dispositions of dependent adult abuse investigations.

**57.39(6)** Pursuant to Iowa Code chapter 235B, a mandatory reporter of dependent adult abuse is any person who, in the course of employment, examines, attends, counsels, or treats a dependent adult and reasonably believes the dependent adult has suffered abuse. This includes a member of the staff or employee of a health care facility. (II, III)

If a staff member or employee is required to report pursuant to this subrule, the staff member or employee shall immediately notify the person in charge of the facility or the person's designated agent, and the person in charge or the designated agent shall make the report to the department of human services. (II, III)

**481—57.40(135C) Resident records.** Each resident shall be ensured confidential treatment of all information contained in the resident's records, including information contained in an automatic data bank. The resident's written consent shall be required for the release of information to persons not otherwise authorized under law to receive it. (II)

**57.40(1)** The facility shall limit access to any medical records to staff and consultants providing professional service to the resident. This is not meant to preclude access by representatives of state and federal regulatory agencies. (II)

**57.40(2)** Similar procedures shall safeguard the confidentiality of residents' personal records, e.g., financial records and social services records. Only those personnel concerned with the financial affairs of the residents may have access to the financial records. This is not meant to preclude access by representatives of state and federal regulatory agencies. (II)

**57.40(3)** The resident, or the resident's responsible party, shall be entitled to examine all information contained in the resident's record and shall have the right to secure full copies of the record at reasonable cost upon request, unless the physician determines the disclosure of the record or section thereof is contraindicated in which case this information will be deleted prior to making the record available to the resident or responsible party. This determination and the reasons for it must be documented in the resident's record. (II)

**481—57.41(135C) Dignity preserved.** The resident shall be treated with consideration, respect, and full recognition of dignity and individuality, including privacy in treatment and in care for personal needs. (II)

**57.41(1)** Staff shall display respect for residents when speaking with, caring for, or talking about them, as constant affirmation of their individuality and dignity as human beings. (II)

**57.41(2)** Schedules of daily activities shall allow maximum flexibility for residents to exercise choice about what they will do and when they will do it. Residents' individual preferences regarding such things as menus, clothing, religious activities, friendships, activity programs, entertainment, sleeping and eating, also times to retire at night and arise in the morning shall be elicited and considered by the facility. (II)

**57.41(3)** Residents shall be examined and treated in a manner that maintains the privacy of their bodies. A closed door or a drawn curtain shall shield the resident from passersby. People not involved in the care of the residents shall not be present without the resident's consent while the resident is being examined or treated. (II)

**57.41(4)** Privacy of a resident's body also shall be maintained during toileting, bathing, and other activities of personal hygiene, except as needed for resident safety or assistance. (II)

**57.41(5)** Staff shall knock and be acknowledged before entering a resident's room unless the resident is not capable of a response. This shall not apply under emergency conditions. (II)

**481—57.42(135C) Resident work.** No resident may be required to perform services for the facility, except as provided by Iowa Code sections 35D.14 and 347B.5. (II)

**57.42(1)** Residents may not be used to provide a source of labor for the facility against their will. Physician's approval is required for all work programs. (I, II)

**57.42(2)** Residents who perform work for the facility must receive remuneration unless the work is part of their approved training program. Persons on the resident census performing work shall not be used to replace paid employees in fulfilling staffing requirements. (II)

**481—57.43(135C) Communications.** Each resident may communicate, associate, and meet privately with persons of the resident's choice, unless to do so would infringe upon the rights of other residents, and may send and receive personal mail unopened. (II)

**57.43(1)** Subject to reasonable scheduling restrictions, visiting policies and procedures shall permit residents to receive visits from anyone they wish. Visiting hours shall be posted. (II)

**57.43(2)** Reasonable, regular visiting hours shall not be less than 12 hours per day and shall take into consideration the special circumstances of each visitor. A particular visitor(s) may be restricted by the facility for one of the following reasons:

- a. The resident refuses to see the visitor(s). (II)
- b. The resident's physician documents specific reasons why such a visit would be harmful to the resident's health. (II)
- c. The visitor's behavior is unreasonably disruptive to the functioning of the facility (this judgment must be made by the administrator and the reasons shall be documented and kept on file). (II)

**57.43(3)** Decisions to restrict a visitor are reviewed and reevaluated: each time the medical orders are reviewed by the physician; at least quarterly by the facility's staff; or at the resident's request. (II)

**57.43(4)** Space shall be provided for residents to receive visitors in reasonable comfort and privacy. (II)

**57.43(5)** Telephones consistent with ANSI standards (405.1134(c)) shall be available and accessible for residents to make and receive calls with privacy. Residents who need help shall be assisted in using the telephone. (II)

**57.43(6)** Arrangements shall be made to provide assistance to residents who require help in reading or sending mail. (II)

**57.43(7)** Residents shall be permitted to leave the facility and environs at reasonable times unless there are justifiable reasons established in writing by the attending physician, qualified intellectual disabilities professional, or facility administrator for refusing permission. (II)

**57.43(8)** Residents shall not have their personal lives regulated beyond reasonable adherence to meal schedules, bedtime hours, and other written policies which may be necessary for the orderly management of the facility and as required by these rules. However, residents shall be encouraged to participate in recreational programs. (II)

[ARC 0766C, IAB 5/29/13, effective 7/3/13]

**481—57.44(135C) Resident activities.** Each resident may participate in activities of social, religious, and community groups at the resident's discretion unless contraindicated for reasons documented by the attending physician or qualified intellectual disabilities professional as appropriate in the resident's resident record. (II)

**57.44(1)** Residents who wish to meet with or participate in activities of social, religious, or other community groups in or outside of the facility shall be informed, encouraged, and assisted to do so. (II)

**57.44(2)** All residents shall have the freedom to refuse to participate in these activities. (II)  
[ARC 0766C, IAB 5/29/13, effective 7/3/13]

**481—57.45(135C) Resident property.** Each resident may retain and use personal clothing and possessions as space permits and provided such use is not otherwise prohibited by these rules. (II)

**57.45(1)** Residents shall be permitted to keep reasonable amounts of personal clothing and possessions for their use while in the facility. The personal property shall be kept in a safe location which is convenient to the resident. (II)

**57.45(2)** Residents shall be advised, prior to or at the time of admission, of the kinds and amounts of clothing and possessions permitted for personal use, and whether the facility will accept responsibility for maintaining these items, e.g., cleaning and laundry. (II)

**57.45(3)** Any personal clothing or possessions retained by the facility for the resident during the resident's stay shall be identified and recorded on admission and a record placed on the resident's chart. The facility shall be responsible for secure storage of the items, and they shall be returned to the resident promptly upon request or upon discharge from the facility. (II)

**57.45(4)** A resident's personal property shall not be used without the written consent of the resident or the resident's guardian. (II)

**57.45(5)** A resident's personal property shall be returned to the resident when it has been used without the written consent of the resident or the resident's guardian. The department may report findings that a resident's property has been used without written consent to the local law enforcement agency, as appropriate. (II)

**481—57.46(135C) Family visits.** Each resident, if married, shall be ensured privacy for visits by the resident's spouse; if both are residents in the facility, they shall be permitted to share a room, if available. (II)

**57.46(1)** The facility shall provide for needed privacy in visits between spouses. (II)

**57.46(2)** Spouses who are residents in the same facility shall be permitted to share a room, if available, unless one of their attending physicians documents in the medical record those specific reasons why such an arrangement would have an adverse effect on the health of the resident. (II)

**57.46(3)** Family members shall be permitted to share a room, if available, if requested by both parties, unless one of their attending physicians documents in the medical record those specific reasons why such an agreement would have an adverse effect on the health of the resident. (II)

**481—57.47(135C) Choice of physician.** Each resident shall be permitted free choice of a physician and a pharmacy, if accessible. The facility may require the pharmacy selected to utilize a drug distribution system compatible with the system currently used by the facility. (II)

**481—57.48(135C) Incompetent residents.**

**57.48(1)** Each facility shall provide that all rights and responsibilities of the resident devolve to the resident's responsible party when a resident is adjudicated incompetent in accordance with state law or, in the case of a resident who has not been adjudicated incompetent under the laws of the state, in accordance with 42 CFR 483.10. This subrule is not intended to limit the authority of any individual acting pursuant to Iowa Code chapter 144A. (II)

**57.48(2)** The fact that a resident has been adjudicated incompetent does not absolve the facility from advising the resident of these rights to the extent the resident is able to understand them. The facility shall also advise the responsible party, if any, and acquire a statement indicating an understanding of residents' rights. (II)

**481—57.49(135C) County care facilities.** In addition to Chapter 57 licensing rules, county care facilities licensed as residential care facilities must also comply with department of human services rules, 441—Chapter 37. Violations of any standard established by the department of human services is a Class II violation pursuant to 481—56.2(135C).

**481—57.50(135C) Another business or activity in a facility.** A facility is allowed to have another business or activity in a health care facility or in the same physical structure of the facility, if the other business or activity is under the control of and is directly related to and incidental to the operation of the health care facility, or the business or activity is approved by the department and the state fire marshal.

To obtain the approval of the department and the state fire marshal, the facility must submit to the department a written request for approval which identifies the service(s) to be offered by the business and addresses the factors outlined in paragraphs "a" through "j" of this rule. (I, II, III)

**57.50(1)** The following factors will be considered by the department in determining whether a business or activity will interfere with the use of the facility by residents, interfere with services provided to residents, or be disturbing to residents:

- a. Health and safety risks for residents;
- b. Compatibility of the proposed business or activity with the facility program;
- c. Noise created by the proposed business or activity;
- d. Odors created by the proposed business or activity;
- e. Use of entrances and exits for the business or activity in regard to safety and disturbance of residents and interference with delivery of services;
- f. Use of the facility's corridors or rooms as thoroughfares to the business or activity in regard to safety and disturbance of residents and interference with delivery of services;
- g. Proposed staffing for the business or activity;
- h. Sharing of services and staff between the proposed business or activity and the facility;
- i. Facility layout and design; and
- j. Parking area utilized by the business or activity.

**57.50(2)** Approval of the state fire marshal shall be obtained before approval of the department will be considered.

**57.50(3)** A business or activity conducted in a health care facility or in the same physical structure as a health care facility shall not reduce space, services or staff available to residents below minimums required in these rules and 481—Chapter 60. (I, II, III)

**481—57.51(135C) Respite care services.** Respite care services means an organized program of temporary supportive care provided for 24 hours or more to a person in order to relieve the usual caregiver of the person from providing continual care to the person. A residential care facility which chooses to provide respite care services must meet the following requirements related to respite services and must be licensed as a residential care facility.

**57.51(1)** A residential care facility which chooses to provide respite care services is not required to obtain a separate license or pay a license fee.

**57.51(2)** Rule 481—57.36(135C), regarding involuntary discharge or transfer rights, does not apply to residents who are being cared for under a respite care contract.

**57.51(3)** Pursuant to rule 481—57.14(135C), the facility shall have a contract with each resident in the facility. When the resident is there for respite care services, the contract shall specify the time period during which the resident will be considered to be receiving respite care services. At the end of that period, the contract may be amended to extend that period of time. The contract shall specifically state the resident may be involuntarily discharged while being considered as a respite care resident. The contract shall meet other requirements under 481—57.14(135C), except the requirements under subrule 57.14(7).

**57.51(4)** Respite care services shall not be provided by a health care facility to persons requiring a level of care which is higher than the level of care the facility is licensed to provide.

These rules are intended to implement Iowa Code sections 10A.202, 10A.402, 135C.6(1), 135C.14, 135C.23(2), 135C.25, 135C.36, 227.4, 235B.1(6), and 235B.1(11).

- [Filed 8/6/76, Notice 4/19/76—published 8/23/76, effective 9/27/76]
- [Filed without Notice 10/4/76—published 10/20/76, effective 11/24/76]
- [Filed emergency 12/21/76—published 1/12/77, effective 1/12/77]
- [Filed without Notice 2/4/77—published 2/23/77, effective 3/30/77]
- [Filed 8/18/77, Notice 3/9/77—published 9/7/77, effective 10/13/77]
- [Filed without Notice 10/14/77—published 11/2/77, effective 12/8/77]
- [Filed 1/20/78, Notice 12/14/77—published 2/8/78, effective 3/15/78]
- [Filed 5/26/78, Notice 3/8/78—published 6/14/78, effective 7/19/78]
- [Filed 7/7/78, Notice 5/31/78—published 7/26/78, effective 9/1/78]
- [Filed 10/13/78, Notice 9/6/78—published 11/1/78, effective 12/7/78]
- [Filed 11/9/78, Notice 6/28/78—published 11/29/78, effective 1/3/79]
- [Filed emergency 11/22/78—published 12/13/78, effective 1/3/79]
- [Filed 5/20/82, Notice 12/23/81—published 6/9/82, effective 7/14/82]
- [Filed 1/10/86, Notice 11/6/85—published 1/29/86, effective 3/5/86<sup>1</sup>]
- [Filed 5/16/86, Notice 1/1/86—published 6/4/86, effective 7/9/86]
- [Filed emergency 7/1/86—published 7/16/86, effective 7/1/86]<sup>2</sup>
- [Filed emergency 9/19/86—published 10/8/86, effective 9/19/86]
- [Filed 3/12/87, Notice 1/28/87—published 4/8/87, effective 5/13/87]
- [Filed emergency 6/25/87—published 7/15/87, effective 7/1/87]
- [Filed 2/5/88, Notice 10/7/87—published 2/24/88, effective 3/30/88]<sup>o</sup>
- [Filed 4/28/88, Notice 12/16/87—published 5/18/88, effective 6/22/88]
- [Filed 5/26/88, Notice 4/20/88—published 6/15/88, effective 7/20/88]
- [Filed 9/30/88, Notice 8/24/88—published 10/19/88, effective 11/23/88]
- [Filed 12/9/88, Notices 8/24/88, 10/5/88—published 12/28/88, effective 2/1/89]
- [Filed 6/23/89, Notice 5/17/89—published 7/12/89, effective 8/16/89]
- [Filed 7/20/89, Notice 6/14/89—published 8/9/89, effective 9/13/89]
- [Filed 8/16/89, Notices 4/19/89, 7/12/89—published 9/6/89, effective 10/11/89]
- [Filed 3/14/91, Notice 9/19/90—published 4/3/91, effective 5/8/91]
- [Filed emergency 5/10/91—published 5/29/91, effective 5/10/91]
- [Filed 1/31/92, Notice 11/13/91—published 2/19/92, effective 7/1/92]
- [Filed 3/12/92, Notice 12/11/91—published 4/1/92, effective 5/6/92]
- [Filed 5/21/93, Notice 11/25/92—published 6/9/93, effective 7/14/93<sup>3</sup>]

[Filed 3/11/94, Notice 9/15/93—published 3/30/94, effective 5/4/94]

[Filed 5/16/95, Notice 3/15/95—published 6/7/95, effective 7/12/95]

[Filed 7/11/97, Notice 4/23/97—published 7/30/97, effective 9/3/97]

[Filed emergency 7/25/97—published 8/13/97, effective 7/25/97]

[Filed emergency 11/14/97—published 12/3/97, effective 11/14/97]

[Filed 11/14/97, Notice 8/13/97—published 12/3/97, effective 1/7/98]

[Filed 3/31/98, Notice 12/3/97—published 4/22/98, effective 5/27/98]

[Filed 7/9/98, Notice 4/22/98—published 7/29/98, effective 9/2/98]

[Filed 1/15/04, Notice 10/1/03—published 2/4/04, effective 3/10/04]

[Filed 1/15/04, Notice 12/10/03—published 2/4/04, effective 3/10/04]

[Filed 7/13/05, Notice 6/8/05—published 8/3/05, effective 9/7/05]

[Filed 9/20/06, Notice 8/2/06—published 10/11/06, effective 11/15/06]

[Filed 11/14/07, Notice 10/10/07—published 12/5/07, effective 1/9/08]

[Filed 7/9/08, Notice 1/30/08—published 7/30/08, effective 9/3/08]

[Filed ARC 0663C (Notice ARC 0513C, IAB 12/12/12), IAB 4/3/13, effective 5/8/13]

[Filed ARC 0766C (Notice ARC 0601C, IAB 2/6/13), IAB 5/29/13, effective 7/3/13]

[Filed ARC 0903C (Notice ARC 0776C, IAB 5/29/13), IAB 8/7/13, effective 9/11/13]

[Filed ARC 1050C (Notice ARC 0907C, IAB 8/7/13), IAB 10/2/13, effective 11/6/13]

<sup>0</sup> Two or more ARCs

<sup>1</sup> Effective date of 470—57.15(2)“a” and “b” delayed until the expiration of 45 calendar days into the 1987 session of the General Assembly pursuant to Iowa Code section 17A.8(9), IAB 6/4/86.

<sup>2</sup> See IAB, Inspections and Appeals Department.

<sup>3</sup> Effective date of 481—57.12(2)“a,” last paragraph, delayed 70 days by the Administrative Rules Review Committee at its meeting held July 8, 1993.

## OBJECTION

At its February 13 meeting the Administrative Rules Review Committee voted the following objection: [Subrules 57.23(2)“b,” 58.26(2)“b,” 59.31(2)“b,” 63.21(3)“b,” published IAB 12/13/78]

The committee objects to the amendments to 470\* IAC 57.23(2)“b,” 58.26(2)“b,” 59.31(2)“b” and 63.21(3)“b,” which strike the phrase “Twenty-five percent of the staffing may be provided by qualified volunteers. The time shall be spent in working with the organized program activity.”, on the grounds these provisions are unreasonable. It is the understanding of the committee these deletions in effect require facilities to employ a person to coordinate recreation activities. It is the feeling of the committee this would result in higher per bed costs without demonstrably improving the services rendered to the patient. Volunteers have always played a major role in health care institutions, and no evidence has been submitted indicating a decline in that role or in public interest in donating time and energy.

These amendments appear in the 12-13-78 IAB, and have been filed under the emergency provisions of chapter 17A, 1979 Code.

\*Chapter 57 transferred to Inspections and Appeals[481], IAC 7/15/87.

CHAPTER 58  
NURSING FACILITIES

[Prior to 7/15/87, Health Department[470] Ch 58]

**481—58.1(135C) Definitions.** For the purpose of these rules, the following terms shall have the meaning indicated in this chapter. The definitions set out in Iowa Code section 135C.1 shall be considered to be incorporated verbatim in the rules. The use of the words “shall” and “must” indicates those standards are mandatory. The use of the words “should” and “could” indicates those standards are recommended.

“*Accommodation*” means the provision of lodging, including sleeping, dining, and living areas.

“*Administrator*” means a person licensed pursuant to Iowa Code chapter 147 who administers, manages, supervises, and is in general administrative charge of a nursing facility, whether or not such individual has an ownership interest in such facility, and whether or not the functions and duties are shared with one or more individuals.

“*Alcoholic*” means a person in a state of dependency resulting from excessive or prolonged consumption of alcoholic beverages as defined in Iowa Code section 125.2.

“*Ambulatory*” means the condition of a person who immediately and without aid of another is physically or mentally capable of traveling a normal path to safety, including the ascent and descent of stairs.

“*Basement*” means that part of a building where the finish floor is more than 30 inches below the finish grade.

“*Board*” means the regular provision of meals.

“*Chairfast*” means capable of maintaining a sitting position but lacking the capacity of bearing own weight, even with the aid of a mechanical device or another individual.

“*Communicable disease*” means a disease caused by the presence of viruses or microbial agents within a person’s body, which agents may be transmitted either directly or indirectly to other persons.

“*Department*” means the state department of inspections and appeals.

“*Distinct part*” means a clearly identifiable area or section within a health care facility, consisting of at least a residential unit, wing, floor, or building containing contiguous rooms.

“*Drug addiction*” means a state of dependency, as medically determined, resulting from excessive or prolonged use of drugs as defined in Iowa Code chapter 124.

“*Medication*” means any drug including over-the-counter substances ordered and administered under the direction of the physician.

“*Nonambulatory*” means the condition of a person who immediately and without aid of another is not physically or mentally capable of traveling a normal path to safety, including the ascent and descent of stairs.

“*Nourishing snack*” is defined as a verbal offering of items, single or in combination, from the basic food groups. Adequacy of the “nourishing snack” will be determined both by resident interviews and by evaluation of the overall nutritional status of residents in the facility.

“*Person directed care environment*” means the provision of care and services provided in a facility that promotes decision making and choices by the resident, enhances the primary caregiver’s capacity to respond to each resident’s needs, and promotes a homelike environment. Examples of a person directed care environment include, but are not limited to, the Green House concept, the Eden alternative, service houses and neighborhoods.

“*Personal care*” means assistance with the activities of daily living which the recipient can perform only with difficulty. Examples are assistance in getting in and out of bed, assistance with personal hygiene and bathing, assistance with dressing, meal assistance, and supervision over medications which can be self-administered.

“*Potentially hazardous food*” means a food that is natural or synthetic and that requires temperature control because it is in a form capable of supporting the rapid and progressive growth of infectious or toxigenic microorganisms, the growth and toxin production of clostridium botulinum, or in raw shell eggs, the growth of salmonella enteritidis. Potentially hazardous food includes an animal food (a food of animal origin) that is raw or heat-treated; a food of plant origin that is heat-treated or consists of raw

seed sprouts; cut melons; and garlic and oil mixtures that are not acidified or otherwise modified at a food processing plant in a way that results in mixtures that do not support growth of bacteria.

*“Program of care”* means all services being provided for a resident in a health care facility.

*“Qualified intellectual disabilities professional”* means a psychologist, physician, registered nurse, educator, social worker, physical or occupational therapist, speech therapist or audiologist who meets the educational requirements for the profession, as required in the state of Iowa, and having one year’s experience working with persons with an intellectual disability.

*“Qualified nurse”* means a registered nurse or a licensed practical nurse, as defined in Iowa Code chapter 152.

*“Rate”* means that daily fee charged for all residents equally and shall include the cost of all minimum services required in these rules and regulations.

*“Responsible party”* means the person who signs or cosigns the admission agreement required in 481—58.13(135C) or the resident’s guardian or conservator if one has been appointed. In the event that a resident does not have a guardian, conservator or other person signing the admission agreement, the term “responsible party” shall include the resident’s sponsoring agency, e.g., the department of human services, the U.S. Department of Veterans Affairs, religious groups, fraternal organizations, or foundations that assume responsibility and advocate for their client patients and pay for their health care.

*“Restraints”* means any chemical, manual method or physical or mechanical device, material, or equipment attached to the resident’s body that the individual cannot remove easily which restricts freedom of movement or normal access to one’s body.

*“Substantial evening meal”* is defined as an offering of three or more menu items at one time, one of which includes a high protein such as meat, fish, eggs or cheese. The meal would represent no less than 20 percent of the day’s total nutritional requirements.

[ARC 0766C, IAB 5/29/13, effective 7/3/13]

**481—58.2(135C) Variances.** Variances from these rules may be granted by the director of the department of inspections and appeals for good and sufficient reason when the need for variance has been established; no danger to the health, safety, or welfare of any resident results; alternate means are employed or compensating circumstances exist and the variance will apply only to an individual nursing facility. Variances will be reviewed at the discretion of the director of the department of inspections and appeals.

**58.2(1)** To request a variance, the licensee must:

- a. Apply for variance in writing on a form provided by the department;
- b. Cite the rule or rules from which a variance is desired;
- c. State why compliance with the rule or rules cannot be accomplished;
- d. Explain alternate arrangements or compensating circumstances which justify the variance;
- e. Demonstrate that the requested variance will not endanger the health, safety, or welfare of any resident.

**58.2(2)** Upon receipt of a request for variance, the director of inspections and appeals will:

- a. Examine the rule from which variance is requested to determine that the request is necessary and reasonable;
- b. If the request meets the above criteria, evaluate the alternate arrangements or compensating circumstances against the requirement of the rules;
- c. Examine the effect of the requested variance on the health, safety, or welfare of the residents;
- d. Consult with the applicant if additional information is required.

**58.2(3)** Based upon these studies, approval of the variance will be either granted or denied within 120 days of receipt.

**481—58.3(135C) Application for licensure.**

**58.3(1)** Initial application and licensing. In order to obtain an initial nursing facility license, for a nursing facility which is currently licensed, the applicant must:

*a.* Meet all of the rules, regulations, and standards contained in 481—Chapters 58 and 61. Applicable exceptions found in rule 481—61.2(135C) shall apply based on the construction date of the facility.

*b.* Submit a letter of intent and a written résumé of the resident care program and other services provided for departmental review and approval;

*c.* Make application at least 30 days prior to the change of ownership of the facility on forms provided by the department;

*d.* Submit a floor plan of each floor of the nursing facility, drawn on 8½- × 11-inch paper showing room areas in proportion, room dimensions, room numbers for all rooms, including bathrooms, and designation of the use to which room will be put and window and door location;

*e.* Submit a photograph of the front and side elevation of the nursing facility;

*f.* Submit the statutory fee for a nursing facility license;

*g.* Meet the requirements of a nursing facility for which licensure application is made;

*h.* Comply with all other local statutes and ordinances in existence at the time of licensure;

*i.* Have a certificate signed by the state fire marshal or deputy state fire marshal as to compliance with fire safety rules and regulations.

**58.3(2)** In order to obtain an initial nursing facility license for a facility not currently licensed as a nursing facility, the applicant must:

*a.* Meet all of the rules, regulations, and standards contained in 481—Chapters 58 and 61. Exceptions noted in 481—subrule 61.1(2) shall not apply;

*b.* Submit a letter of intent and a written résumé of the resident care program and other services provided for departmental review and approval;

*c.* Make application at least 30 days prior to the change of ownership of the facility on forms provided by the department;

*d.* Submit a floor plan of each floor of the nursing facility, drawn on 8½- × 11-inch paper showing room areas in proportion, room dimensions, room numbers for all rooms, including bathrooms, and designation of the use to which room will be put and window and door locations;

*e.* Submit a photograph of the front and side elevation of the nursing facility;

*f.* Submit the statutory fee for a nursing facility license;

*g.* Comply with all other local statutes and ordinances in existence at the time of licensure;

*h.* Have a certificate signed by the state fire marshal or deputy state fire marshal as to compliance with fire safety rules and regulations.

**58.3(3)** *Renewal application.* In order to obtain a renewal of the nursing facility license, the applicant must:

*a.* Submit the completed application form 30 days prior to annual license renewal date of nursing facility license;

*b.* Submit the statutory license fee for a nursing facility with the application for renewal;

*c.* Have an approved current certificate signed by the state fire marshal or deputy state fire marshal as to compliance with fire safety rules and regulations;

*d.* Submit appropriate changes in the résumé to reflect any changes in the resident care program or other services.

**58.3(4)** Licenses are issued to the person or governmental unit which has responsibility for the operation of the facility and authority to comply with all applicable statutes, rules or regulations.

The person or governmental unit must be the owner of the facility or, if the facility is leased, the lessee.

#### **481—58.4(135C) General requirements.**

**58.4(1)** The license shall be displayed in a conspicuous place in the facility which is viewed by the public. (III)

**58.4(2)** The license shall be valid only in the possession of the licensee to whom it is issued.

**58.4(3)** The posted license shall accurately reflect the current status of the nursing facility. (III)

**58.4(4)** Licenses expire one year after the date of issuance or as indicated on the license.

**58.4(5)** No nursing facility shall be licensed for more beds than have been approved by the health facilities construction review committee.

**58.4(6)** Each citation or a copy of each citation issued by the department for a class I or class II violation shall be prominently posted by the facility in plain view of the residents, visitors, and persons inquiring about placement in the facility. The citation or copy of the citation shall remain posted until the violation is corrected to the satisfaction of the department. (III)

**481—58.5(135C) Notifications required by the department.** The department shall be notified:

**58.5(1)** Within 48 hours, by letter, of any reduction or loss of nursing or dietary staff lasting more than seven days which places the staffing ratio below that required for licensing. No additional residents shall be admitted until the minimum staffing requirements are achieved; (III)

**58.5(2)** Of any proposed change in the nursing facility's functional operation or addition or deletion of required services; (III)

**58.5(3)** Thirty days before addition, alteration, or new construction is begun in the nursing facility or on the premises; (III)

**58.5(4)** Thirty days in advance of closure of the nursing facility; (III)

**58.5(5)** Within two weeks of any change in administrator; (III)

**58.5(6)** When any change in the category of license is sought; (III)

**58.5(7)** Prior to the purchase, transfer, assignment, or lease of a nursing facility, the licensee shall:

- a. Inform the department of the pending sale, transfer, assignment, or lease of the facility; (III)
- b. Inform the department of the name and address of the prospective purchaser, transferee, assignee, or lessee at least 30 days before the sale, transfer, assignment, or lease is completed; (III)
- c. Submit a written authorization to the department permitting the department to release all information of whatever kind from the department's files concerning the licensee's nursing facility to the named prospective purchaser, transferee, assignee, or lessee. (III)

**58.5(8)** Pursuant to the authorization submitted to the department by the licensee prior to the purchase, transfer, assignment, or lease of a nursing facility, the department shall upon request send or give copies of all recent licensure surveys and of any other pertinent information relating to the facility's licensure status to the prospective purchaser, transferee, assignee, or lessee; costs for such copies shall be paid by the prospective purchaser.

**481—58.6(135C) Witness fees.** Rescinded IAB 3/30/94, effective 5/4/94. See 481—subrule 50.6(4).

**481—58.7(135C) Licenses for distinct parts.**

**58.7(1)** Separate licenses may be issued for distinct parts of a health care facility which are clearly identifiable, containing contiguous rooms in a separate wing or building or on a separate floor of the facility and which provide care and services of separate categories.

**58.7(2)** The following requirements shall be met for a separate licensing of a distinct part:

a. The distinct part shall serve only residents who require the category of care and services immediately available to them within that part; (III)

b. The distinct part shall meet all the standards, rules, and regulations pertaining to the category for which a license is being sought;

c. A distinct part must be operationally and financially feasible;

d. A separate staff with qualifications appropriate to the care and services being rendered must be regularly assigned and working in the distinct part under responsible management; (III)

e. Separately licensed distinct parts may have certain services such as management, building maintenance, laundry, and dietary in common with each other.

**481—58.8(135C) Administrator.**

**58.8(1)** Each nursing facility shall have one person in charge, duly licensed as a nursing home administrator or acting in a provisional capacity. (III)

**58.8(2)** A licensed administrator may act as an administrator for not more than two nursing facilities.

- a. The distance between the two facilities shall be no greater than 50 miles. (II)
- b. The administrator shall spend the equivalent of three full eight-hour days per week in each facility. (II)
- c. The administrator may be responsible for no more than 150 beds in total if the administrator is an administrator of more than one facility. (II)

**58.8(3)** The licensee may be the licensed nursing home administrator providing the licensee meets the requirements as set forth in these regulations and devotes the required time to administrative duties. Residency in the facility does not in itself meet the requirement. (III)

**58.8(4)** A provisional administrator may be appointed on a temporary basis by the nursing facility licensee to assume the administrative duties when the facility, through no fault of its own, has lost its administrator and has been unable to replace the administrator provided that no facility licensed under Iowa Code chapter 135C shall be permitted to have a provisional administrator for more than 6 months in any 12-month period and further provided that:

- a. The department has been notified prior to the date of the administrator's appointment; (III)
- b. The board of examiners for nursing home administrators has approved the administrator's appointment and has confirmed such appointment in writing to the department. (III)

**58.8(5)** In the absence of the administrator, a responsible person shall be designated in writing to the department to be in charge of the facility. (III) The person designated shall:

- a. Be knowledgeable of the operation of the facility; (III)
- b. Have access to records concerned with the operation of the facility; (III)
- c. Be capable of carrying out administrative duties and of assuming administrative responsibilities; (III)
- d. Be at least 18 years of age; (III)
- e. Be empowered to act on behalf of the licensee during the administrator's absence concerning the health, safety, and welfare of the residents; (III)
- f. Have had training to carry out assignments and take care of emergencies and sudden illness of residents. (III)

**58.8(6)** A licensed administrator in charge of two facilities shall employ an individual designated as a full-time assistant administrator for each facility. (III)

**58.8(7)** An administrator of only one facility shall be considered as a full-time employee. Full-time employment is defined as 40 hours per week. (III)

#### **481—58.9(135C) Administration.**

**58.9(1)** The licensee shall:

- a. Assume the responsibility for the overall operation of the nursing facility; (III)
- b. Be responsible for compliance with all applicable laws and with the rules of the department; (III)
- c. Establish written policies, which shall be available for review, for the operation of the nursing facility. (III)

**58.9(2)** The administrator shall:

- a. Be responsible for the selection and direction of competent personnel to provide services for the resident care program; (III)
- b. Be responsible for the arrangement for all department heads to annually attend a minimum of ten contact hours of educational programs to increase skills and knowledge needed for the position; (III)
- c. Be responsible for a monthly in-service educational program for all employees and to maintain records of programs and participants; (III)
- d. Make available the nursing facility payroll records for departmental review as needed; (III)
- e. Be required to maintain a staffing pattern of all departments. These records must be maintained for six months and are to be made available for departmental review. (III)

**481—58.10(135C) General policies.**

**58.10(1)** There shall be written personnel policies in facilities of more than 15 beds to include hours of work, and attendance at educational programs. (III)

**58.10(2)** There shall be a written job description developed for each category of worker. The job description shall include title of job, job summary, qualifications (formal education and experience), skills needed, physical requirements, and responsibilities. (III)

**58.10(3)** There shall be written personnel policies for each facility. Personnel policies shall include the following requirements:

- a. Employees shall have a physical examination before employment. (I, II, III)
- b. Employees shall have a physical examination at least every four years. (I, II, III)
- c. Screening and testing for tuberculosis shall be conducted pursuant to 481—Chapter 59. (I, II, III)

**58.10(4)** Health certificates for all employees shall be available for review. (III)

**58.10(5)** Rescinded IAB 10/19/88, effective 11/23/88.

**58.10(6)** There shall be written policies for emergency medical care for employees and residents in case of sudden illness or accident which includes the individual to be contacted in case of emergency. (III)

**58.10(7)** The facility shall have a written agreement with a hospital for the timely admission of a resident who, in the opinion of the attending physician, requires hospitalization. (III)

**58.10(8)** Infection control program. Each facility shall have a written and implemented infection control and exposure control program with policies and procedures based on the guidelines issued by the Centers for Disease Control and Prevention, U.S. Department of Health and Human Services. (I, II, III) CDC guidelines are available at <http://www.cdc.gov/ncidod/dhqp/index.html>.

**58.10(9)** Infection control committee. Each facility shall establish an infection control committee of representative professional staff responsible for overall infection control in the facility. (III)

a. The committee shall annually review and revise the infection control policies and procedures to monitor effectiveness and suggest improvement. (III)

b. The committee shall meet at least quarterly, submit reports to the administrator, and maintain minutes in sufficient detail to document its proceedings and actions. (III)

c. The committee shall monitor the health aspect and the environment of the facility. (III)

**58.10(10)** There shall be written policies for resident care programs and services as outlined in these rules. (III)

**58.10(11)** Prior to the removal of a deceased resident/patient from a facility, the funeral director or person responsible for transporting the body shall be notified by the facility staff of any special precautions that were followed by the facility having to do with the mode of transmission of a known or suspected communicable disease. (III)

[ARC 0663C, IAB 4/3/13, effective 5/8/13]

**481—58.11(135C) Personnel.**

**58.11(1) General qualifications.**

a. No person with a current record of habitual alcohol intoxication or addiction to the use of drugs shall serve in a managerial role of a nursing facility. (II)

b. No person under the influence of alcohol or intoxicating drugs shall be permitted to provide services in a nursing facility. (II)

c. No person shall be allowed to provide services in a facility if the person has a disease:

- (1) Which is transmissible through required workplace contact, (I, II, III)
- (2) Which presents a significant risk of infecting others, (I, II, III)
- (3) Which presents a substantial possibility of harming others, and (I, II, III)
- (4) For which no reasonable accommodation can eliminate the risk. (I, II, III)

Refer to Guidelines for Infection Control in Hospital Personnel, Centers for Disease Control, U.S. Department of Health and Human Services, PB85-923402 to determine (1), (2), (3) and (4).

d. Reserved.

*e.* Individuals with either physical or mental disabilities may be employed for specific duties, but only if that disability is unrelated to that individual's ability to perform the duties of the job. (III)

*f.* Persons employed in all departments, except the nursing department of a nursing facility shall be qualified through formal training or through prior experience to perform the type of work for which they have been employed. Prior experience means at least 240 hours of full-time employment in a field related to their duties. Persons may be hired in laundry, housekeeping, activities and dietary without experience or training if the facility institutes a formal in-service training program to fit the job description in question and documents such as having taken place within 30 days after the initial hiring of such untrained employees. (III)

*g.* Rescinded, effective 7/14/82.

*h.* The health services supervisor shall be a qualified nurse as defined in these regulations. (II)

*i.* Those persons employed as nurse's aides, orderlies, or attendants in a nursing facility who have not completed the state-approved 75-hour nurse's aide program shall be required to participate in a structured on-the-job training program of 20 hours' duration to be conducted prior to any resident contact, except that contact required by the training program. This educational program shall be in addition to facility orientation. Each individual shall demonstrate competencies covered by the curriculum. This shall be observed and documented by an R.N. and maintained in the personnel file. No aide shall work independently until this is accomplished, nor shall the aide's hours count toward meeting the minimum hours of nursing care required by the department. The curriculum shall be approved by the department. An aide who has completed the state-approved 75-hour course may model skills to be learned.

Further, such personnel shall be enrolled in a state-approved 75-hour nurse's aide program to be completed no later than six months from the date of employment. If the state-approved 75-hour program has been completed prior to employment, the on-the-job training program requirement is waived. The 20-hour course is in addition to the 75-hour course and is not a substitute in whole or in part. The 75-hour program, approved by the department, may be provided by the facility or academic institution.

Newly hired aides who have completed the state-approved 75-hour course shall demonstrate competencies taught in the 20-hour course upon hire. This shall be observed and documented by an R.N. and maintained in the personnel file.

All personnel administering medications must have completed the state-approved training program in medication administration. (II)

*j.* There shall be an organized ongoing in-service educational and training program planned in advance for all personnel in all departments. (II, III)

*k.* Nurse aides, orderlies or attendants in a nursing facility who have received training other than the Iowa state-approved program, must pass a challenge examination approved by the department of inspections and appeals. Evidence of prior formal training in a nursing aide, orderly, attendant, or other comparable program must be presented to the facility or institution conducting the challenge examination before the examination is given. The approved facility or institution, following department of inspections and appeals guidelines, shall make the determination of who is qualified to take the examination. Documentation of the challenge examinations administered shall be maintained.

**58.11(2) Nursing supervision and staffing.**

*a.* Rescinded IAB 8/7/91, effective 7/19/91.

*b.* Where only part-time nurses are employed, one nurse shall be designated health service supervisor. (III)

*c.* A qualified nurse shall be employed to relieve the supervising nurses, including charge nurses, on holidays, vacation, sick leave, days off, absences or emergencies. Pertinent information for contacting such relief person shall be posted at the nurse's station. (III)

*d.* When the health service supervisor serves as the administrator of a facility 50 beds and over, a qualified nurse must be employed to relieve the health service supervisor of nursing responsibilities. (III)

*e.* The department may establish on an individual facility basis the numbers and qualifications of the staff required in the facility using as its criteria the services being offered and the needs of the residents. (III)

*f.* Additional staffing, above the minimum ratio, may be required by the department commensurate with the needs of the individual residents. (III)

*g.* The minimum hours of resident care personnel required for residents needing intermediate nursing care shall be 2.0 hours per resident day computed on a seven-day week. A minimum of 20 percent of this time shall be provided by qualified nurses. If the maximum medical assistance rate is reduced below the 74th percentile, the requirement will return to 1.7 hours per resident per day computed on a seven-day week. A minimum of 20 percent of this time shall be provided by qualified nurses. (II, III)

*h.* The health service supervisor's hours worked per week shall be included in computing the 20 percent requirement.

*i.* A nursing facility of 75 beds or more shall have a qualified nurse on duty 24 hours per day, seven days a week. (II, III)

*j.* In facilities under 75 beds, if the health service supervisor is a licensed practical nurse, the facility shall employ a registered nurse, for at least four hours each week for consultation, who must be on duty at the same time as the health service supervisor. (II, III)

(1) This shall be an on-site consultation and documentation shall be made of the visit. (III)

(2) The registered nurse-consultant shall have responsibilities clearly outlined in a written agreement with the facility. (III)

(3) Consultation shall include but not be limited to the following: counseling the health service supervisor in the management of the health services; (III) reviewing and evaluating the health services in determining that the needs of the residents are met; (II, III) conducting a review of medications at least monthly if the facility does not employ a registered nurse part-time. (II, III)

*k.* Facilities with 75 or more beds must employ a health service supervisor who is a registered nurse. (II)

*l.* There shall be at least two people who shall be capable of rendering nursing service, awake, dressed, and on duty at all times. (II)

*m.* Physician's orders shall be implemented by qualified personnel. (II, III)

**58.11(3)** *Employee criminal record checks, child abuse checks and dependent adult abuse checks and employment of individuals who have committed a crime or have a founded abuse.* The facility shall comply with the requirements found in Iowa Code section 135C.33 as amended by 2013 Iowa Acts, Senate File 347, and rule 481—50.9(135C) related to completion of criminal record checks, child abuse checks, and dependent adult abuse checks and to employment of individuals who have committed a crime or have a founded abuse. (I, II, III)

[ARC 0903C, IAB 8/7/13, effective 9/11/13]

#### **481—58.12(135C) Admission, transfer, and discharge.**

##### **58.12(1)** *General admission policies.*

*a.* No resident shall be admitted or retained in a nursing facility who is in need of greater services than the facility can provide. (II, III)

*b.* No nursing facility shall admit more residents than the number of beds for which it is licensed, except guest rooms for visitors. (II, III)

*c.* There shall be no more beds erected than is stipulated on the license. (II, III)

*d.* There shall be no more beds erected in a room than its size and other characteristics will permit. (II, III)

*e.* The admission of a resident to a nursing facility shall not give the facility or any employee of the facility the right to manage, use, or dispose of any property of the resident except with the written authorization of the resident or the resident's legal representative. (III)

*f.* The admission of a resident shall not grant the nursing facility the authority or responsibility to manage the personal affairs of the resident except as may be necessary for the safety of the resident and safe and orderly management of the facility as required by these rules. (III)

*g.* A nursing facility shall provide for the safekeeping of personal effects, funds, and other property of its residents. The facility may require that items of exceptional value or which would

convey unreasonable responsibilities to the licensee be removed from the premises of the facility for safekeeping. (III)

*h.* Rescinded, effective 7/14/82.

*i.* Funds or properties received by the nursing facility belonging to or due a resident, expendable for the resident's account, shall be trust funds. (III)

*j.* Infants and children under the age of 16 shall not be admitted to health care facilities for adults unless given prior written approval by the department. A distinct part of a health care facility, segregated from the adult section, may be established based on a program of care submitted by the licensee or applicant which is commensurate with the needs of the residents of the health care facility and has received the department's review and approval. (III)

*k.* No health care facility, and no owner, administrator, employee or representative thereof shall act as guardian, trustee, or conservator for any resident's property, unless such resident is related to the person acting as guardian within the third degree of consanguinity.

*l.* Within 30 days of a resident's admission to a health care facility receiving reimbursement through the medical assistance program under Iowa Code chapter 249A, the facility shall ask the resident or the resident's personal representative whether the resident is a veteran and shall document the response. If the facility determines that the resident is a potential veteran, the facility shall report the resident's name along with the names of the resident's spouse and any dependent children, as well as the name of the contact person for this information, to the Iowa department of veterans affairs. Where appropriate, the facility may also report such information to the Iowa department of human services.

If a resident is eligible for benefits through the United States Department of Veterans Affairs or other third-party payor, the facility first shall seek reimbursement from the identified payor source before seeking reimbursement from the medical assistance program established under Iowa Code chapter 249A.

The provisions of this paragraph shall not apply to the admission of an individual as a resident to a state mental health institute for acute psychiatric care or to the admission of an individual to the Iowa Veterans Home. (II, III)

**58.12(2) Discharge or transfer.**

*a.* Prior notification shall be made to the resident, as well as the resident's next of kin, legal representative, attending physician, and sponsoring agency, if any, prior to transfer or discharge of any resident. (III)

*b.* Proper arrangements shall be made by the nursing facility for the welfare of the resident prior to transfer or discharge in the event of an emergency or inability to reach the next of kin or legal representative. (III)

*c.* The licensee shall not refuse to discharge or transfer a resident when the physician, family, resident, or legal representative requests such a discharge or transfer. (II, III)

*d.* Advance notification will be made to the receiving facility prior to the transfer of any resident. (III)

*e.* When a resident is transferred or discharged, the appropriate record as set forth in 58.15(2) "k" of these rules will accompany the resident. (II, III)

*f.* Prior to the transfer or discharge of a resident to another health care facility, arrangements to provide for continuity of care shall be made with the facility to which the resident is being sent. (II, III)

**481—58.13(135C) Contracts.** Each contract shall:

**58.13(1)** State the base rate or scale per day or per month, the services included, and the method of payment; (III)

**58.13(2)** Contain a complete schedule of all offered services for which a fee may be charged in addition to the base rate. Furthermore, the contract shall: (III)

*a.* Stipulate that no further additional fees shall be charged for items not contained in complete schedule of services as set forth in 58.13(3); (III)

*b.* State the method of payment of additional charges; (III)

*c.* Contain an explanation of the method of assessment of such additional charges and an explanation of the method of periodic reassessment, if any, resulting in changing such additional charges; (III)

*d.* State that additional fees may be charged to the resident for nonprescription drugs, other personal supplies, and services by a barber, beautician, etc.; (III)

**58.13(3)** Contain an itemized list of those services, with the specific fee the resident will be charged and method of payment, as related to the resident's current condition, based on the nursing assessment at the time of admission, which is determined in consultation with the administrator; (III)

**58.13(4)** Include the total fee to be charged initially to the specific resident; (III)

**58.13(5)** State the conditions whereby the facility may make adjustments to the facility's overall fees for resident care as a result of changing costs. (III) Furthermore, the contract shall provide that the facility shall give:

*a.* Written notification to the resident, or responsible party when appropriate, of changes in the overall rates of both base and additional charges at least 30 days prior to effective date of such changes; (III)

*b.* Notification to the resident, or responsible party when appropriate, of changes in additional charges, based on a change in the resident's condition. Notification must occur prior to the date such revised additional charges begin. If notification is given orally, subsequent written notification must also be given within a reasonable time, not to exceed one week, listing specifically the adjustments made; (III)

**58.13(6)** State the terms of agreement in regard to refund of all advance payments in the event of transfer, death, voluntary or involuntary discharge; (III)

**58.13(7)** State the terms of agreement concerning the holding and charging for a bed when a resident is hospitalized or leaves the facility temporarily for recreational or therapeutic reasons. The terms shall contain a provision that the bed will be held at the request of the resident or the resident's responsible party.

*a.* The facility shall ask the resident or responsible party if the resident wants the bed held. This request shall be made before the resident leaves or within 48 hours after the resident leaves. The inquiry and the response shall be documented. (II)

*b.* The facility shall reserve the bed when requested for as long as payments are made in accordance with the contract. (II)

**58.13(8)** State the conditions under which the involuntary discharge or transfer of a resident would be effected; (III)

**58.13(9)** State the conditions of voluntary discharge or transfer; (III)

**58.13(10)** Set forth any other matters deemed appropriate by the parties to the contract. No contract or any provision thereof shall be drawn or construed so as to relieve any health care facility of any requirement or obligation imposed upon it by this chapter or any standards or rules in force pursuant to this chapter; (III)

**58.13(11)** Each party shall receive a copy of the signed contract. (III)

#### **481—58.14(135C) Medical services.**

**58.14(1)** Each resident in a nursing facility shall designate a licensed physician who may be called when needed. Professional management of a resident's care shall be the responsibility of the hospice program when:

*a.* The resident is terminally ill, and

*b.* The resident has elected to receive hospice services under the federal Medicare program from a Medicare-certified hospice program, and

*c.* The facility and the hospice program have entered into a written agreement under which the hospice program takes full responsibility for the professional management of hospice care.

**58.14(2)** Each resident admitted to a nursing facility shall have had a physical examination prior to admission. If the resident is admitted directly from a hospital, a copy of the hospital admission physical

and discharge summary may be made part of the record in lieu of an additional physical examination. A record of the examination, signed by the physician, shall be a part of the resident's record. (III)

**58.14(3)** Arrangements shall be made to have a physician available to furnish medical care in case of emergency. (II, III)

**58.14(4)** Rescinded, effective 7/14/82.

**58.14(5)** The person in charge shall immediately notify the physician of any accident, injury, or adverse change in the resident's condition. (I, II, III)

**58.14(6)** A schedule listing the names and telephone numbers of the physicians shall be posted in each nursing station. (III)

**58.14(7)** Residents shall be admitted to a nursing facility only on a written order signed by a physician certifying that the individual being admitted requires no greater degree of nursing care than the facility is licensed to provide. (III)

**58.14(8)** Physician delegation of tasks. Each resident shall be visited by or shall visit the resident's physician at least twice a year. The year period shall be measured from the date of admission and is not to include preadmission physicals.

*a.* For a skilled nursing patient, the resident must be seen by a physician for the initial comprehensive visit. Additional visits are required at least once every 30 days for 90 days after admission and at least once every 60 days thereafter. After the initial comprehensive visit, alternate required visits may be performed by an advanced registered nurse practitioner, clinical nurse specialist or physician assistant who is working in collaboration with a physician, as outlined in Table 1. (III)

*b.* Notwithstanding the provisions of 42 CFR 483.40, any required physician task or visit in a nursing facility may also be performed by an advanced registered nurse practitioner, clinical nurse specialist, or physician assistant who is working in collaboration with a physician, as outlined in Table 1. (III)

*c.* In dually certified skilled nursing/nursing facilities, the advanced registered nurse practitioner, clinical nurse specialist, and physician assistant must follow the skilled nursing facility requirements for services for skilled nursing facility stays. For nursing facility stays in skilled nursing/nursing facilities, any required physician task or visit may be performed by an advanced registered nurse practitioner, clinical nurse specialist, or physician assistant working in collaboration with the physician. (III)

*d.* Nurse practitioners, clinical nurse specialists, and physician assistants may perform other tasks that are not reserved to the physician such as visits outside the normal schedule needed to address new symptoms or other changes in medical status. (III)

Table 1: Authority for non-physician practitioners to perform visits, sign orders, and sign certifications/recertifications when permitted by state law\*

	Initial Comprehensive Visit/Orders	Other Required Visits <sup>1</sup>	Other Medically Necessary Visits and Orders <sup>2</sup>	Certification/Recertification
<b>Skilled Nursing Facilities</b>				
Physician assistant, nurse practitioner and clinical nurse specialist employed by the facility	May not perform/May not sign	May perform alternate visits	May perform and sign	May not sign
Physician assistant, nurse practitioner and clinical nurse specialist not a facility employee	May not perform/May not sign	May perform alternate visits	May perform and sign	May sign subject to state requirements

	Initial Comprehensive Visit/Orders	Other Required Visits <sup>1</sup>	Other Medically Necessary Visits and Orders <sup>2</sup>	Certification/Recertification
Nursing Facilities				
Nurse practitioner, clinical nurse specialist, and physician assistant employed by the facility	May not perform/May not sign	May not perform	May perform and sign	Not applicable <sup>+</sup>
Nurse practitioner, clinical nurse specialist, and physician assistant not a facility employee	May perform/May sign	May perform	May perform and sign	Not applicable <sup>+</sup>

\*As permitted by state law governing the scope and practice of nurse practitioners, clinical nurse specialists, and physician assistants.

<sup>1</sup> Other required visits include the skilled nursing resident monthly visits that may be alternated between physician and advanced registered nurse practitioners, clinical nurse specialists, or physician assistants after the initial comprehensive visit is completed.

<sup>2</sup> Medically necessary visits may be performed prior to the initial comprehensive visit.

<sup>+</sup> This requirement relates specifically to coverage of Part A Medicare stays, which can take place only in a Medicare-certified skilled nursing facility.

[ARC 1048C, IAB 10/2/13, effective 11/6/13]

#### 481—58.15(135C) Records.

**58.15(1) Resident admission record.** The licensee shall keep a permanent record on all residents admitted to a nursing facility with all entries current, dated, and signed. This shall be a part of the resident clinical record. (III) The admission record form shall include:

- a. Name and previous address of resident; (III)
- b. Birth date, sex, and marital status of resident; (III)
- c. Church affiliation; (III)
- d. Physician's name, telephone number, and address; (III)
- e. Dentist's name, telephone number, and address; (III)
- f. Name, address, and telephone number of next of kin or legal representative; (III)
- g. Name, address, and telephone number of person to be notified in case of emergency; (III)
- h. Mortician's name, telephone number, and address; (III)
- i. Pharmacist's name, telephone number, and address. (III)

**58.15(2) Resident clinical record.** There shall be a separate clinical record for each resident admitted to a nursing facility with all entries current, dated, and signed. (III) The resident clinical record shall include:

- a. Admission record; (III)
- b. Admission diagnosis; (III)
- c. Physical examination: The record of the admission physical examination and medical history shall portray the current medical status of the resident and shall include the resident's name, sex, age, medical history, tuberculosis status, physical examination, diagnosis, statement of chief complaints, estimation of restoration potential and results of any diagnostic procedures. The report of the physical examination shall be signed by the physician. (III)
- d. Physician's certification that the resident requires no greater degree of nursing care than the facility is licensed to provide; (III)
- e. Physician's orders for medication, treatment, and diet in writing and signed by the physician quarterly; (III)
- f. Progress notes.
  - (1) Physician shall enter a progress note at the time of each visit; (III)

(2) Other professionals, i.e., dentists, social workers, physical therapists, pharmacists, and others shall enter a progress note at the time of each visit; (III)

g. All laboratory, X-ray, and other diagnostic reports; (III)

h. Nurse's record including:

(1) Admitting notes including time and mode of transportation; room assignment; disposition of valuables; symptoms and complaints; general condition; vital signs; and weight; (II, III)

(2) Routine notes including physician's visits; telephone calls to and from the physician; unusual incidents and accidents; change of condition; social interaction; and P.R.N. medications administered including time and reason administered, and resident's reaction; (II, III)

(3) Discharge or transfer notes including time and mode of transportation; resident's general condition; instructions given to resident or legal representative; list of medications and disposition; and completion of transfer form for continuity of care; (II, III)

(4) Death notes including notification of physician and family to include time, disposition of body, resident's personal possessions and medications; and complete and accurate notes of resident's vital signs and symptoms preceding death; (III)

i. Medication record.

(1) An accurate record of all medications administered shall be maintained for each resident. (II, III)

(2) Schedule II drug records shall be kept in accordance with state and federal laws; (II, III)

j. Death record. In the event of a resident's death, notations in the resident's record shall include the date and time of the resident's death, the circumstances of the resident's death, the disposition of the resident's body, and the date and time that the resident's family and physician were notified of the resident's death; (III)

k. Transfer form.

(1) The transfer form shall include identification data from the admission record, name of transferring institution, name of receiving institution, and date of transfer; (III)

(2) The nurse's report shall include resident attitudes, behavior, interests, functional abilities (activities of daily living), unusual treatments, nursing care, problems, likes and dislikes, nutrition, current medications (when last given), and condition on transfer; (III)

(3) The physician's report shall include reason for transfer, medications, treatment, diet, activities, significant laboratory and X-ray findings, and diagnosis and prognosis; (III)

l. Consultation reports shall indicate services rendered by allied health professionals in the facility or in health-centered agencies such as dentists, physical therapists, podiatrists, oculists, and others. (III)

**58.15(3) Resident personal record.** Personal records may be kept as a separate file by the facility.

a. Personal records may include factual information regarding personal statistics, family and responsible relative resources, financial status, and other confidential information.

b. Personal records shall be accessible to professional staff involved in planning for services to meet the needs of the resident. (III)

c. When the resident's records are closed, the information shall become a part of the final record. (III)

d. Personal records shall include a duplicate copy of the contract(s). (III)

**58.15(4) Incident record.**

a. Each nursing facility shall maintain an incident record report and shall have available incident report forms. (III)

b. Report of incidents shall be in detail on a printed incident report form. (III)

c. The person in charge at the time of the incident shall prepare and sign the report. (III)

d. The report shall cover all accidents where there is apparent injury or where hidden injury may have occurred. (III)

e. The report shall cover all accidents or unusual occurrences within the facility or on the premises affecting residents, visitors, or employees. (III)

f. A copy of the incident report shall be kept on file in the facility. (III)

**58.15(5) Retention of records.**

- a. Records shall be retained in the facility for five years following termination of services. (III)
- b. Records shall be retained within the facility upon change of ownership. (III)
- c. Rescinded, effective 7/14/82.
- d. When the facility ceases to operate, the resident's record shall be released to the facility to which the resident is transferred. If no transfer occurs, the record shall be released to the individual's physician. (III)

**58.15(6) Reports to the department.** The licensee shall furnish statistical information concerning the operation of the facility to the department on request. (III)

**58.15(7) Personnel record.**

- a. An employment record shall be kept for each employee, consisting of the following information: name and address of employee, social security number of employee, date of birth of employee, date of employment, experience and education, references, position in the home, criminal history and dependent adult abuse background checks, and date and reason for discharge or resignation. (III)
- b. The personnel records shall be made available for review upon request by the department. (III)

**481—58.16(135C) Resident care and personal services.**

**58.16(1)** Beds shall be made daily and adjusted as necessary. A complete change of linen shall be made at least once a week and more often if necessary. (III)

**58.16(2)** Residents shall receive sufficient supervision so that their personal cleanliness is maintained. (II, III)

**58.16(3)** Residents shall have clean clothing as needed to present a neat appearance, to be free of odors, and to be comfortable. Clothing shall be based on resident choice and shall be appropriate to residents' activities and to the weather. (III)

**58.16(4)** Rescinded, effective 7/14/82.

**58.16(5)** Residents shall be encouraged to leave their rooms and make use of the recreational room or living room of the facility. (III)

**58.16(6)** Residents shall not be required to pass through another's bedroom to reach a bathroom, living room, dining room, corridor, or other common areas of the facility. (III)

**58.16(7)** Rescinded, effective 7/14/82.

**58.16(8)** Uncontrollable residents shall be transferred or discharged from the facility in accordance with contract arrangements and requirements of Iowa Code chapter 135C. (II, III)

**58.16(9)** Except for those who request differently, residents who are not bedfast shall be fully dressed each day to maintain self-esteem and promote the residents' normal lifestyles. (III)

**58.16(10)** Residents shall receive a bath of their choice, based on the facility's accommodations, as needed to maintain proper hygiene. (II, III)

**481—58.17** Rescinded, effective 7/14/82.

**481—58.18(135C) Nursing care.**

**58.18(1)** Individual health care plans shall be based on resident treatment decisions, the nature of the illness or disability, treatment, and care prescribed. Goals shall be developed by each discipline providing service, treatment, and care. These plans shall be in writing, revised as necessary, and kept current. They shall be made available to all those rendering the services and for review by the department. (III)

**58.18(2)** Residents shall be protected against hazards to themselves and others or the environment. (II, III)

**58.18(3)** The facility shall provide resident and family education as an integral part of restorative and supportive care. (III)

**58.18(4)** The facility shall provide prompt response from qualified staff for the resident's use of the nurse call system. (II, III) (Prompt response being considered as no longer than 15 minutes.)

**481—58.19(135C) Required nursing services for residents.** The program plan for nursing facilities shall have the following required nursing services under the 24-hour direction of qualified nurses with ancillary coverage as set forth in these rules:

**58.19(1) Activities of daily living.**

- a. Bathing; (II, III)
- b. Daily oral hygiene (denture care); (II, III)
- c. Routine shampoo; (II, III)
- d. Nail care; (III)
- e. Shaving; (III)
- f. Daily care and application of prostheses (glasses, hearing aids, glass eyes, limb prosthetics, braces, or other assistive devices); (II, III)
- g. Ambulation with equipment if applicable, or transferring, or positioning; (I, II, III)
- h. Daily routine range of motion; (II, III)
- i. Mobility (assistance with wheelchair, mechanical lift, or other means of locomotion); (I, II, III)
- j. Elimination.
  - (1) Assistance to and from the bathroom and perineal care; (II, III)
  - (2) Bedpan assistance; (II, III)
  - (3) Care for incontinent residents; (II, III)
  - (4) Bowel and bladder training programs including in-dwelling catheter care (i.e., insertion and irrigation), enema and suppository administration, and monitoring and recording of intake and output, including solid waste; (I, II, III)
- k. Colostomy care (to be performed only by a registered nurse or licensed practical nurse or by a qualified aide under the direction of a registered nurse or licensed practical nurse); (I, II, III)
- l. Ileostomy care (to be performed only by a registered nurse or licensed practical nurse or by a qualified aide under the direction of a registered nurse or licensed practical nurse); (I, II, III)
- m. All linens necessary; (III)
- n. Nutrition and meal service.
  - (1) Regular, therapeutic, modified diets, and snacks; (I, II, III)
  - (2) Mealtime preparation of resident; (II, III)
  - (3) Assistance to and from meals; (II, III)
  - (4) In-room meal service or tray service; (II, III)
  - (5) Assistance with food preparation and meal assistance including total assistance if needed; (II, III)
  - (6) Assistance with adaptive devices; (II, III)
  - (7) Enteral nutrition (to be performed by a registered nurse or licensed practical nurse only); (I, II, III)
- o. Promote initiation of self-care for elements of resident care; (II, III)
- p. Oral suctioning (to be performed only by a registered nurse or licensed practical nurse or by a qualified aide under the direction of a registered nurse or licensed practical nurse). (I, II)

**58.19(2) Medication and treatment.**

- a. Administration of all medications as ordered by the physician including oral, instillations, topical, injectable (to be injected by a registered nurse or licensed practical nurse only); (I, II)
- b. Wound care; (I, II)
- c. Blood glucose monitoring; (I, II)
- d. Vital signs, blood pressure, and weights; (I, II)
- e. Ambulation and transfer; (II, III)
- f. Provision of restraints; (I, II)
- g. Administration of oxygen (to be performed only by a registered nurse or licensed practical nurse or by a qualified aide under the direction of a registered nurse or licensed practical nurse); (I, II)
- h. Provision of all treatments; (I, II, III)
- i. Provision of emergency medical care, including arranging for transportation, in accordance with written policies and procedures of the facility; (I, II, III)

*j.* Provision of accurate assessment and timely intervention for all residents who have an onset of adverse symptoms which represent a change in mental, emotional, or physical condition. (I, II, III)

**481—58.20(135C) Duties of health service supervisor.** Every nursing facility shall have a health service supervisor who shall:

**58.20(1)** Direct the implementation of the physician's orders; (I, II)

**58.20(2)** Plan for and direct the nursing care, services, treatments, procedures, and other services in order that each resident's needs and choices, where practicable, are met; (II, III)

**58.20(3)** Review the health care needs and choices, where practicable, of each resident admitted to the facility and assist the attending physician in planning for the resident's care; (II, III)

**58.20(4)** Develop and implement a written health care plan in cooperation with, to the extent practicable, the resident, the resident's family or the resident's legal representative, and others in accordance with instructions of the attending physician as follows:

*a.* The written health care plan, based on the assessment and reassessment of the resident's health needs and choices, where practicable, is personalized for the individual resident and indicates care to be given, goals to be accomplished, and methods, approaches, and modifications necessary to achieve best results; (III)

*b.* The health service supervisor is responsible for preparing, reviewing, supervising the implementation, and revising the written health care plan; (III)

*c.* The health care plan is readily available for use by all personnel caring for the resident; (III)

**58.20(5)** Initiate preventative and restorative nursing procedures for each resident so as to achieve and maintain the highest possible degree of function, self-care, and independence based on resident choice, where practicable; (II, III)

**58.20(6)** Supervise health services personnel to ensure they perform the following restorative measures in their daily care of residents:

*a.* Maintaining good bodily alignment and proper positioning; (II, III)

*b.* Making every effort to keep the resident active except when contraindicated by physician's orders, and encouraging residents to achieve independence in activities of daily living by teaching self-care, transfer, and ambulation activities; (III)

*c.* Assisting residents to adjust to their disabilities, to use their prosthetic devices, and to redirect their interests as necessary; (III)

*d.* Assisting residents to carry out prescribed therapy exercises between visits of the therapist; (III)

*e.* Assisting residents with routine range of motion exercises; (III)

**58.20(7)** Plan and conduct nursing staff orientation and in-service programs and provide for training of nurse's aides; (III)

**58.20(8)** Plan with the resident and the resident's physician and family and health-related agencies for the care of the resident upon discharge; (III)

**58.20(9)** Designate a responsible person to be in charge during absences; (III)

**58.20(10)** Be responsible for all assignments and work schedules for all health services personnel to ensure that the health needs of the residents are met; (III)

**58.20(11)** Ensure that all nurse's notes are descriptive of the care rendered including the resident's response; (III)

**58.20(12)** Visit each resident routinely to be knowledgeable of the resident's current condition; (III)

**58.20(13)** Evaluate in writing the performance of each individual on the health care staff on at least an annual basis. This evaluation shall be available for review in the facility to the department; (III)

**58.20(14)** Keep the administrator informed of the resident's status; (III)

**58.20(15)** Teach and coordinate rehabilitative health care including activities of daily living, promotion and maintenance of optimal physical and mental functioning; (III)

**58.20(16)** Supervise serving of meals to ensure that individuals unable to assist themselves are promptly fed and that special eating adaptive devices are available as needed; (II, III)

**58.20(17)** Make available a nursing procedure manual which shall include all procedures practiced in the facility; (III)

**58.20(18)** Participate with the administrator in the formulation of written policies and procedures for resident services; (III)

**58.20(19)** The person in charge shall immediately notify the family of any accident, injury, or adverse change in the resident's condition requiring physician's notification. (III)

**481—58.21(135C) Drugs, storage, and handling.**

**58.21(1)** Drug storage for residents who are unable to take their own medications and require supervision shall meet the following requirements:

*a.* A cabinet with a lock, convenient to nursing service, shall be provided and used for storage of all drugs, solutions, and prescriptions; (III)

*b.* The drug storage cabinet shall be kept locked when not in use; (III)

*c.* The medication cabinet key shall be in the possession of the person directly responsible for issuing medications; (II, III)

*d.* Double-locked storage of Schedule II drugs shall not be required under single unit package drug distribution systems in which the quantity stored does not exceed a three-day supply and a missing dose can be readily detected. (II)

**58.21(2)** Drugs for external use shall be stored separately from drugs for internal use. (III)

**58.21(3)** Medications requiring refrigeration shall be kept in a refrigerator and separated from food and other items. A method for locking these medications shall be provided. (III)

**58.21(4)** All potent, poisonous, or caustic materials shall be stored separately from drugs. They shall be plainly labeled and stored in a specific, well-illuminated cabinet, closet, or storeroom and made accessible only to authorized persons. (I, II)

**58.21(5)** All flammable materials shall be specially stored and handled in accordance with applicable local and state fire regulations. (II)

**58.21(6)** A properly trained person shall be charged with the responsibility of administering nonparenteral medications.

*a.* The individual shall have knowledge of the purpose of the drugs, their dangers, and contraindications.

*b.* This person shall be a licensed nurse or physician or shall have successfully completed a department-approved medication aide course or passed a department-approved medication aide challenge examination administered by an area community college.

*c.* Prior to taking a department-approved medication aide course, the individual shall:

(1) Successfully complete an approved nurse aide course, nurse aide training and testing program or nurse aide competency examination.

(2) Be employed in the same facility for at least six consecutive months prior to the start of the medication aide course. This requirement is not subject to waiver.

(3) Have a letter of recommendation for admission to the medication aide course from the employing facility.

*d.* A person who is a nursing student or a graduate nurse may take the challenge examination in place of taking a medication aide course. This individual shall do all of the following before taking the medication aide challenge examination:

(1) Complete a clinical or nursing theory course within six months before taking the challenge examination;

(2) Successfully complete a nursing program pharmacology course within one year before taking the challenge examination;

(3) Provide to the community college a written statement from the nursing program's pharmacology or clinical instructor indicating the individual is competent in medication administration.

(4) Successfully complete a department-approved nurse aide competency evaluation.

*e.* A person who has written documentation of certification as a medication aide in another state may become a medication aide in Iowa by successfully completing a department-approved nurse aide competency examination and a medication aide challenge examination.

The requirements of paragraph "c" of this subrule do not apply to this individual.

**58.21(7)** Unless the unit dose system is used, the person assigned the responsibility of medication administration must complete the procedure by personally preparing the dose, observing the actual act of swallowing the oral medication, and charting the medication. (II) In facilities where the unit dose system is used, the person assigned the responsibility must complete the procedure by observing the actual act of swallowing the medication and charting the medication. Medications shall be prepared on the same shift of the same day that they are administered, (II) unless the unit dose system is used.

**58.21(8)** An accurate written record of medications administered shall be made by the individual administering the medication. (III)

**58.21(9)** Records shall be kept of all Schedule II drug medications received and dispensed in accordance with the controlled drug and substance Act. (III)

**58.21(10)** Any unusual resident reaction shall be reported to the physician at once. (II)

**58.21(11)** A policy shall be established by the facility in conjunction with a licensed pharmacist to govern the distribution of prescribed medications to residents who are on leave from the facility. (III)

*a.* Medication may be issued to residents who will be on leave from a facility for less than 24 hours. Notwithstanding the prohibition against paper envelopes in 58.21(14) “*a*,” non-child-resistant containers may be used. Each container may hold only one medication. A label on each container shall indicate the date, the resident’s name, the facility, the medication, its strength, dose, and time of administration.

*b.* Medication for residents on leave from a facility longer than 24 hours shall be obtained in accordance with requirements established by the Iowa board of pharmacy examiners.

*c.* Medication distributed as above may be issued only by a nurse responsible for administering medication. (I, II, III)

**58.21(12)** Emergency medications. A nursing facility shall provide emergency medications pursuant to the following requirements: (III)

*a.* Prescription drugs as well as nonprescription items must be prescribed or approved by the physician, in consultation with the pharmacist, who provides emergency service to the facility; (III)

*b.* The emergency medications shall be stored in an accessible place; (III)

*c.* A list of the emergency medications and quantities of each item shall be maintained by the facility; (III)

*d.* The container holding the emergency medications shall be closed with a seal which may be broken when drugs are required in an emergency or for inspection; (III)

*e.* Any item removed from the emergency medications shall be replaced within 48 hours; (III)

*f.* A permanent record shall be kept of each time the emergency medications are used; (III)

*g.* The emergency medications shall be inspected by a pharmacist at least once every three months to determine the stability of items. (III)

**58.21(13)** Drug handling.

*a.* Bulk supplies of prescription drugs shall not be kept in a nursing facility unless a licensed pharmacy is established in the facility under the direct supervision and control of a pharmacist. (III)

*b.* Inspection of drug storage condition shall be made by the health service supervisor and a registered pharmacist not less than once every three months. The inspection shall be verified by a report signed by the nurse and pharmacist and filed with the administrator. The report shall include, but not be limited to, certifying absence of the following: expired drugs, deteriorated drugs, improper labeling, drugs for which there is no current physician’s order, and drugs improperly stored. (III)

*c.* If the facility permits licensed nurses to dilute or reconstitute drugs at the nursing station, distinctive supplementary labels shall be available for the purpose. The notation on the label shall be so made as to be indelible. (III)

*d.* Dilution and reconstitution of drugs and their labeling shall be done by the pharmacist whenever possible. If not possible, the following shall be carried out only by the licensed nurse:

(1) Specific directions for dilution or reconstitution and expiration date should accompany the drug; (III)

(2) A distinctive supplementary label shall be affixed to the drug container when diluted or reconstituted by the nurse for other than immediate use. (III) The label shall bear the following:

resident's name, dosage and strength per unit/volume, nurse's name, expiration date, and date and time of dilution. (III)

**58.21(14) Drug safeguards.**

*a.* All prescribed medications shall be clearly labeled indicating the resident's full name, physician's name, prescription number, name and strength of drug, dosage, directions for use, date of issue, and name and address and telephone number of pharmacy or physician issuing the drug. Where unit dose is used, prescribed medications shall, as a minimum, indicate the resident's full name, physician's name, name and strength of drug, and directions for use. Standard containers shall be utilized for dispensing drugs. Paper envelopes shall not be considered standard containers. (III)

*b.* Medication containers having soiled, damaged, illegible or makeshift labels, or medication samples shall be returned to the issuing pharmacist, pharmacy, or physician for relabeling or disposal. (III)

*c.* There shall be no medications or any solution in unlabeled containers. (II, III)

*d.* The medications of each resident shall be kept or stored in the originally received containers. (II, III)

*e.* Labels on containers shall be clearly legible and firmly affixed. No label shall be superimposed on another label of a drug container. (II, III)

*f.* When a resident is discharged or leaves the facility, the unused prescription shall be sent with the resident or with a legal representative only upon the written order of a physician. (III)

*g.* Unused prescription drugs prescribed for residents who are deceased shall be returned to the supplying pharmacist. (III)

*h.* Prescriptions shall be refilled only with the permission of the attending physician. (II, III)

*i.* No medications prescribed for one resident may be administered to or allowed in the possession of another resident. (II)

*j.* Instructions shall be requested of the Iowa board of pharmacy examiners concerning disposal of unused Schedule II drugs prescribed for residents who have died or for whom the Schedule II drug was discontinued. (III)

*k.* There shall be a formal routine for the proper disposal of discontinued medications within a reasonable but specified time. These medications shall not be retained with the resident's current medications. Discontinued drugs shall be destroyed by the responsible nurse with a witness and a notation made to that effect or returned to the pharmacist for destruction or resident credit. Drugs listed under the Schedule II drugs shall be disposed of in accordance with the provisions of the Iowa board of pharmacy examiners. (II, III)

*l.* All medication orders which do not specifically indicate the number of doses to be administered or the length of time the drug is to be administered shall be stopped automatically after a given time period. The automatic stop order may vary for different types of drugs. The physician, in consultation with the pharmacist serving the home, shall institute policies and provide procedures for review and endorsement of stop orders on drugs. This policy shall be conveniently located for personnel administering medications. (II, III)

*m.* No resident shall be allowed to keep possession of any medications unless the attending physician has certified in writing on the resident's medical record that the resident is mentally and physically capable of doing so. (II)

*n.* Residents who have been certified in writing by the physician as capable of taking their own medications may retain these medications in their bedroom, but locked storage must be provided. (II)

*o.* No medications or prescription drugs shall be administered to a resident without a written order signed by the attending physician. (II)

*p.* A qualified nurse shall:

(1) Establish a medication schedule system which identifies the time and dosage of each medication prescribed for each resident, is based on the resident's desired routine, and is approved by the resident's physician. (II, III)

(2) Establish a medication record containing the information specified above needed to monitor each resident's drug regimen. (II, III)

*q.* Telephone orders shall be taken by a qualified nurse. Orders shall be written into the resident's record and signed by the person receiving the order. Telephone orders shall be submitted to the physician for signature within 48 hours. (III)

*r.* A pharmacy operating in connection with a nursing facility shall comply with the provisions of the pharmacy law requiring registration of pharmacies and the regulations of the Iowa board of pharmacy examiners. (III)

*s.* In a nursing facility with a pharmacy or drug supply, service shall be under the personal supervision of a pharmacist licensed to practice in the state of Iowa. (III)

**58.21(15) Drug administration.**

*a.* Injectable medications shall be administered as permitted by Iowa law by a qualified nurse, physician, pharmacist, or physician assistant (PA). In the case of a resident who has been certified by the resident's physician or physician assistant (PA) as capable of taking the resident's own insulin, the resident may inject the resident's own insulin. (II)

*b.* An individual inventory record shall be maintained for each Schedule II drug prescribed for each resident. (II)

*c.* The health service supervisor shall be responsible for the supervision and direction of all personnel administering medications. (II)

[ARC 1050C, IAB 10/2/13, effective 11/6/13]

**481—58.22(135C) Rehabilitative services.** Rehabilitative services shall be provided to maintain function or improve the resident's ability to carry out the activities of daily living.

**58.22(1) Physical therapy services.**

*a.* Each facility shall have a written agreement with a licensed physical therapist to provide physical therapy services. (III)

*b.* Physical therapy shall be rendered only by a physical therapist licensed to practice in the state of Iowa. All personnel assisting with the physical therapy of residents must be under the direction of a licensed physical therapist. (II, III)

*c.* The licensed physical therapist shall:

(1) Evaluate the resident and prepare a physical therapy treatment plan conforming to the medical orders and goals; (III)

(2) Consult with other personnel in the facility who are providing resident care and plan with them for the integration of a physical therapy treatment program into the overall health care plan; (III)

(3) Instruct the nursing personnel responsible for administering selected restorative procedures between treatments; (III)

(4) Present programs in the facility's in-service education programs. (III)

*d.* Treatment records in the resident's medical chart shall include:

(1) The physician's prescription for treatment; (III)

(2) An initial evaluation note by the physical therapist; (III)

(3) The physical therapy care plan defining clearly the long-term and short-term goals and outlining the current treatment program; (III)

(4) Notes of the treatments given and changes in the resident's condition; (III)

(5) A complete discharge summary to include recommendations for nursing staff and family. (III)

*e.* There shall be adequate facilities, space, appropriate equipment, and storage areas as are essential to the treatment or examinations of residents. (III)

**58.22(2) Other rehabilitative services.**

*a.* The facility shall arrange for specialized and supportive rehabilitative services when such services are ordered by a physician. (III) These may include audiology and occupational therapy.

*b.* Audiology services shall be under the direction of a person licensed in the state of Iowa by the board of speech pathology and audiology. (II, III)

*c.* Occupational therapy services shall be under the direction of a qualified occupational therapist who is currently registered by the American Occupational Therapy Association. (II, III)

*d.* The appropriate professional shall:

- (1) Develop the treatment plan and administer or direct treatment in accordance with the physician's prescription and rehabilitation goals; (III)
- (2) Consult with other personnel within the facility who are providing resident care and plan with them for the integration of a treatment program into the overall health care plan. (III)

**481—58.23(135C) Dental, diagnostic, and other services.****58.23(1) Dental services.**

- a. The nursing facility personnel shall assist residents to obtain regular and emergency dental services. (III)
- b. Transportation arrangements shall be made when necessary for the resident to be transported to the dentist's office. (III)
- c. Dental services shall be performed only on the request of the resident, responsible relative, or legal representative. The resident's physician shall be advised of the resident's dental problems. (III)
- d. All dental reports or progress notes shall be included in the clinical record. (III)
- e. Nursing personnel shall assist the resident in carrying out dentist's recommendations. (III)
- f. Dentists shall be asked to participate in the in-service program of the facility. (III)

**58.23(2) Diagnostic services.**

- a. The nursing facility shall make provisions for promptly securing required clinical laboratory, X-ray, and other diagnostic services. (III)
- b. All diagnostic services shall be provided only on the written, signed order of a physician. (III)
- c. Agreements shall be made with the local hospital laboratory or independent laboratory to perform specific diagnostic tests when they are required. (III)
- d. Transportation arrangements for residents shall be made, when necessary, to and from the source of service. (III)
- e. Copies of all diagnostic reports shall be requested by the facility and included in the resident's clinical record. (III)
- f. The physician ordering the specific diagnostic service shall be promptly notified of the results. (III)
- g. Simple tests such as customarily done by nursing personnel for diabetic residents may be performed in the facility. (III)

**58.23(3) Other services.**

- a. The nursing facility shall assist residents to obtain such supportive services as requested by the physician. (III)
- b. Transportation arrangements shall be made when necessary. (III)
- c. Services could include the need for prosthetic devices, glasses, hearing aids, and other necessary items. (III)

**481—58.24(135C) Dietary.**

**58.24(1) Organization of dietetic services.** The facility shall meet the needs of the residents and provide the services listed in this standard. If the service is contracted out, the contractor shall meet the same standard. A written agreement shall be formulated between the facility and the contractor and shall convey to the department the right to inspect the food service facilities of the contractor. (III)

- a. There shall be written policies and procedures for dietetic services that include staffing, nutrition, menu planning, therapeutic diets, preparation, service, ordering, receiving, storage, sanitation, and staff hygiene. The policies and procedures shall be made available for use by dietetic services. (III)
- b. There shall be written job descriptions for each position in dietetic services. The job descriptions shall be made available for use by dietetic services. (III)

**58.24(2) Dietary staffing.**

- a. The facility shall employ a qualified dietary supervisor who:
  - (1) Is a qualified dietitian as defined in 58.24(2)“e”; or
  - (2) Is a graduate of a dietetic technician training program approved by the American Dietetic Association; or

(3) Is a certified dietary manager certified by the certifying board for dietary managers of the Dietary Managers Association (DMA) and maintains that credential through 45 hours of DMA-approved continuing education; or

(4) Has completed a DMA-approved course curriculum necessary to take the certification examination required to become a certified dietary manager; or

(5) Has documented evidence of at least two years' satisfactory work experience in food service supervision and who is in an approved dietary manager association program and will successfully complete the program within 12 months of the date of enrollment; or

(6) Has completed or is in the final 90-hour training course approved by the department. (II, III)

b. The supervisor shall have overall supervisory responsibility for dietetic services and shall be employed for a sufficient number of hours to complete management responsibilities that include:

(1) Participating in regular conferences with consultant dietitian, administrator and other department heads; (III)

(2) Writing menus with consultation from the dietitian and seeing that current menus are posted and followed and that menu changes are recorded; (III)

(3) Establishing and maintaining standards for food preparation and service; (II, III)

(4) Participating in selection, orientation, and in-service training of dietary personnel; (II, III)

(5) Supervising activities of dietary personnel; (II, III)

(6) Maintaining up-to-date records of residents identified by name, location and diet order; (III)

(7) Visiting residents to learn individual needs and communicating with other members of the health care team regarding nutritional needs of residents when necessary; (II, III)

(8) Keeping records of repairs of equipment in dietetic services. (III)

c. The facility shall employ sufficient supportive personnel to carry out the following functions:

(1) Preparing and serving adequate amounts of food that are handled in a manner to be bacteriologically safe; (II, III)

(2) Washing and sanitizing dishes, pots, pans and equipment at temperatures required by procedures described elsewhere; (II, III)

(3) Serving of therapeutic diets as prescribed by the physician and following the planned menu. (II, III)

d. The facility may assign simultaneous duties in the kitchen and laundry, housekeeping, or nursing service to appropriately trained personnel. Proper sanitary and personal hygiene procedures shall be followed as outlined under the rules pertaining to staff hygiene. (II, III)

e. If the dietetic service supervisor is not a licensed dietitian, a consultant dietitian is required. The consultant dietitian shall be licensed by the state of Iowa pursuant to Iowa Code chapter 152A.

f. Consultants' visits shall be scheduled to be of sufficient duration and at a time convenient to:

(1) Record, in the resident's medical record, any observations, assessments and information pertinent to medical nutrition therapy; (I, II, III)

(2) Work with residents and staff on resident care plans; (III)

(3) Consult with the administrator and others on developing and implementing policies and procedures; (III)

(4) Write or approve general and therapeutic menus; (III)

(5) Work with the dietetic supervisor on developing procedures, recipes and other management tools; (III)

(6) Present planned in-service training and staff development for food service employees and others. Documentation of consultation shall be available for review in the facility by the department. (III)

g. In facilities licensed for more than 15 beds, dietetic services shall be available for a minimum of a 12-hour span extending from the time of preparation of breakfast through supper. (III)

**58.24(3) Nutrition and menu planning.**

a. Menus shall be planned and followed to meet the nutritional needs of each resident in accordance with the physician's orders and in consideration of the resident's choices and preferences. (II, III)

b. Menus shall be planned to provide 100 percent of the daily recommended dietary allowances as established by the Food and Nutrition Board of the National Research Council of the National Academy of Sciences. A current copy of the Simplified Diet Manual published by Blackwell Publishing, Ames, Iowa, shall be available and used in the planning and serving of all meals. (II)

c. At least three meals or their equivalent shall be served daily, at regular hours comparable to normal mealtimes in the community. (II)

(1) There shall be no more than a 14-hour span between a substantial evening meal and breakfast except as provided in subparagraph (3) below. (II, III)

(2) The facility shall offer snacks at bedtime daily. (II, III)

(3) When a nourishing snack is provided at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast of the following day. The current resident group must agree to this meal span and a nourishing snack must be served. (II)

d. Menus shall include a variety of foods prepared in various ways. The same menu shall not be repeated on the same day of the following week. (III)

e. Menus shall be written at least one week in advance. The current menu shall be located in an accessible place in the dietetic service department for easy use by persons purchasing, preparing and serving food. (III)

f. Records of menus as served shall be filed and maintained for 30 days and shall be available for review by department personnel. When substitutions are necessary, they shall be of similar nutritive value and recorded. (III)

g. A file of tested recipes adjusted to the number of people to be served in the facility shall be maintained. (III)

h. Alternate foods shall be offered to residents who refuse the food served. (II, III)

**58.24(4) Therapeutic diets.**

a. Therapeutic diets shall be prescribed by the attending physician. A current therapeutic diet manual shall be readily available to attending physicians, nurses and dietetic service personnel. This manual shall be used as a guide for writing menus for therapeutic diets. A licensed dietitian shall be responsible for writing and approving the therapeutic menu and reviewing procedures for preparation and service of food. (III)

b. Personnel responsible for planning, preparing and serving therapeutic diets shall receive instructions on those diets. (III)

**58.24(5) Food preparation and service.**

a. Methods used to prepare foods shall be those which conserve nutritive value and flavor and meet the taste preferences of the residents. (III)

b. Foods shall be attractively served. (III)

c. Foods shall be cut up, chopped, ground or blended to meet individual needs. (II, III)

d. Self-help devices shall be provided as needed. (II, III)

e. Table service shall be attractive. (III)

f. Plasticware, china and glassware that are unsightly, unsanitary or hazardous because of chips, cracks or loss of glaze shall be discarded. (III)

g. All food that is transported through public corridors shall be covered. (III)

h. All potentially hazardous food or beverages capable of supporting rapid and progressive growth of microorganisms that can cause food infections or food intoxication shall be maintained at temperatures of 41°F or below or at 140°F or above at all times, except during necessary periods of preparation. Frozen food shall be maintained frozen. (I, II, III)

i. Potentially hazardous food that is cooked, cooled and reheated for hot holding shall be reheated so that all parts of the food reach a temperature of at least 165°F for 15 seconds. (I, II, III)

j. Food must be reheated to 165°F within no more than two hours after the heating process begins. (I, II, III)

k. Cooked potentially hazardous food shall be cooled:

(1) Within two hours, from 140°F to 70°F; and

(2) Within four hours, from 70°F to 41°F or less. (I, II, III)

**58.24(6) Dietary ordering, receiving, and storage.**

- a. All food and beverages shall be of wholesome quality and procured from sources approved or considered satisfactory by federal, state and local authorities. Food or beverages from unlabeled, rusty, leaking, broken or damaged containers shall not be served. (I, II, III)
- b. A minimum of at least a one-week supply of staple foods and a three-day supply of perishable foods shall be maintained on the premises to meet the planned menu needs until the next food delivery. Supplies shall be appropriate to meet the requirements of the menu. (III)
- c. All milk shall be pasteurized. (III)
- d. Milk may be served in individual, single-use containers. Milk may be served from refrigerated bulk milk dispensers or from the original container. Milk served from a refrigerated bulk milk dispenser shall be dispensed directly into the glass or other container from which the resident drinks. (II, III)
- e. Records which show amount and kind of food purchased shall be retained for three months and shall be made available to the department upon request. (III)
- f. Dry or staple items shall be stored at least six inches (15 cm) above the floor in a ventilated room, not subject to sewage or wastewater backflow, and protected from condensation, leakage, rodents or vermin in accordance with the Food Code, 1999 edition. (III)
- g. Pesticides, other toxic substances and drugs shall not be stored in the food preparation or storage areas used for food or food preparation equipment and utensils. Soaps, detergents, cleaning compounds or similar substances shall not be stored in food storage rooms or areas. (II)
- h. Food storage areas shall be clean at all times. (III)
- i. There shall be a reliable thermometer in each refrigerator, freezer and in storerooms used for food. (III)
- j. Foods held in refrigerated or other storage areas shall be appropriately covered. Food that was prepared and not served shall be stored appropriately, clearly identifiable and dated. (III)

**58.24(7) Sanitation in food preparation area.**

- a. Unless otherwise indicated in this chapter or 481—Chapter 61, the sanitary provisions as indicated in Chapters 3, 4 and 7 of the 1999 Food Code, U.S. Public Health Service, Food and Drug Administration, Washington, DC 20204, shall apply.
- b. Residents may be allowed in the food preparation area. (III)
- c. The food preparation area may be used as a dining area for residents, staff or food service personnel. (III)
- d. All food service areas shall be kept clean, free from litter and rubbish, and protected from rodents, animals, roaches, flies and other insects. (II, III)
- e. All utensils, counters, shelves and equipment shall be kept clean, maintained in good repair, and shall be free from breaks, corrosion, cracks and chipped areas. (II, III)
- f. There shall be effective written procedures established for cleaning all work and serving areas. (III)
- g. A schedule of cleaning duties to be performed daily shall be posted. (III)
- h. An exhaust system and hood shall be clean, operational and maintained in good repair. (III)
- i. Spillage and breakage shall be cleaned up immediately and disposed of in a sanitary manner. (III)
- j. Wastes from the food service that are not disposed of by mechanical means shall be kept in leakproof, nonabsorbent, tightly closed containers when not in immediate use and shall be disposed of frequently. (III)
- k. The food service area shall be located so it will not be used as a passageway by residents, guests or non-food service staff. (III)
- l. The walls, ceilings and floors of all rooms in which food is prepared and served shall be in good repair, smooth, washable, and shall be kept clean. Walls and floors in wet areas should be moisture-resistant. (III)
- m. Ice shall be stored and handled in such a manner as to prevent contamination. Ice scoops should be sanitized daily and kept in a clean container. (III)
- n. There shall be no animals or birds in the food preparation area. (III)

*o.* All utensils used for eating, drinking, and preparing and serving food and drink shall be cleaned and disinfected or discarded after each use. (III)

*p.* If utensils are washed and rinsed in an automatic dishmachine, one of the following methods shall be used:

(1) When a conventional dishmachine is utilized, the utensils shall be washed in a minimum of 140°F using soap or detergent and sanitized in a hot water rinse of not less than 170°F. (II, III)

(2) When a chemical dishmachine is utilized, the utensils shall be washed in a minimum of 120°F using soap or detergent and sanitized using a chemical sanitizer that is automatically dispensed by the machine and is in a concentration equivalent to 50 parts per million (ppm) available chlorine. (II, III)

*q.* If utensils are washed and rinsed in a three-compartment sink, the utensils shall be thoroughly washed in hot water at a minimum temperature of 110°F using soap or detergent, rinsed in hot water to remove soap or detergent, and sanitized by one of the following methods:

(1) Immersion for at least 30 seconds in clean water at 180°F; (II, III)

(2) Immersion in water containing bactericidal chemical at a minimum concentration as recommended by the manufacturer. (II, III)

*r.* After sanitation, the utensils shall be allowed to drain and dry in racks or baskets on nonabsorbent surfaces. Drying cloths shall not be used. (III)

*s.* Procedures for washing and handling dishes shall be followed in order to protect the welfare of the residents and employees. Persons handling dirty dishes shall not handle clean dishes without first washing their hands. (III)

*t.* A mop and mop pail shall be provided for exclusive use in kitchen and food storage areas. (III)

**58.24(8) *Hygiene of food service personnel.***

*a.* Personnel, if involved in dietetic services, shall be trained in basic food sanitation techniques, shall be clean and wear clean clothing, including a cap or a hairnet sufficient to contain, cover and restrain hair. Beards, mustaches and sideburns that are not closely cropped and neatly trimmed shall be covered. (III)

*b.* Personnel shall be excluded from duty when affected by skin infections or communicable diseases in accordance with the facility's infection control policies. (II, III)

*c.* Employee street clothing stored in the food service area shall be in a closed area. (III)

*d.* Food preparation sinks shall not be used for hand washing. Separate hand-washing facilities with soap, hot and cold running water, and single-use towels shall be used properly. (II, III)

*e.* The use of tobacco shall be prohibited in the food preparation area. (III)

**58.24(9) *Paid nutritional assistants.*** A paid nutritional assistant means an individual who meets the requirements of this subrule and who is an employee of the facility or an employee of a temporary employment agency employed by the facility. A facility may use an individual working in the facility as a paid nutritional assistant only if that individual has successfully completed a state-approved training program for paid nutritional assistants. (I, II, III)

*a. Training program requirements.*

(1) A state-approved training program for paid nutritional assistants must include, at a minimum, eight hours of training in the following areas:

1. Feeding techniques.

2. Assistance with feeding and hydration.

3. Communication and interpersonal skills.

4. Appropriate responses to resident behavior.

5. Safety and emergency procedures, including the Heimlich maneuver.

6. Infection control.

7. Resident rights.

8. Recognizing changes in residents that are inconsistent with their normal behavior and reporting these changes to the supervisory nurse.

(2) In addition to the training program requirements specified above, the training program must include at least four hours of classroom study, two hours of supervised laboratory work, and two hours of supervised clinical experience.

(3) A facility that offers a paid nutritional assistant training program must provide sufficient supplies in order to teach the objectives of the course.

(4) All paid nutritional assistant training program instructors shall be registered nurses. Other qualified health care professionals may assist the instructor in teaching the classroom portion and clinical or laboratory experiences. The ratio of students to instructor shall not exceed ten students per instructor in the clinical setting.

(5) Each individual enrolled in a paid nutritional assistant training program shall complete a 50-question multiple choice written test and must obtain a score of 80 percent or higher. In addition, the individual must successfully perform the feeding of a resident in a clinical setting. A registered nurse shall conduct the final competency determination.

(6) If an individual does not pass either the written test or competency demonstration, the individual may retest the failed portion a second time. If the individual does not pass either the written test or competency demonstration portion the second time, the individual shall not be allowed to retest.

*b. Program approval.* A facility or other entity may not offer or teach a paid nutritional assistant training program until the department has approved the program. Individuals trained in a program not approved by the department will not be allowed to function as paid nutritional assistants.

(1) A facility or other institution offering a paid nutritional assistant training program must provide the following information about the training program to the department before offering the program or teaching paid nutritional assistants:

1. Policies and procedures for program administration.
2. Qualifications of the instructors.
3. Maintenance of program records, including attendance records.
4. Criteria for determining competency.
5. Program costs and refund policies.
6. Lesson plans, including the objectives to be taught, skills demonstrations, assignments, quizzes, and classroom, laboratory and clinical hours.

(2) The facility or other institution offering a paid nutritional assistant training program must submit the materials specified above for department review. The department shall, within ten days of receipt of the material, advise the facility or institution whether the program is approved, or request additional information to assist the department in determining whether the curriculum meets the requirements for a paid nutritional assistant training program. Before approving any paid nutritional assistant training program, the department shall determine whether the curriculum meets the requirements specified in this subrule. The department shall maintain a list of facilities and institutions eligible to provide paid nutritional assistant training. (I, II, III)

(3) A facility shall maintain a record of all individuals who have successfully completed the required training program and are used by the facility as paid nutritional assistants. The individual shall complete the training program with a demonstration of knowledge and competency skills necessary to serve as a paid nutritional assistant. (I, II, III)

(4) Upon successful completion of the training program, the facility or other institution providing the training shall, within ten calendar days, provide the individual with a signed and dated certificate of completion. A facility that employs paid nutritional assistants shall maintain on file copies of the completed certificate and skills checklist for each individual who has successfully completed the training program. (I, II, III)

*c. Working restrictions.*

(1) A paid nutritional assistant must work under the supervision of a registered nurse or a licensed practical nurse. In an emergency, a paid nutritional assistant must call a supervisory nurse for help on the resident call system. (I, II, III)

(2) A facility must ensure that a paid nutritional assistant feeds only residents who have no complicated feeding problems. Complicated feeding problems include, but are not limited to, difficulty swallowing, recurrent lung aspirations, and tube, parenteral or intravenous feedings. The facility must base resident selection on the charge nurse's assessment and the resident's latest assessment and plan of care. (I, II, III)

**481—58.25(135C) Social services program.**

**58.25(1)** The administrator or designee shall be responsible for developing a written, organized orientation program for all residents. (III)

**58.25(2)** The program shall be planned and implemented to resolve or reduce personal, family, business, and emotional problems that may interfere with the medical or health care, recovery, and rehabilitation of the individual. (III)

**58.25(3)** The social services plan, including specific goals and regular evaluation of progress, shall be incorporated into the overall plan of care. (III)

**481—58.26(135C) Resident activities program.**

**58.26(1) Organized activities.** Each nursing facility shall provide an organized resident activity program for the group and for the individual resident which shall include suitable activities for evenings and weekends. (III)

*a.* The activity program shall be designed to meet the needs and interests of each resident and to assist residents in continuing normal activities within limitations set by the resident's physician. This shall include helping residents continue in their individual interests or hobbies. (III)

*b.* The program shall include individual goals for each resident. (III)

*c.* The program shall include both group and individual activities. (III)

*d.* No resident shall be forced to participate in the activity program. (III)

*e.* The activity program shall include suitable activities for those residents unable to leave their rooms. (III)

*f.* The program shall be incorporated into the overall health plan and shall be designed to meet the goals as written in the plan.

**58.26(2) Coordination of activities program.**

*a.* Each nursing facility shall employ a person to direct the activities program. (III)

*b.* Staffing for the activity program shall be provided on the minimum basis of 35 minutes per licensed bed per week. (II, III)

*c.* The activity coordinator shall have completed the activity coordinators' orientation course offered through the department within six months of employment or have comparable training and experience as approved by the department. (III)

*d.* The activity coordinator shall attend workshops or educational programs which relate to activity programming. These shall total a minimum of ten contact hours per year. These programs shall be approved by the department. (III)

*e.* There shall be a written plan for personnel coverage when the activity coordinator is absent during scheduled working hours. (III)

**58.26(3) Duties of activity coordinator.** The activity coordinator shall:

*a.* Have access to all residents' records excluding financial records; (III)

*b.* Coordinate all activities, including volunteer or auxiliary activities and religious services; (III)

*c.* Keep all necessary records including:

(1) Attendance; (III)

(2) Individual resident progress notes recorded at regular intervals (at least quarterly). A copy of these notes shall be placed in the resident's clinical record; (III)

(3) Monthly calendars, prepared in advance. (III)

*d.* Coordinate the activity program with all other services in the facility; (III)

*e.* Participate in the in-service training program in the facility. This shall include attending as well as presenting sessions. (III)

**58.26(4) Supplies, equipment, and storage.**

*a.* Each facility shall provide a variety of supplies and equipment of a nature calculated to fit the needs and interests of the residents. (III) These may include: books (standard and large print), magazines, newspapers, radio, television, and bulletin boards. Also appropriate would be box games, game equipment, songbooks, cards, craft supplies, record player, movie projector, piano, outdoor equipment, etc.

- b. Storage shall be provided for recreational equipment and supplies. (III)
- c. Locked storage should be available for potentially dangerous items such as scissors, knives, and toxic materials. (III)

<sup>1</sup> Emergency, pursuant to Iowa Code section 17A.5(2)“b”(2).

<sup>2</sup> Objection filed 2/14/79; see Objection following 481—Ch 57.

**481—58.27(135C) Resident advocate committee.** Each facility shall have a resident advocate committee in accordance with Iowa Code section 135C.25, which shall operate within the scope of the rules for resident advocate committees promulgated by the department on aging. (II)

**58.27(1) Role of committee in complaint investigations.**

a. The department shall notify the facility’s resident advocate committee of a complaint from the public. The department shall not disclose the name of a complainant.

b. The department may refer complaints to the resident advocate committee for initial evaluation or investigation by the committee pursuant to rules promulgated by the department on aging. Within ten days of completion of the investigation, the committee shall report to the department in writing the results of the evaluation or the investigation.

c. When the department investigates a complaint, upon conclusion of its investigation, it shall notify the resident advocate committee and the department on aging of its findings, including any citations and fines issued.

d. Results of all complaint investigations addressed by the resident advocate committee shall be forwarded to the department within ten days of completion of the investigation.

**58.27(2)** The resident advocate committee shall, upon department request, be responsible for monitoring correction of substantiated complaints.

**58.27(3)** When requested, names, addresses and telephone numbers of family members shall be given to the resident advocate committee, unless the family refuses. The facility shall provide a form on which a family member may refuse to have the family member’s name, address or telephone number given to the resident advocate committee.

This rule is intended to implement Iowa Code section 135C.25.

**481—58.28(135C) Safety.** The licensee of a nursing facility shall be responsible for the provision and maintenance of a safe environment for residents and personnel. (III)

**58.28(1) Fire safety.**

a. All nursing facilities shall meet the fire safety rules and regulations as promulgated by the state fire marshal. (I, II)

b. The size of the facility and needs of the residents shall be taken into consideration in evaluating safety precautions and practices.

**58.28(2) Safety duties of administrator.** The administrator shall have a written emergency plan to be followed in the event of fire, tornado, explosion, or other emergency. (III)

a. The plan shall be posted. (III)

b. In-service shall be provided to ensure that all employees are knowledgeable of the emergency plan. (III)

**58.28(3) Resident safety.**

a. Residents shall be permitted to smoke only where proper facilities are provided. Smoking shall not be permitted in bedrooms. Smoking by residents considered to be careless shall be prohibited except when the resident is under direct supervision. (II, III)

b. Smoking is prohibited in all rooms where oxygen is being administered or in rooms where oxygen is stored. (II, III)

c. Whenever full or empty tanks of oxygen are being used or stored, they shall be securely supported in an upright position. (II, III)

d. Smoking shall be permitted only in posted areas. (II, III)

*e.* Each resident shall receive adequate supervision to ensure against hazard from self, others, or elements in the environment. (II, III)

**481—58.29(135C) Resident care.**

**58.29(1)** There shall be a readily available supply of self-help and ambulation devices such as wheelchairs, walkers, and such other devices maintained in good repair that will meet the current needs of all residents. (III)

**58.29(2)** The facility shall ensure that each ambulatory resident has well-fitting shoes to provide support and prevent slipping. (III)

**58.29(3)** Equipment for personal care shall be maintained in a safe and sanitary condition. (II, III)

**58.29(4)** The expiration date for sterile equipment shall be exhibited on its wrappings. (III)

**58.29(5)** Residents who have been known to wander shall be provided with appropriate means of identification. (II, III)

**58.29(6)** Electric heating pads, blankets, or sheets shall be used only on the written order of a physician, when allowed by the Life Safety Code or applicable state or local fire regulations. (II, III)

**481—58.30** Rescinded, effective 7/14/82.

**481—58.31(135C) Housekeeping.**

**58.31(1)** Written procedures shall be established and implemented for daily and weekly cleaning schedules. (III)

**58.31(2)** Each resident unit shall be cleaned on a routine schedule. (III)

**58.31(3)** All rooms, corridors, storage areas, linen closets, attics, and basements shall be kept in a clean, orderly condition, free of unserviceable furniture and equipment and accumulations of refuse. (III)

**58.31(4)** A hallway or corridor shall not be used for storage of equipment. (III)

**58.31(5)** All odors shall be kept under control by cleanliness and proper ventilation. (III)

**58.31(6)** Clothing worn by personnel shall be clean and washable. (III)

**58.31(7)** Housekeeping and maintenance personnel shall be provided with well-constructed and properly maintained equipment appropriate to the function for which it is to be used. (III)

**58.31(8)** All furniture, bedding, linens, and equipment shall be cleaned periodically and before use by another resident. (III)

**58.31(9)** Polishes used on floors shall provide a nonslip finish. (III)

**58.31(10)** \*Throw or scatter rugs shall not be permitted. (III)

\*Objection. For text of Objection, see IAC Supp., Part I, 9/7/77. For text of Filed rules, 470—Chapter 58, see IAC Supp. 10/5/77.

**58.31(11)** Entrances, exits, steps, and outside walkways shall be kept free from ice, snow, and other hazards. (II, III)

**58.31(12)** Residents shall not have access to storage areas for all cleaning agents, bleaches, insecticides, or any other poisonous, dangerous, or flammable materials. (II, III)

**58.31(13)** Sufficient numbers of noncombustible trash containers, which have covers, shall be available. (III)

**58.31(14)** Definite procedures shall be established for training housekeeping personnel. (III)

**58.31(15)** Rescinded IAB 12/6/06, effective 1/10/07.

**58.31(16)** There shall be provisions for the cleaning and storage of housekeeping equipment and supplies for each nursing unit. (III)

**58.31(17)** Bathtubs, shower stalls, or lavatories shall not be used for laundering, cleaning of utensils and mops, or for storage. (III)

**58.31(18)** Bedside utensils shall be stored in enclosed cabinets. (III)

**58.31(19)** Kitchen sinks shall not be used for the cleaning of mops, soaking of laundry, cleaning of bedside utensils, nursing utensils, or dumping of wastewater. (III)

**58.31(20)** Personal possessions of residents which may constitute hazards to themselves or others shall be removed and stored. (III)

**481—58.32(135C) Maintenance.**

**58.32(1)** Each facility shall establish a maintenance program in writing to ensure the continued maintenance of the facility, to promote good housekeeping procedures, and to ensure sanitary practices throughout the facility. (III)

**58.32(2)** The building, grounds, and other buildings shall be maintained in a clean, orderly condition and in good repair. (III)

**58.32(3)** Draperies and furniture shall be clean and in good repair. (III)

**58.32(4)** Cracks in plaster, peeling wallpaper or paint, and tears or splits in floor coverings shall be promptly repaired or replaced in a professional manner. (III)

**58.32(5)** The electrical systems, including appliances, cords, and switches, shall be maintained to guarantee safe functioning and comply with the national electrical code. (III)

**58.32(6)** All plumbing fixtures shall function properly and comply with the state plumbing code. (III)

**58.32(7)** Yearly inspections of the heating and cooling systems shall be made to guarantee safe operation. Documentation of these inspections shall be available for review. (III)

**58.32(8)** The building, grounds, and other buildings shall be kept free of breeding areas for flies, other insects, and rodents. (III)

**58.32(9)** The facility shall be kept free of flies, other insects, and rodents. (III)

**58.32(10)** Maintenance personnel.

*a.* A written program shall be established for the orientation of maintenance personnel. (III)

*b.* Maintenance personnel shall:

(1) Follow established written maintenance programs; (III)

(2) Be provided with appropriate, well-constructed, and properly maintained equipment. (III)

**481—58.33(135C) Laundry.**

**58.33(1)** All soiled linens shall be collected in and transported to the laundry room in closed, leakproof laundry bags or covered, impermeable containers. (III)

**58.33(2)** Except for related activities, the laundry room shall not be used for other purposes. (III)

**58.33(3)** Procedures shall be written for the proper handling of wet, soiled, and contaminated linens. (III)

**58.33(4)** Residents' personal laundry shall be marked with an identification. (III)

**58.33(5)** Bed linens, towels, and washcloths shall be clean and stain-free. (III)

**481—58.34(135C) Garbage and waste disposal.**

**58.34(1)** All garbage shall be gathered, stored, and disposed of in a manner that will not permit transmission of disease, create a nuisance, or provide a breeding or feeding place for vermin or insects. (III)

**58.34(2)** All containers for refuse shall be watertight, rodent-proof, and have tight-fitting covers. (III)

**58.34(3)** All containers shall be thoroughly cleaned each time the containers are emptied. (III)

**58.34(4)** All wastes shall be properly disposed of in compliance with local ordinances and state codes. (III)

**58.34(5)** Special provision shall be made for the disposal of soiled dressings and similar items in a safe, sanitary manner. (III)

**481—58.35(135C) Buildings, furnishings, and equipment.**

**58.35(1)** *Buildings—general requirements.*

*a.* For purposes of computation of usable floor space in bedrooms and other living areas of the facility, that part of the room having no less than seven feet of ceiling height shall be used. Usable floor space may include irregularities in the rooms such as alcoves and offsets with approval of the department. Usable floor space shall not include space needed for corridor door swings or wardrobes being used as a substitute for closet space. (III)

b. Battery-operated, portable emergency lights in good working condition shall be available at all times, at a ratio of one light per one employee on duty from 6 p.m. to 6 a.m. (III)

c. All windows shall be supplied with curtains and shades or drapes which are kept clean and in good repair. (III)

d. Light fixtures shall be so equipped to prevent glare and to prevent hazards to the residents. (III)

e. Exposed heating pipes, hot water pipes, or radiators in rooms and areas used by residents and within reach of residents shall be covered or protected to prevent injury or burns to residents. (II, III)

f. All fans located within seven feet of the floor shall be protected by screen guards of not more than one-half-inch mesh. (III)

g. Whenever glass sliding doors or transparent panels are used, they shall be marked conspicuously. (III)

h. The facility shall meet the equivalent requirements of the appropriate group occupancy of the state building code. (III)

i. No part of any room shall be enclosed, subdivided, or partitioned unless such part is separately lighted and ventilated and meets such other requirements as its usage and occupancy dictates, except closets used for the storage of residents' clothing. (III)

**58.35(2) *Furnishings and equipment.***

a. All furnishings and equipment shall be durable, cleanable, and appropriate to its function and in accordance with the department's approved program of care. (III)

b. All resident areas shall be decorated, painted, and furnished to provide a home-like atmosphere. (III)

c. Upholstery materials shall be moisture- and soil-resistant, except on furniture provided by the resident and the property of the resident. (III)

**58.35(3) *Dining and living rooms.***

a. Every facility shall have a dining room and a living room easily accessible to all residents. (III)

b. Dining rooms and living rooms shall at no time be used as bedrooms. (III)

c. Dining rooms and living rooms shall be available for use by residents at appropriate times to provide periods of social and diversional individual and group activities. (III)

d. A combination dining room and living room may be permitted if the space requirements of a multipurpose room as provided in 58.35(3) "e" are met. (III)

e. Multipurpose rooms. When space is provided for multipurpose dining and activities and recreational purposes, the area shall total at least 30 square feet per licensed bed for the first 100 beds and 27 square feet per licensed bed for all beds in excess of 100. An open area of sufficient size shall be provided to permit group activities such as religious meetings or presentation of demonstrations or entertainment. (III)

f. Living rooms.

(1) Living rooms shall be maintained for the use of residents and their visitors and may be used for recreational activities. (III)

(2) Living rooms shall be suitably provided with parlor furniture, television and radio receivers in good working order, recreational material such as games, puzzles, and cards, and reading material such as current newspapers and magazines. Furnishings and equipment of the room should be such as to allow group activities. (III)

(3) Card tables or game tables shall be made available. The tables should be of a height to allow a person seated in a wheelchair to partake in the games or card playing. (III)

(4) Chairs of proper height and appropriate to their use shall be provided for seating residents at game tables and card tables. (III)

g. Dining rooms.

(1) Dining rooms shall be furnished with dining tables and chairs appropriate to the size and function of the facility. These rooms and furnishings shall be kept clean and sanitary. (III)

(2) Dining tables and chairs shall be provided. (III)

(3) Dining tables should be so constructed that a person seated in a wheelchair can dine comfortably. (III)

(4) Tables shall be of sturdy construction with smooth, durable, nonpermeable tops that can be cleaned with a detergent sanitizing solution. (III)

(5) Dining chairs shall be sturdy and comfortable. Some arm chairs should be provided for ease of movement for some residents. (III)

(6) Residents shall be encouraged to eat in the dining room. (III)

**58.35(4) Bedrooms.**

a. Each resident shall be provided with a standard, single, or twin bed that is substantially constructed and in good repair. Rollaway beds, metal cots, or folding beds are not acceptable. Seventy-five percent of the beds shall have a spring with an adjustable head and foot section. A resident shall have the right to sleep in a chair per the resident's request and to have the bed removed from the room to allow for additional space. (III)

b. Each bed shall be equipped with the following: casters or glides unless a low bed and mattress are being used for fall precautions; a clean, comfortable, well-constructed mattress approximately five inches thick and standard in size for the bed; clean, comfortable pillows of average size; and moisture-proof covers and sheets as necessary to keep the mattress and pillows dry and clean. (III)

c. Each resident shall have a bedside table with a drawer to accommodate personal possessions. (III)

d. There shall be a comfortable chair, either a rocking chair or armchair, per resident bed. The resident's personal wishes shall be considered. (III)

e. There shall be drawer space for each resident's clothing. In a multiple bedroom, drawer space shall be assigned each resident. (III)

f. Walls, ceilings, and floors shall have easily cleanable surfaces and shall be kept clean and in good repair. (III)

g. Beds and other furnishings shall not obstruct free passage to and through doorways. (III)

h. Clothing shall be hung in closets or wardrobes available in each room. (III)

i. Beds shall not be placed with the head of the bed in front of a window or radiator. (III)

j. Beds shall not be placed in such a manner that the side of the bed is against the radiator or in close proximity to it unless it is covered so as to protect the resident from contact with it or from excessive heat. (III)

k. Reading lamps shall be provided each resident in the resident's room. (III)

l. Each room shall have sufficient accessible mirrors to serve the resident's needs. Mirrors are not required if the room is located in a CCDI unit and the mirrors cause concern for the resident. (III)

m. Sturdy, adjustable overbed tables shall be provided for each resident who is unable to eat in the dining room. (III)

n. Each resident bedroom shall have a door. The door shall be the swing type and shall not swing into the corridor. (III)

**58.35(5) Heating.** A centralized heating system capable of maintaining a minimum temperature of 78°F (26°C) shall be provided. Portable units or space heaters are prohibited from being used in the facility except in an emergency. (III)

**58.35(6) Water supply.**

a. Every facility shall have an adequate water supply from an approved source. A municipal source of supply shall be considered as meeting this requirement. (III)

b. Private sources of supply shall be tested annually and the report submitted with the annual application for license. (III)

c. A bacterially unsafe source of supply shall be grounds for denial, suspension, or revocation of license. (III)

d. The department may require testing of private sources of supply at its discretion in addition to the annual test. The facility shall supply reports of such tests as directed by the department. (III)

e. Hot and cold running water under pressure shall be available in the facility. (III)

f. Prior to construction of a new facility or new water source, private sources of supply shall be surveyed and shall comply with the requirements of the department of health. (III)

**58.35(7) Nonambulatory residents.**

- a. All nonambulatory residents shall be housed on the grade level floor. (II, III)
- b. These provisions in "a" above relating to nonambulatory residents are not applicable if the facility has a suitably sized elevator.

**481—58.36(135C) Family and employee accommodations.**

**58.36(1)** Children under 14 years of age shall not be allowed into the service areas. (III)

**58.36(2)** The residents' bedrooms shall not be occupied by employees or family members of the licensee. (III)

**58.36(3)** In facilities where the total occupancy of family, employees, and residents is five or less, one toilet and one tub or shower shall be the minimum requirement. (III)

**58.36(4)** In facilities where the total occupancy of family, employees, and residents is more than five, separate bathing and toilet facilities shall be required for the family or employees distinct from such areas provided for residents. (III)

**58.36(5)** In all health care facilities, if the family or employees live within the facility, separate living quarters and recreation facilities shall be required for the family or employees distinct from such areas provided for residents. (III)

**481—58.37(135C) Animals.** Animals may be permitted within the facility with prior approval of the department and under controlled conditions. (III)

**481—58.38(135C) Supplies.****58.38(1) Linen supplies.**

a. There shall be an adequate supply of linen so that each resident shall have at least three washcloths, hand towels, and bath towels per week. (III)

b. A complete change of bed linens shall be available in the linen storage area for each bed. (III)

c. Sufficient lightweight, clean, serviceable blankets shall be available. All blankets shall be laundered as often as necessary for cleanliness and freedom from odors. (III)

d. Each bed shall be provided with clean, washable bedspreads. There shall be a supply available when changes are necessary. (III)

e. Uncrowded and convenient storage shall be provided for linens, pillows, and bedding. (III)

**58.38(2) First-aid kit.** A first-aid emergency kit shall be available on each floor in every facility. (II, III)

**58.38(3) Supplies and equipment for nursing services.**

a. All nursing care equipment shall be properly sanitized or sterilized before use by another resident. (II)

b. There shall be disposable or one-time use items available with provisions for proper disposal to prevent reuse except as allowed by 58.10(8) "h," 481—paragraph 59.12(10) "h," or 481—paragraph 64.12(14) "h." (I, II, III)

c. Convenient, safe storage shall be provided for bath and toilet supplies, bathroom scales, mechanical lifts, and shower chairs. (III)

d. Sanitary and protective storage shall be provided for all equipment and supplies. (III)

e. All items that must be sterilized shall be autoclaved unless sterile disposable items are furnished which are promptly disposed of after a single use. (III)

f. Supplies and equipment for nursing and personal care sufficient in quantities to meet the needs of the residents shall be provided and, as a minimum, include the following: (III)

Bath basins	Rectal tubes
Soap containers	Catheters and catheterization equipment
Denture cups	Douche nozzle
Emesis basins	Oxygen therapy equipment
Mouthwash cups	Naso-gastric feeding equipment

Bedpans	Wheelchairs
Urinals	Moisture-proof draw sheets
Enema equipment	Moisture-proof pillow covers
Commodes	Moisture-proof mattress covers
Quart graduate measure	Foot tubs
Thermometer for measurement of bath water temperature	Metal pitcher
Oral thermometer	Disinfectant solutions
Rectal thermometer	Alcohol
Basins for sterilizing thermometers	Lubricating jelly
Basins for irrigations	Skin lotion
Asepto syringes	Applicators
Sphygmomanometer	Tongue blades
Paper towels	Toilet paper
Paper handkerchiefs	Rubber gloves or disposable gloves
Insulin syringes	Scales for nonambulatory patients
2 cc hypodermic syringes	Tourniquet
Weight scales	Suction machine
Hypodermic needles	Medicine dispensing containers
Stethoscope	Bandages
Ice caps	Adhesive
Hot water bottles	Portable linen hampers
	Denture identification equipment
	Tracheotomy care equipment

**481—58.39(135C) Residents' rights in general.**

**58.39(1)** Each facility shall ensure that policies and procedures are written and implemented which include, at a minimum, all of the following provisions (subrules 58.39(2) to 58.39(6)) and which govern all areas of service provided by the facility. These policies and procedures shall be available to staff, residents, their families or legal representatives and the public and shall be reviewed annually. (II)

**58.39(2)** Policies and procedures shall address the admission and retention of persons with histories of dangerous or disturbing behavior. For the purposes of the subrule, persons with histories of dangerous or disturbing behavior are those persons who have been found to be seriously mentally impaired pursuant to Iowa Code section 229.13 or 812.1 within six months of the request for admission to the facility. In addition to establishing the criteria for admission and retention of persons so defined, the policies and procedures shall provide for:

*a.* Reasonable precautions to prevent the resident from harming self, other residents, or employees of the facility.

*b.* Treatment of persons with mental illness as defined in Iowa Code section 229.1(1) and which is provided in accordance with the individualized health care plan.

*c.* Ongoing and documented staff training on individualized health care planning for persons with mental illness.

**58.39(3)** Policies and procedures regarding the admission, transfer, and discharge of residents shall ensure that:

*a.* Only those persons are accepted whose needs can be met by the facility directly or in cooperation with community resources or other providers of care with which it is affiliated or has contracts. (II)

*b.* As changes occur in residents' physical or mental condition, necessitating services or care which cannot be adequately provided by the facility, they are transferred promptly to other appropriate facilities. (II)

**58.39(4)** Policies and procedures regarding the use of chemical and physical restraints shall define the use of said restraints and identify the individual who may authorize the application of physical restraints in emergencies, and describe the mechanism for monitoring and controlling their use. (II)

**58.39(5)** Policies and procedures shall include a method for submitting complaints and recommendations by residents or their responsible party and for ensuring a response and disposition by the facility. (II)

**58.39(6)** Policies and procedures shall include provisions governing access to, duplication of, and dissemination of information from the residents' records. (II)

**58.39(7)** Policies and procedures shall include a provision that each resident shall be fully informed of the resident's rights and responsibilities as a resident and of all rules governing resident conduct and responsibilities. This information must be provided upon admission, or in the case of residents already in the facility, upon the facility's adoption or amendment of residents' rights policies. (II)

*a.* The facility shall make known to residents what they may expect from the facility and its staff, and what is expected from them. The facility shall communicate these expectations during the period of not more than two weeks before or five days after admission. The communication shall be in writing, e.g., in a separate handout or brochure describing the facility, and interpreted verbally, e.g., as part of a preadmission interview, resident counseling, or in individual or group orientation sessions following admission. (II)

*b.* Residents' rights and responsibilities shall be presented in language understandable to the resident. If the facility serves residents who are non-English speaking or deaf, steps shall be taken to translate the information into a foreign or sign language. In the case of blind residents, either Braille or a recording shall be provided. Residents shall be encouraged to ask questions about their rights and responsibilities and these questions shall be answered. (II)

*c.* A statement shall be signed by the resident, or the resident's responsible party, indicating an understanding of these rights and responsibilities, and shall be maintained in the record. The statement shall be signed no later than five days after admission, and a copy of the signed statement shall be given to the resident or responsible party, if applicable. In the case of an intellectually disabled resident, the signature shall be witnessed by a person not associated with or employed by the facility. The witness may be a parent, guardian, Medicaid agency representative, etc. (II)

*d.* In order to ensure that residents continue to be aware of these rights and responsibilities during their stay, a written copy shall be prominently posted in a location that is available to all residents. (II)

*e.* All residents shall be advised within 30 days following changes made in the statement of residents' rights and responsibilities. Appropriate means shall be utilized to inform non-English speaking, deaf, or blind residents of such changes. (II)

**58.39(8)** Each resident or responsible party shall be fully informed in a contract as required in rule 481—58.13(135C), prior to or at the time of admission and during the resident's stay, of services available in the facility, and of related charges including any charges for services not covered under the Title XIX program or not covered by the facility's basic per diem rate. (II)

**58.39(9)** Each resident or responsible party shall be fully informed by a physician of the resident's health and medical condition unless medically contraindicated (as documented by a physician in the resident's record). Each resident shall be afforded the opportunity to participate in the planning of the resident's total care and medical treatment, which may include, but is not limited to, nursing care, nutritional care, rehabilitation, restorative therapies, activities, and social work services. Each resident only participates in experimental research conducted under the U.S. Department of Health and Human Services' protection from research risks policy and then only upon the resident's informed written consent. Each resident has the right to refuse treatment except as provided by Iowa Code chapter 229. In the case of a confused or intellectually disabled individual, the responsible party shall be informed by the physician of the resident's medical condition and be afforded the opportunity to participate in the planning of the resident's total care and medical treatment, to be informed of the medical condition, and to refuse to participate in experimental research. (II)

*a.* The requirement that residents shall be informed of their conditions, involved in the planning of their care, and advised of any significant changes in either shall be communicated to every physician responsible for the medical care of residents in the facility. (II)

*b.* The administrator or designee shall be responsible for working with attending physicians in the implementation of this requirement. (II)

*c.* If the physician determines or in the case of a confused or intellectually disabled resident the responsible party determines that informing the resident of the resident's condition is contraindicated, this decision and reasons for it shall be documented in the resident's record by the physician. (II)

*d.* The resident's plan of care shall be based on the physician's orders. It shall be developed upon admission by appropriate facility staff and shall include participation by the resident if capable. Residents shall be advised of alternative courses of care and treatment and their consequences when such alternatives are available. The resident's preference about alternatives shall be elicited and honored if feasible.

*e.* Any clinical investigation involving residents must be under the sponsorship of an institution with a human subjects review board functioning in accordance with the requirements of Public Law 93-348, as implemented by Part 46 of Title 45 of the Code of Federal Regulations, as amended to December 1, 1981 (45 CFR 46). A resident being considered for participation in experimental research must be fully informed of the nature of the experiment, e.g., medication, treatment, and understand the possible consequences of participating or not participating. The resident's (or responsible party's) written informed consent must be received prior to participation. (II)

This rule is intended to implement Iowa Code section 135C.23(2).  
[ARC 0766C, IAB 5/29/13, effective 7/3/13]

#### **481—58.40(135C) Involuntary discharge or transfer.**

**58.40(1)** A facility shall not involuntarily discharge or transfer a resident from a facility except: for medical reasons; for the resident's welfare or that of other residents; for nonpayment for the resident's stay (as contained in the contract for the resident's stay), except as prohibited by Title XIX of the Social Security Act, 42 U.S.C. 1396 to 1396k by reason of action pursuant to Iowa Code chapter 229; by reason of negative action by the Iowa department of social services; and by reason of negative action by the professional standards review organization. A resident shall not be transferred or discharged solely because the cost of the resident's care is being paid under Iowa Code chapter 249A, or because the resident's source of payment is changing from private support to payment under chapter 249A. (I, II)

*a.* "Medical reasons" for transfer or discharge are based on the resident's needs and are determined and documented in the resident's record by the attending physician. Transfer or discharge may be required to provide a different level of care. In the case of transfer or discharge for the reason that the resident's condition has improved such that the resident no longer needs the level of care being provided by the facility, the determination that such medical reason exists is the exclusive province of the professional standards review organization or utilization review process in effect for residents whose care is paid in full or in part by Title XIX. (II)

*b.* "Welfare" of a resident or that of other residents refers to their social, emotional, or physical well-being. A resident might be transferred or discharged because the resident's behavior poses a continuing threat to the resident (e.g., suicidal) or to the well-being of other residents or staff (e.g., the resident's behavior is incompatible with the resident's needs and rights). Evidence that the resident's continued presence in the facility would adversely affect the resident's own welfare or that of other residents shall be made by the administrator or designee and shall be in writing and shall include specific information to support this determination.

*c.* Involuntary transfer or discharge of a resident from a facility shall be preceded by a written notice to the resident or responsible party at least 30 days in advance of the proposed transfer or discharge. The 30-day requirement shall not apply in any of the following instances:

(1) If an emergency transfer or discharge is mandated by the resident's health care needs and is in accord with the written orders and medical justification of the attending physician. Emergency transfers

or discharges may also be mandated to protect the health, safety, or well-being of other residents and staff from the resident being transferred. (II)

(2) If the transfer or discharge is subsequently agreed to by the resident or the resident's responsible party, and notification is given to the responsible party, physician, and the person or agency responsible for the resident's placement, maintenance, and care in the facility.

(3) If the discharge or transfer is the result of a final, nonappealable decision by the department of social services or the professional standards review organization.

*d.* The notice required by paragraph "c" shall contain all of the following information:

(1) The stated reason for the proposed transfer or discharge. (II)

(2) The effective date of the proposed transfer or discharge. (II)

(3) A statement in not less than 12-point type (elite), which reads: "You have a right to appeal the facility's decision to transfer or discharge you. If you think you should not have to leave this facility, you may request a hearing in writing or verbally with the Iowa state department of inspections and appeals (hereinafter referred to as "department") within 7 days after receiving this notice. You have a right to be represented at the hearing by an attorney or any other individual of your choice. If you request a hearing, it will be held no later than 14 days after receipt of your request by the department and you will not be transferred prior to a final decision. Provision may be made for extension of the 14-day requirement upon request to the department of inspections and appeals designee in emergency circumstances. If you lose the hearing, you will not be transferred before the expiration of 30 days following receipt of the original notice of the discharge or transfer, or no sooner than 5 days following final decision of such hearing. To request a hearing or receive further information, call the department at (515)281-4115 or you may write to the department to the attention of: Administrator, Division of Health Facilities, Department of Inspections and Appeals, Lucas State Office Building, Des Moines, Iowa 50319-0083." (II)

*e.* A request for a hearing made under 58.40(1)"d"(3) shall stay a transfer or discharge pending a hearing or appeal decision. (II)

*f.* The type of hearing shall be determined by a representative of the department. Notice of the date, time, and place of the hearing shall be sent by certified mail or delivered in person to the licensee, resident, responsible party, and Iowa department on aging long-term care ombudsman of record not later than five full business days after receipt of request. This notice shall also inform the licensee, resident or responsible party that they have a right to appear at the hearing in person or be represented by their attorneys or other individual. The hearing shall be dismissed if neither party is present or represented at the hearing. If only one party appears or is represented, the hearing shall proceed with one party present. The Iowa department on aging long-term care ombudsman shall have the right to appear at the hearing.

*g.* The hearing shall be heard by a department of inspections and appeals designee pursuant to Iowa Code chapter 17A. (The hearing shall be public unless the resident or representative requests in writing that it be closed.) The licensee or designee shall have the opportunity to present to the representative of the department any oral testimony or written materials to show by a preponderance of the evidence just cause why a transfer or discharge may be made. The resident and responsible party shall also have an opportunity to present to the representative of the department any oral testimony or written material to show just cause why a transfer or discharge should not be made. In a determination as to whether a transfer or discharge is authorized, the burden of proof rests on the party requesting the transfer or discharge.

*h.* Based upon all testimony and materials submitted to the representative of the department, the representative shall issue, in accordance with Iowa Code chapter 17A, written findings of fact and conclusions of law and issue a decision and order in respect to the adverse action. This decision shall be mailed by certified mail to the licensee, resident, responsible party, and department on aging long-term care ombudsman within 10 working days after the hearing has been concluded. The representative shall have the power to issue fines and citations against the facility in appropriate circumstances.

A request for review of a proposed decision in which the department is the final decision maker shall be made within 15 days of issuance of the proposed decision, unless otherwise provided by statute. Requests shall be mailed or delivered by either party to the Director, Department of Inspections and Appeals, Lucas State Office Building, Des Moines, Iowa 50319-0083. Failure to request review will

preclude judicial review unless the department reviews a proposed decision upon its own motion within 15 days of the issuance of the decision.

*i.* A copy of the notice required by paragraph “*c*” shall be personally delivered to the resident and a copy placed in the resident’s record. A copy shall also be transmitted to the department, the resident’s responsible party, physician, the person or agency responsible for the resident’s placement, maintenance, and care in the facility, and the department on aging long-term care ombudsman.

*j.* If the basis for an involuntary transfer or discharge is the result of a negative action by the Iowa department of human services or the professional standards review organization (Iowa Foundation for Medical Care), appeals shall be filed with those agencies as appropriate. Continued payment shall be consistent with rules of those agencies.

*k.* If nonpayment is the basis for involuntary transfer or discharge, the resident shall have the right to make full payment up to the date that the discharge or transfer is to be made and then shall have the right to remain in the facility. (II)

*l.* The involuntary transfer or discharge shall be discussed with the resident, the resident’s responsible party, and the person or agency responsible for the resident’s placement, maintenance, and care in the facility within 48 hours after notice of discharge has been received. The explanation and discussion of the reasons for involuntary transfer or discharge shall be given by the facility administrator or other appropriate facility representative as the administrator’s designee. The content of the discussion and explanation shall be summarized in writing and shall include the names of the individuals involved in the discussions and made part of the resident’s record. (II)

*m.* The resident shall receive counseling services before (by the sending facility) and after (by the receiving facility) the involuntary transfer to minimize the possible adverse effects of the involuntary transfer. Counseling shall be documented in the resident’s record. (II)

(1) Counseling shall be provided by a qualified individual who meets one of the following criteria:

1. Has a bachelor’s or master’s degree in social work from an accredited college. (II)

2. Is a graduate of an accredited four-year college and has had at least one year of full-time paid employment in a social work capacity with a public or private agency. (II)

3. Has been employed in a social work capacity for a minimum of four years in a public or private agency. (II)

4. Is a licensed psychologist or psychiatrist. (II)

5. Is any other person of the resident’s choice. (II)

(2) The facility shall develop a plan to provide for the orderly and safe transfer or discharge of each resident to be transferred or discharged. (II)

(3) The receiving health care facility of a resident involuntarily discharged or transferred shall immediately formulate and implement a plan of care which takes into account possible adverse effects the transfer may cause. (II)

*n.* In the case of an emergency transfer or discharge as outlined in 58.40(1)“*c*”(1), the resident must still be given a written notice prior to or within 48 hours following transfer or discharge. A copy of this notice must be placed in the resident’s file and it must contain all the information required by 58.40(1)“*d*”(1) and (2). In addition, the notice must contain a statement in not less than 12-point type (elite), which reads: “You have a right to appeal the facility’s decision to transfer or discharge you on an emergency basis. If you think you should not have to leave this facility, you may request a hearing in writing or verbally with the Iowa state department of inspections and appeals within 7 days after receiving this notice. If you request a hearing, it will be held no later than 14 days after receipt of your request by the department. You may be transferred or discharged before the hearing is held or before a final decision is rendered. If you win the hearing, you have the right to be transferred back into the facility. To request a hearing or receive further information, call the department at (515)281-4115 or you may write to the department to the attention of: Administrator, Division of Health Facilities, Department of Inspections and Appeals, Lucas State Office Building, Des Moines, Iowa 50319-0083.” A hearing requested pursuant to this subrule shall be held in accordance with paragraphs “*f*,” “*g*,” and “*h*.” (II)

*o.* Residents shall not have the right to a hearing to contest an involuntary discharge or transfer resulting from the revocation of the facility’s license by the department of inspections and appeals. In

the case of a facility voluntarily closing, a period of 30 days must be allowed for an orderly transfer of residents to other facilities.

**58.40(2) Intrafacility transfer:**

*a.* Residents shall not be relocated from room to room within a licensed health care facility arbitrarily. (I, II) Involuntary relocation may occur only in the following situations and such situation shall be documented in the resident's record.

- (1) Incompatibility with or disturbing to other roommates, as documented in the resident's record.
- (2) For the welfare of the resident or other residents of the facility.
- (3) For medical, nursing or psychosocial reasons, as documented in the resident's record, as judged by the attending physician, nurse or social worker in the case of a facility which groups residents by medical, nursing or psychosocial needs.

(4) To allow a new admission to the facility which would otherwise not be possible due to separation of roommates by sex.

(5) In the case of a resident whose source of payment was previously private, but who now is eligible for Title XIX assistance, the resident may be transferred from a private room to a semiprivate room or from one semiprivate room to another.

(6) Reasonable and necessary administrative decisions regarding the use and functioning of the building.

*b.* Unreasonable and unjustified reasons for changing a resident's room without the concurrence of the resident, or responsible party include:

- (1) Change from private pay status to Title XIX, except as outlined in 58.40(2) "a"(5). (II)
- (2) As punishment or behavior modification, except as specified in 58.40(2) "a"(1). (II)
- (3) Discrimination on the basis of race or religion. (II)

*c.* If intrafacility relocation is necessary for reasons outlined in paragraph "a," the resident shall be notified at least 48 hours prior to the transfer and the reason therefor shall be explained. The responsible party shall be notified as soon as possible. The notification shall be documented in the resident's record and signed by the resident or responsible party. (II)

*d.* If emergency relocation is required to protect the safety or health of the resident or other residents, the notification requirements may be waived. The conditions of the emergency shall be documented. The family or responsible party shall be notified immediately or as soon as possible of the condition requiring emergency relocation and such notification shall be documented. (II)

**481—58.41(135C) Residents' rights.** Each resident shall be encouraged and assisted throughout the resident's period of stay, to exercise rights as a resident and as a citizen and may voice grievances and recommend changes in policies and services to administrative staff or to outside representatives of the resident's choice, free from interference, coercion, discrimination, or reprisal. (II)

**58.41(1)** The facility shall provide ongoing opportunities for residents to be aware of and to exercise their rights as residents. Residents shall be kept informed of issues or pending decisions of the facility that affect them and their views shall be solicited prior to action. (II)

**58.41(2)** The facility shall implement a written procedure for registering and resolving grievances and recommendations by residents or their responsible party. The procedure shall ensure protection of the resident from any form of reprisal or intimidation. The written procedure shall include:

- a.* Designation of an employee responsible for handling grievances and recommendations. (II)
- b.* A method of investigating and assessing the validity of a grievance or recommendation. (II)
- c.* Methods of resolving grievances. (II)
- d.* Methods of recording grievances and actions taken. (II)

**58.41(3)** The facility shall post in a prominent area the name, telephone number, and address of the ombudsman, survey agency, local law enforcement agency, and resident advocate committee members and the text of Iowa Code section 135C.46 to provide to residents a further course of redress. (II)

**481—58.42(135C) Financial affairs—management.** Each resident who has not been assigned a guardian or conservator by the court may manage the resident's own personal financial affairs, and

to the extent, under written authorization by the resident that the facility assists in management, the management shall be carried out in accordance with Iowa Code section 135C.24. (II)

**58.42(1)** The facility shall maintain a written account of all residents' funds received by or deposited with the facility. (II)

**58.42(2)** An employee shall be designated in writing to be responsible for resident accounts. (II)

**58.42(3)** The facility shall keep on deposit personal funds over which the resident has control in accordance with Iowa Code section 135C.24(2). Should the resident request these funds, they shall be given to the resident on request with receipts maintained by the facility and a copy to the resident. In the case of a confused or intellectually disabled resident, the resident's responsible party shall designate a method of disbursing the resident's funds. (II)

**58.42(4)** If the facility makes financial transactions on a resident's behalf, the resident must receive or acknowledge that the resident has seen an itemized accounting of disbursements and current balances at least quarterly. A copy of this statement shall be maintained in the resident's financial or business record. (II)

**58.42(5)** A resident's personal funds shall not be used without the written consent of the resident or the resident's guardian. (II)

**58.42(6)** A resident's personal funds shall be returned to the resident when the funds have been used without the written consent of the resident or the resident's guardian. The department may report findings that resident funds have been used without written consent to the audits division or the local law enforcement agency, as appropriate. (II)

[ARC 0766C, IAB 5/29/13, effective 7/3/13]

**481—58.43(135C) Resident abuse prohibited.** Each resident shall receive kind and considerate care at all times and shall be free from mental and physical abuse. Each resident shall be free from chemical and physical restraints except as follows: when authorized in writing by a physician for a specified period of time; when necessary in an emergency to protect the resident from injury to the resident or to others, in which case restraints may be authorized by designated professional personnel who promptly report the action taken to the physician; and in the case of an intellectually disabled individual when ordered in writing by a physician and authorized by a designated qualified intellectual disabilities professional for use during behavior modification sessions. Mechanical supports used in normative situations to achieve proper body position and balance shall not be considered to be a restraint. (II)

**58.43(1)** Mental abuse includes, but is not limited to, humiliation, harassment, and threats of punishment or deprivation. (II)

**58.43(2)** Physical abuse includes, but is not limited to, corporal punishment and the use of restraints as punishment. (II)

**58.43(3)** Drugs such as tranquilizers may not be used as chemical restraints to limit or control resident behavior for the convenience of staff. (II)

**58.43(4)** Physicians' orders are required to utilize all types of physical restraints and shall be renewed at least quarterly. (II) Physical restraints are defined as the following:

Type I—the equipment used to promote the safety of the individual but is not applied directly to their person. Examples: divided doors and totally enclosed cribs.

Type II—the application of a device to the body to promote safety of the individual. Examples: vest devices, soft-tie devices, hand socks, geriatric chairs.

Type III—the application of a device to any part of the body which will inhibit the movement of that part of the body only. Examples: wrist, ankle or leg restraints and waist straps.

**58.43(5)** Physical restraints are not to be used to limit resident mobility for the convenience of staff and must comply with life safety requirements. If a resident's behavior is such that it may result in injury to the resident or others and any form of physical restraint is utilized, it should be in conjunction with a treatment procedure(s) designed to modify the behavioral problems for which the resident is restrained, or as a last resort, after failure of attempted therapy. (I, II)

**58.43(6)** Each time a Type II or III restraint is used documentation on the nurse's progress record shall be made which includes type of restraint and reasons for the restraint and length of time resident

was restrained. The documentation of the use of Type III restraint shall also include the time of position change. (II)

**58.43(7)** Each facility shall implement written policies and procedures governing the use of restraints which clearly delineate at least the following:

- a.* Physicians' orders shall indicate the specific reasons for the use of restraints. (II)
- b.* Their use is temporary and the resident will not be restrained for an indefinite amount of time. (I, II)
- c.* A qualified nurse shall make the decision for the use of a Type II or Type III restraint for which there shall be a physician's order. (II)
- d.* A resident placed in a Type II or III restraint shall be checked at least every 30 minutes by appropriately trained staff. No form of restraint shall be used or applied in such a manner as to cause injury or the potential for injury and provide a minimum of discomfort to resident restrained. (I, II)
- e.* Reorders are issued only after the attending physician reviews the resident's condition. (II)
- f.* Their use is not employed as punishment, for the convenience of the staff, or as a substitute for supervision or program. (I, II)
- g.* The opportunity for motion and exercise shall be provided for a period of not less than ten minutes during each two hours in which Type II and Type III restraints are employed, except when resident is sleeping. However, when resident awakens, this shall be provided. This shall be documented each time. A check sheet may serve this purpose. (I, II)
- h.* Locked restraints or leather restraints shall not be permitted except in life-threatening situations. Straight jackets and secluding residents behind locked doors shall not be employed. (I, II)
- i.* Nursing assessment of the resident's need for continued application of a Type III restraint shall be made every 12 hours and documented on the nurse's progress record. Documentation shall include the type of restraint, reason for the restraint and the circumstances. Nursing assessment of the resident's need for continued application of either a Type I or Type II restraint and nursing evaluation of the resident's physical and mental condition shall be made every 30 days and documented on the nurse's progress record. (II)
- j.* A divided door equipped with a securing device that may be readily opened by personnel shall be considered an appropriate means of temporarily confining a resident in the resident's room. (II)
- k.* Divided doors shall be of the type that when the upper half is closed the lower section shall close. (II)
- l.* Methods of restraint shall permit rapid removal of the resident in the event of fire or other emergency. (I, II)
- m.* The facility shall provide orientation and ongoing education programs in the proper use of restraints.

**58.43(8)** In the case of an intellectually disabled individual who participates in a behavior modification program involving use of restraints or aversive stimuli, the program shall be conducted only with the informed consent of the individual's parent or responsible party. Where restraints are employed, an individualized program shall be developed by the interdisciplinary team with specific methodologies for monitoring its progress. (II)

*a.* The resident's responsible party shall receive a written account of the proposed plan of the use of restraints or aversive stimuli and have an opportunity to discuss the proposal with a representative(s) of the treatment team. (II)

*b.* The responsible party must consent in writing prior to the use of the procedure. Consent may also be withdrawn in writing. (II)

**58.43(9)** Upon a claim of dependent adult abuse of a resident being reported, the administrator of the facility shall separate the victim and accused abuser immediately and maintain that separation until the abuse investigation is completed. (I, II)

**58.43(10)** Suspected abuse reports. The department shall investigate all complaints of dependent adult abuse which are alleged to have happened in a health care facility. The department shall inform the department of human services of the results of all evaluations and dispositions of dependent adult abuse investigations.

**58.43(11)** Pursuant to Iowa Code chapter 235B, a mandatory reporter of dependent adult abuse is any person who, in the course of employment, examines, attends, counsels, or treats a dependent adult and reasonably believes the dependent adult has suffered abuse. This includes a member of the staff or employee of a health care facility. (II, III)

If a staff member or employee is required to report pursuant to this subrule, the staff member or employee shall immediately notify the person in charge of the facility or the person's designated agent, and the person in charge or the designated agent shall make the report to the department of human services. (II, III)

This rule is intended to implement Iowa Code sections 135C.14, 235B.3(1), and 235B.3(11).  
[ARC 0766C, IAB 5/29/13, effective 7/3/13]

**481—58.44(135C) Resident records.** Each resident shall be ensured confidential treatment of all information contained in the resident's records, including information contained in an automatic data bank. The resident's written consent shall be required for the release of information to persons not otherwise authorized under law to receive it. (II)

**58.44(1)** The facility shall limit access to any medical records to staff and consultants providing professional service to the resident. This is not meant to preclude access by representatives of state and federal regulatory agencies. (II)

**58.44(2)** Similar procedures shall safeguard the confidentiality of residents' personal records, e.g., financial records and social services records. Only those personnel concerned with the financial affairs of the residents may have access to the financial records. This is not meant to preclude access by representatives of state and federal regulatory agencies. (II)

**58.44(3)** The resident, or the resident's responsible party, shall be entitled to examine all information contained in the resident's record and shall have the right to secure full copies of the record at reasonable cost upon request, unless the physician determines the disclosure of the record or section thereof is contraindicated in which case this information will be deleted prior to making the record available to the resident or responsible party. This determination and the reasons for it must be documented in the resident's record. (II)

**481—58.45(135C) Dignity preserved.** The resident shall be treated with consideration, respect, and full recognition of dignity and individuality, including privacy in treatment and in care for personal needs. (II)

**58.45(1)** Staff shall display respect for residents when speaking with, caring for, or talking about them, as constant affirmation of their individuality and dignity as human beings. (II)

**58.45(2)** Schedules of daily activities shall allow maximum flexibility for residents to exercise choice about what they will do and when they will do it. Residents' individual preferences regarding such things as menus, clothing, religious activities, friendships, activity programs, entertainment, sleeping and eating, also times to retire at night and arise in the morning shall be elicited and considered by the facility. (II)

**58.45(3)** Residents shall be examined and treated in a manner that maintains the privacy of their bodies. A closed door or a drawn curtain shall shield the resident from passersby. People not involved in the care of the residents shall not be present without the resident's consent while the resident is being examined or treated. (II)

**58.45(4)** Privacy of a resident's body also shall be maintained during toileting, bathing, and other activities of personal hygiene, except as needed for resident safety or assistance. (II)

**58.45(5)** Staff shall knock and be acknowledged before entering a resident's room unless the resident is not capable of a response. This shall not apply in emergency conditions. (II)

**481—58.46(135C) Resident work.** No resident may be required to perform services for the facility, except as provided by Iowa Code sections 35D.14 and 347B.5. (II)

**58.46(1)** Residents may not be used to provide a source of labor for the facility against their will. Physician's approval is required for all work programs. (I, II)

**58.46(2)** If the plan of care requires activities for therapeutic or training reasons, the plan for these activities shall be professionally developed and implemented. Therapeutic or training goals must be clearly stated and measurable and the plan shall be time limited and reviewed at least quarterly. (II)

**58.46(3)** Residents who perform work for the facility must receive remuneration unless the work is part of their approved training program. Persons on the resident census performing work shall not be used to replace paid employees in fulfilling staffing requirements. (II)

**481—58.47(135C) Communications.** Each resident may communicate, associate, and meet privately with persons of the resident's choice, unless to do so would infringe upon the rights of other residents, and may send and receive personal mail unopened. (II)

**58.47(1)** Subject to reasonable scheduling restrictions, visiting policies and procedures shall permit residents to receive visits from anyone they wish. Visiting hours shall be posted. (II)

**58.47(2)** Reasonable, regular visiting hours shall not be less than 12 hours per day and shall take into consideration the special circumstances of each visitor. A particular visitor(s) may be restricted by the facility for one of the following reasons:

- a. The resident refuses to see the visitor(s). (II)
- b. The resident's physician documents specific reasons why such a visit would be harmful to the resident's health. (II)
- c. The visitor's behavior is unreasonably disruptive to the functioning of the facility (this judgment must be made by the administrator and the reasons shall be documented and kept on file). (II)

**58.47(3)** Decisions to restrict a visitor are reviewed and reevaluated: each time the medical orders are reviewed by the physician; at least quarterly by the facility's staff; or at the resident's request. (II)

**58.47(4)** Space shall be provided for residents to receive visitors in reasonable comfort and privacy. (II)

**58.47(5)** Telephones consistent with ANSI standards (405.1134(c)) shall be available and accessible for residents to make and receive calls with privacy. Residents who need help shall be assisted in using the telephone. (II)

**58.47(6)** Arrangements shall be made to provide assistance to residents who require help in reading or sending mail. (II)

**58.47(7)** Residents shall be permitted to leave the facility and environs at reasonable times unless there are justifiable reasons established in writing by the attending physician, qualified intellectual disabilities professional or facility administrator for refusing permission. (II)

**58.47(8)** Residents shall not have their personal lives regulated beyond reasonable adherence to meal schedules, bedtime hours, and other written policies which may be necessary for the orderly management of the facility and as required by these rules. However, residents shall be encouraged to participate in recreational programs. (II)

[ARC 0766C, IAB 5/29/13, effective 7/3/13]

**481—58.48(135C) Resident activities.** Each resident may participate in activities of social, religious, and community groups at the resident's discretion unless contraindicated for reasons documented by the attending physician or qualified intellectual disabilities professional as appropriate in the resident's record. (II)

**58.48(1)** Residents who wish to meet with or participate in activities of social, religious, or other community groups in or outside of the facility shall be informed, encouraged, and assisted to do so. (II)

**58.48(2)** All residents shall have the freedom to refuse to participate in these activities. (II)

[ARC 0766C, IAB 5/29/13, effective 7/3/13]

**481—58.49(135C) Resident property.** Each resident may retain and use personal clothing and possessions as space permits and provided such use is not otherwise prohibited by these rules. (II)

**58.49(1)** Residents shall be permitted to keep reasonable amounts of personal clothing and possessions for their use while in the facility. The personal property shall be kept in a safe location which is convenient to the resident. (II)

**58.49(2)** Residents shall be advised, prior to or at the time of admission, of the kinds and amounts of clothing and possessions permitted for personal use, and whether the facility will accept responsibility for maintaining these items, e.g., cleaning and laundry. (II)

**58.49(3)** Any personal clothing or possessions retained by the facility for the resident during the resident's stay shall be identified and recorded on admission and a record placed on the resident's chart. The facility shall be responsible for secure storage of the items, and they shall be returned to the resident promptly upon request or upon discharge from the facility. (II)

**58.49(4)** A resident's personal property shall not be used without the written consent of the resident or the resident's guardian. (II)

**58.49(5)** A resident's personal property shall be returned to the resident when it has been used without the written consent of the resident or the resident's guardian. The department may report findings that a resident's property has been used without written consent to the local law enforcement agency, as appropriate. (II)

**481—58.50(135C) Family visits.** Each resident, if married, shall be ensured privacy for visits by the resident's spouse; if both are residents in the facility, they shall be permitted to share a room if available. (II)

**58.50(1)** The facility shall provide for needed privacy in visits between spouses. (II)

**58.50(2)** Spouses who are residents in the same facility shall be permitted to share a room, if available, unless one of their attending physicians documents in the medical record those specific reasons why an arrangement would have an adverse effect on the health of the resident. (II)

**58.50(3)** Family members shall be permitted to share a room, if available, if requested by both parties, unless one of their attending physicians documents in the medical record those specific reasons why such an agreement would have an adverse effect on the health of the resident. (II)

**481—58.51(135C) Choice of physician and pharmacy.** Each resident shall be permitted free choice of a physician and a pharmacy, if accessible. The facility may require the pharmacy selected to utilize a drug distribution system compatible with the system currently used by the facility.

A facility shall not require the repackaging of medications dispensed by the Veterans Administration or an institution operated by the Veterans Administration for the purpose of making the drug distribution system compatible with the system used by the facility. (II)

**481—58.52(135C) Incompetent resident.**

**58.52(1)** Each facility shall provide that all rights and responsibilities of the resident devolve to the resident's responsible party when a resident is adjudicated incompetent in accordance with state law or, in the case of a resident who has not been adjudicated incompetent under the laws of the state, in accordance with 42 CFR 483.10. This subrule is not intended to limit the authority of any individual acting pursuant to Iowa Code chapter 144A. (II)

**58.52(2)** The fact that a resident has been adjudicated incompetent does not absolve the facility from advising the resident of these rights to the extent the resident is able to understand them. The facility shall also advise the responsible party, if any, and acquire a statement indicating an understanding of residents' rights. (II)

**481—58.53(135C) County care facilities.** In addition to Chapter 58 licensing rules, county care facilities licensed as nursing facilities must also comply with department of human services rules, 441—Chapter 37. Violation of any standard established by the department of human services is a Class II violation pursuant to 481—56.2(135C).

**481—58.54(73GA,ch 1016) Special unit or facility dedicated to the care of persons with chronic confusion or a dementing illness (CCDI unit or facility).**

**58.54(1)** A nursing facility which chooses to care for residents in a distinct part shall obtain a license for a CCDI unit or facility. In the case of a distinct part, this license will be in addition to its ICF license. The license shall state the number of beds in the unit or facility. (III)

*a.* Application for this category of care shall be submitted on a form provided by the department. (III)

*b.* Plans to modify the physical environment shall be submitted to the department. The plans shall be reviewed based on the requirements of 481—Chapter 61. (III)

**58.54(2)** A statement of philosophy shall be developed for each unit or facility which states the beliefs upon which decisions will be made regarding the CCDI unit or facility. Objectives shall be developed for each CCDI unit or facility as a whole. The objectives shall be stated in terms of expected results. (II, III)

**58.54(3)** A résumé of the program of care shall be submitted to the department for approval at least 60 days before a separate CCDI unit or facility is opened. A new résumé of the program of care shall be submitted when services are substantially changed. (II, III)

The résumé of the program of care shall:

*a.* Describe the population to be served; (II, III)

*b.* State philosophy and objectives; (II, III)

*c.* List admission and discharge criteria; (II, III)

*d.* Include a copy of the floor plan; (II, III)

*e.* List the titles of policies and procedures developed for the unit or facility; (II, III)

*f.* Propose a staffing pattern; (II, III)

*g.* Set out a plan for specialized staff training; (II, III)

*h.* State visitor, volunteer, and safety policies; (II, III)

*i.* Describe programs for activities, social services and families; (II, III) and

*j.* Describe the interdisciplinary care planning team. (II, III)

**58.54(4)** Separate written policies and procedures shall be implemented in each CCDI unit or facility. There shall be:

*a.* Admission and discharge policies and procedures which state the criteria to be used to admit residents and the evaluation process which will be used. These policies shall require a statement from the attending physician agreeing to the placement before a resident can be moved into a CCDI unit or facility. (II, III)

*b.* Safety policies and procedures which state the actions to be taken by staff in the event of a fire, natural disaster, emergency medical or catastrophic event. Safety procedures shall also explain steps to be taken when a resident is discovered to be missing from the unit or facility and when hazardous cleaning materials or potentially dangerous mechanical equipment is being used in the unit or facility. The facility shall identify its method for security of the unit or facility and the manner in which the effectiveness of the security system will be monitored. (II, III)

*c.* Program and service policies and procedures which explain programs and services offered in the unit or facility including the rationale. (III)

*d.* Policies and procedures concerning staff which state minimum numbers, types and qualifications of staff in the unit or facility. (II, III)

*e.* Policies about visiting which suggest times and ensure the residents' rights to free access to visitors. (II, III)

*f.* Quality assurance policies and procedures which list the process and criteria which will be used to monitor and to respond to risks specific to the residents. This shall include, but not be limited to, drug use, restraint use, infections, incidents and acute behavioral events. (II, III)

**58.54(5)** Preadmission assessment of physical, mental, social and behavioral status shall be completed to determine whether the applicant meets admission criteria. This assessment shall be completed by a registered nurse and a staff social worker or social work consultant and shall become part of the permanent record upon admission of the resident. (II, III)

**58.54(6)** All staff working in a CCDI unit or facility shall have training appropriate to the needs of the residents. (II, III)

*a.* Upon assignment to the unit or facility, everyone working in the unit or facility shall be oriented to the needs of people with chronic confusion or dementing illnesses. They shall have special training

appropriate to their job description within 30 days of assignment to the unit or facility. (II, III) The orientation shall be at least six hours. The following topics shall be covered:

- (1) Explanation of the disease or disorder; (II, III)
- (2) Symptoms and behaviors of memory-impaired people; (II, III)
- (3) Progression of the disease; (II, III)
- (4) Communication with CCDI residents; (II, III)
- (5) Adjustment to care facility residency by the CCDI unit or facility residents and their families; (II, III)
- (6) Inappropriate and problem behavior of CCDI unit or facility residents and how to deal with it; (II, III)
- (7) Activities of daily living for CCDI residents; (II, III)
- (8) Handling combative behavior; (II, III) and
- (9) Stress reduction for staff and residents. (II, III)

b. Licensed nurses, certified aides, certified medication aides, social services personnel, housekeeping and activity personnel shall have a minimum of six hours of in-service training annually. This training shall be related to the needs of CCDI residents. The six-hour training shall count toward the required annual in-service training. (II, III)

**58.54(7)** There shall be at least one nursing staff person on a CCDI unit at all times. (I, II, III)

**58.54(8)** The CCDI unit or facility license may be revoked, suspended or denied pursuant to Iowa Code chapter 135C and Iowa Administrative Code 481—Chapter 50.

This rule is intended to implement 1990 Iowa Acts, chapter 1016.

**481—58.55(135C) Another business or activity in a facility.** A facility is allowed to have another business or activity in a health care facility or in the physical structure of the facility, if the other business or activity meets the requirements of applicable state and federal laws, administrative rules, and federal regulations.

To obtain the approval of the department and the state fire marshal, the facility must submit to the department a written request for approval which identifies the service(s) to be offered by the business and addresses the factors outlined in paragraphs “a” through “f” of subrule 58.55(1). (I, II, III)

**58.55(1)** The following factors will be considered by the department in determining whether a business or activity will interfere with the use of the facility by residents, interfere with services provided to residents, or be disturbing to residents:

- a. Health and safety risks for residents;
- b. Noise created by the proposed business or activity;
- c. Odors created by the proposed business or activity;
- d. Use of the facility’s corridors or rooms as thoroughfares to the business or activity in regard to safety and disturbance of residents and interference with delivery of services;
- e. Proposed staffing for the business or activity; and
- f. Sharing of services and staff between the proposed business or activity and the facility.

**58.55(2)** Approval of the state fire marshal shall be obtained before approval of the department will be considered.

**58.55(3)** A business or activity conducted in a health care facility or in the same physical structure as a health care facility shall not reduce space, services or staff available to residents below minimums required in these rules and 481—Chapter 61. (I, II, III)

**481—58.56(135C) Respite care services.** Respite care services means an organized program of temporary supportive care provided for 24 hours or more to a person in order to relieve the usual caregiver of the person from providing continual care to the person. A nursing facility which chooses to provide respite care services must meet the following requirements related to respite services and must be licensed as a nursing facility.

**58.56(1)** A nursing facility certified as a Medicaid nursing facility or Medicare skilled nursing facility must meet all Medicaid and Medicare requirements including CFR 483.12, admission, transfer and discharge rights.

**58.56(2)** A nursing facility which chooses to provide respite care services is not required to obtain a separate license or pay a license fee.

**58.56(3)** Rule 481—58.40(135C) regarding involuntary discharge or transfer rights, does not apply to residents who are being cared for under a respite care contract.

**58.56(4)** Pursuant to rule 481—58.13(135C), the facility shall have a contract with each resident in the facility. When the resident is there for respite care services, the contract shall specify the time period during which the resident will be considered to be receiving respite care services. At the end of that period, the contract may be amended to extend that period of time. The contract shall specifically state the resident may be involuntarily discharged while being considered as a respite care resident. The contract shall meet other requirements under 481—58.13(135C), except the requirements under subrule 58.13(7).

**58.56(5)** Respite care services shall not be provided by a health care facility to persons requiring a level of care which is higher than the level of care the facility is licensed to provide.

#### **481—58.57(135C) Training of inspectors.**

**58.57(1)** Subject to the availability of funding, all nursing facility inspectors shall receive 12 hours of annual continuing education in gerontology, wound care, dementia, falls, or a combination of these subjects.

**58.57(2)** An inspector shall not be personally liable for financing the training required under subrule 58.57(1).

**58.57(3)** The department shall consult with the collective bargaining representative of the inspector in regard to the training required under this rule.

[ARC 8433B, IAB 12/30/09, effective 2/3/10]

These rules are intended to implement Iowa Code sections 10A.202, 10A.402, 135C.6(1), 135C.14, 135C.25, 135C.32, 135C.36 and 227.4 and 1990 Iowa Acts, chapter 1016.

- [Filed 8/6/76, Notice 4/19/76—published 8/23/76, effective 9/27/76]
- [Filed without Notice 10/4/76—published 10/20/76, effective 11/24/76]
- [Filed emergency 12/21/76—published 1/12/77, effective 1/12/77]
- [Filed without Notice 2/4/77—published 2/23/77, effective 3/30/77]
- [Filed 8/18/77, Notice 3/9/77—published 9/7/77, effective 10/13/77]
- [Filed emergency 9/30/77—published 10/19/77, effective 9/30/77]
- [Filed without Notice 10/14/77—published 11/2/77, effective 12/8/77]
- [Filed 1/20/78, Notice 12/14/77—published 2/8/78, effective 3/15/78]
- [Filed 5/26/78, Notice 3/8/78—published 6/14/78, effective 7/19/78]
- [Filed 7/7/78, Notice 5/31/78—published 7/26/78, effective 9/1/78]
- [Filed 10/13/78, Notice 9/6/78—published 11/1/78, effective 12/7/78]
- [Filed 11/9/78, Notice 6/28/78—published 11/29/78, effective 1/3/79]
- [Filed emergency 11/22/78—published 12/13/78, effective 1/3/79]
- [Filed 5/20/82, Notice 12/23/81—published 6/9/82, effective 7/14/82]
- [Filed without Notice 7/16/82—published 8/4/82, effective 9/8/82]
- [Filed 3/11/83, Notice 1/5/83—published 3/30/83, effective 5/4/83]
- [Filed 1/10/86, Notice 11/6/85—published 1/29/86, effective 3/5/86]
- [Filed 5/16/86, Notice 1/1/86—published 6/4/86, effective 7/9/86]
- [Filed emergency 7/1/86—published 7/16/86, effective 7/1/86]<sup>2</sup>
- [Filed 6/27/86, Notice 3/26/86—published 7/16/86, effective 8/20/86]
- [Filed emergency 9/19/86—published 10/8/86, effective 9/19/86]
- [Filed 2/6/87, Notice 10/22/86—published 2/25/87, effective 4/1/87]
- [Filed 2/6/87, Notice 11/5/86—published 2/25/87, effective 4/1/87]
- [Filed 3/12/87, Notice 1/28/87—published 4/8/87, effective 5/13/87]

[Filed emergency 6/25/87—published 7/15/87, effective 7/1/87]  
 [Filed 10/26/87, Notice 8/26/87—published 11/18/87, effective 12/23/87]  
 [Filed 2/5/88, Notice 10/7/87—published 2/24/88, effective 3/30/88]<sup>◇</sup>  
 [Filed 4/28/88, Notice 12/16/87—published 5/18/88, effective 6/22/88]  
 [Filed 5/26/88, Notice 4/20/88—published 6/15/88, effective 7/20/88]  
 [Filed 9/30/88, Notice 8/24/88—published 10/19/88, effective 11/23/88]<sup>◇</sup>  
 [Filed 1/5/89, Notice 10/5/88—published 1/25/89, effective 3/1/89]  
 [Filed 6/23/89, Notice 5/17/89—published 7/12/89, effective 8/16/89]  
 [Filed 7/20/89, Notice 6/14/89—published 8/9/89, effective 9/13/89]  
 [Filed 8/16/89, Notices 4/19/89, 7/12/89—published 9/6/89, effective 10/11/89]  
 [Filed emergency 5/11/90—published 5/30/90, effective 5/11/90]  
 [Filed 3/14/91, Notice 9/19/90—published 4/3/91, effective 5/8/91]  
 [Filed emergency 5/10/91—published 5/29/91, effective 5/10/91]  
 [Filed emergency 7/17/91—published 8/7/91, effective 7/19/91]  
 [Filed 1/31/92, Notice 11/13/91—published 2/19/92, effective 7/1/92]  
 [Filed 3/12/92, Notice 12/11/91—published 4/1/92, effective 5/6/92]  
 [Filed 1/15/93, Notice 11/25/92—published 2/3/93, effective 3/10/93]  
 [Filed 3/11/94, Notice 9/15/93—published 3/30/94, effective 5/4/94]  
 [Filed 5/16/95, Notice 3/15/95—published 6/7/95, effective 7/12/95]  
 [Filed 7/11/97, Notice 4/23/97—published 7/30/97, effective 9/3/97]  
 [Filed emergency 7/25/97—published 8/13/97, effective 7/25/97]  
 [Filed emergency 11/14/97—published 12/3/97, effective 11/14/97]  
 [Filed 11/14/97, Notice 8/13/97—published 12/3/97, effective 1/7/98]  
 [Filed 3/31/98, Notice 12/3/97—published 4/22/98, effective 5/27/98]  
 [Filed 7/9/98, Notice 4/22/98—published 7/29/98, effective 9/2/98]  
 [Filed 1/21/99, Notice 10/7/98—published 2/10/99, effective 3/17/99]  
 [Filed 11/12/99, Notice 10/6/99—published 12/1/99, effective 1/5/00]  
 [Filed 7/17/03, Notice 6/11/03—published 8/6/03, effective 9/10/03]  
 [Filed 1/15/04, Notice 10/1/03—published 2/4/04, effective 3/10/04]  
 [Filed 1/15/04, Notice 12/10/03—published 2/4/04, effective 3/10/04]  
 [Filed 3/12/04, Notice 1/7/04—published 3/31/04, effective 5/5/04]  
 [Filed 3/12/04, Notice 2/4/04—published 3/31/04, effective 5/5/04]  
 [Filed 9/9/04, Notice 8/4/04—published 9/29/04, effective 11/3/04]  
 [Filed 7/13/05, Notice 6/8/05—published 8/3/05, effective 9/7/05]  
 [Filed 9/20/06, Notice 8/2/06—published 10/11/06, effective 11/15/06]  
 [Filed 11/15/06, Notice 10/11/06—published 12/6/06, effective 1/10/07]<sup>◇</sup>  
 [Filed 7/9/08, Notice 1/30/08—published 7/30/08, effective 9/3/08]  
 [Filed ARC 8433B (Notice ARC 8190B, IAB 10/7/09), IAB 12/30/09, effective 2/3/10]  
 [Filed ARC 0663C (Notice ARC 0513C, IAB 12/12/12), IAB 4/3/13, effective 5/8/13]  
 [Filed ARC 0766C (Notice ARC 0601C, IAB 2/6/13), IAB 5/29/13, effective 7/3/13]  
 [Filed ARC 0903C (Notice ARC 0776C, IAB 5/29/13), IAB 8/7/13, effective 9/11/13]  
 [Filed ARC 1048C (Notice ARC 0923C, IAB 8/7/13), IAB 10/2/13, effective 11/6/13]  
 [Filed ARC 1050C (Notice ARC 0907C, IAB 8/7/13), IAB 10/2/13, effective 11/6/13]

<sup>◇</sup> Two or more ARCs

<sup>1</sup> Effective date of 470—58.15(2)“c” delayed 70 days by the Administrative Rules Review Committee, IAB 2/26/86.  
 Effective date of 470—58.15(2)“c” delayed until the expiration of 45 calendar days into the 1987 session of the General Assembly pursuant to Iowa Code section 17A.8(9), IAB 6/4/86.

<sup>2</sup> See IAB, Inspections and Appeals Department.

CHAPTER 62  
RESIDENTIAL CARE FACILITIES  
FOR PERSONS WITH MENTAL ILLNESS (RCF/PMI)

**481—62.1(135C) Definitions.** For the purposes of these rules, the following terms shall have the meaning indicated in this chapter. The definitions set out in Iowa Code section 135C.1 shall be considered incorporated verbatim in the rules. The use of the words “shall” and “must” indicate these standards are mandatory.

“*Abuse*” means any of the following as a result of the willful or negligent acts or omissions of a caretaker:

1. Physical abuse
2. Physical injury to or unreasonable confinement or cruel punishment of a resident
3. Sexual abuse
4. Mental abuse
5. Verbal abuse
6. Exploitation of a resident
7. The deprivation of the minimum food, shelter, clothing, supervision, physical and mental health care, and other care necessary to maintain a resident’s life or health as a result of the acts or omissions of the resident.

“*Academic services*” means those activities provided to assist a person to acquire general information and skills which establish the basis for subsequent acquisition and application of knowledge.

“*Age appropriate*” means those activities, settings, and personal appearance and possessions commensurate with the person’s chronological age.

“*Chronic mental illness*” means a persistent mental or emotional disorder that seriously impairs an adult’s functioning relative to such primary aspects of daily living as personal relations, living arrangements, or employment.

“*Commission*” means the mental health and mental retardation commission.

“*Community living training services*” are those activities provided to assist a person to acquire or sustain the knowledge and skills essential to independent functioning to the person’s maximum potential in the physical and social environment. These services may focus on the following areas:

1. Independent living skills means those skills necessary to sustain oneself in the physical environment and are essential to the management of one’s personal property and business. This includes self-advocacy skills.
2. Socialization skills which include self-awareness and self-control, social responsiveness, group participation, social amenities, and interpersonal skills.
3. Communication skills which include expressive and receptive skills in verbal and nonverbal language including reading and writing.
4. Leisure time and recreational skills which include the skills necessary for a person to use leisure time in a manner which is satisfying and constructive to the person.
5. Parenting skills which include those skills necessary to meet the needs of the person’s child. This service is designed to assist the person with mental illness to acquire or sustain the skills necessary for parenting.

“*Department*” means the Iowa department of inspections and appeals.

“*Diagnosis*” means the investigation and analysis of the cause or nature of a person’s condition, situation, or problem.

“*Direct care staff*” means those staff persons who provide a homelike environment for the residents and assist or supervise the resident in meeting the goals in the resident’s program plan.

“*Evaluation services*” means those activities designed to identify a person’s current functioning level and those factors which are barriers to maintaining the current level or achieving a higher level of functioning.

*“Exploitation”* means the act or process of taking unfair advantage of a resident, or the resident’s physical or financial resources, for one’s own personal or pecuniary profit by the use of undue influence, harassment, duress, deception, false representation, or false pretenses.

*“Goals”* means general statements of attainable expected accomplishments to be achieved in meeting identified needs.

*“Incident”* means all accidental, purposeful, or other occurrences within the facility or on the premises affecting residents, visitors, or employees whether there is apparent injury or where hidden injury may have occurred.

*“Individual program plan (IPP)”* means a written plan for the provision of services to the resident that is developed and implemented using an interdisciplinary process, that is based on the resident’s functional status, strengths and needs, and that identifies service activities designed to enable a person to maintain or move toward independent functioning. The plan identifies a continuum of development and outlines progressive steps and anticipated outcomes of services.

*“Informed consent”* means an agreement by a person, or by the person’s legally authorized representative, based upon an understanding of:

1. A full explanation of the procedures to be followed including an identification of those that are and are not experimental,
2. A description of the attendant discomforts, risks, and benefits to be expected,
3. A disclosure of appropriate alternative procedures that would be advantageous for the person.

*“Interdisciplinary process”* means an approach to assessment, individual program planning, and service implementation in which planning participants function as a team. Each participant utilizing the skills, competencies, insights and perspectives provided by the participant’s training and experience focuses on identifying the service needs of the resident and the resident’s family. The purpose of the process is for participants to review and discuss, face-to-face, all information and recommendations and to reach decisions as a team. Participants share all information and recommendations, and develop as a team a single, integrated, individual program plan to meet the resident’s and, when appropriate, the resident’s family’s needs.

*“Interdisciplinary team”* means the group of persons who develop a single, integrated, individual program plan to meet a resident’s needs for services. The interdisciplinary team consists of, at a minimum, the resident, the resident’s legal guardian, if applicable, the resident’s advocate if desired by the resident, a referral agency representative, other appropriate staff members, other providers of services, and other persons relevant to resident’s needs.

*“Least restrictive environment”* means the environment in which the interventions in the lives of people with mental illness can be carried out with a minimum of limitation, intrusion, disruption, and departure from commonly accepted patterns of living.

It is the environment which allows residents to participate, to the maximum extent possible, in everyday life and to have control over the decisions that affect them. It is an environment that provides needed supports which do not interfere with personal liberty and do not unduly interfere with a person’s access to the normal events of life.

*“Legal services”* means those activities designed to assist the person in exercising constitutional and legislatively enacted rights.

*“Level of functioning”* means a person’s current physiological and psychological status and current academic, community living, self-care, and vocational skills.

*“Long-term residential care facility for persons with mental illness (RCF/PMI)”* means a residential setting to maintain or improve community living skills to reach maximum potential for independent living and to prevent movement to a more restrictive setting.

*“Mechanical restraint”* means a device applied to a person’s limbs, head, or body which restricts a person’s movement and includes but is not limited to leather straps, leather cuffs, camisoles, or handcuffs.

*“Mental abuse”* means, but is not limited to, humiliation, harassment, and threats of punishment or deprivation.

*“Mental illness”* means a substantial disorder of thought or mood which significantly impairs judgment, behavior, or the capacity to recognize reality or the ability to cope with the ordinary demands

of life. Mental disorders include the organic and functional psychoses, neuroses, personality disorders, alcoholism and drug dependence, behavioral disorders and other disorders as defined by the current edition of American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders.

*“Normalization”* means helping persons, in accordance with their needs and preference, to achieve a lifestyle that is consistent with the norms and patterns of general society and in ways which incorporate the age-appropriate and least restrictive principles.

*“Objectives”* means specific, time-limited, and measurable statements showing outcomes or accomplishments necessary to progress toward the goal.

*“Physical abuse”* means, but is not limited to, corporal punishment and the use of restraints as punishment.

*“Physical injury”* means damage to any bodily tissue to the extent the tissue must undergo a healing process in order to be restored to a sound and healthy condition. It may also mean damage to the extent the bodily tissue cannot be restored to a sound and healthy condition, or results in the death of the resident whose bodily tissue sustained the damage.

*“Physical or physiological treatment”* means those activities designed to prevent, halt, control, relieve, or reverse symptoms or conditions which interfere with the physical or physiological functioning of the human body.

*“Physical restraint”* means a technique involving the use of one or more of a staff person’s arms, legs, hands or other body areas to restrict or control the movements of a resident. This does not include the use of mechanical restraint.

*“Physician”* means a person licensed to practice medicine and surgery, osteopathy and surgery, osteopathy, or chiropractic under the laws of this state; but a physician licensed as a physician and surgeon shall be designated as a “physician” or “surgeon”; a person licensed as an osteopath and surgeon shall be designated as an “osteopathic physician” or “osteopathic surgeon”; a person designated as an osteopath shall be designated as an “osteopathic physician”; and a person licensed as a chiropractor shall be designated as a “chiropractor.”

*“Program”* means a set of related resources and services directed to the accomplishment of a fixed set of goals and objectives for any of the following:

1. Special target populations,
2. The population of a specified geographic area(s),
3. A specified purpose, and
4. A person.

*“Psychotherapeutic treatment”* means those activities designed to assist a person in the identification or modification of beliefs, emotions, attitudes, or behaviors in order to maintain or improve the person’s functioning in response to the physical, emotional and social environment.

*“Qualified mental health professional (QMHP)”* means a person who:

Is a psychiatrist, psychologist, social worker, psychiatric nurse or mental health counselor; or

Is a doctor of medicine or osteopathic medicine or has at least a master’s degree or its equivalent with coursework focusing on diagnosis and evaluation and psychotherapeutic treatment of mental health problems and mental illness.

Equivalent means at least 32 semester hours of graduate level study in the following areas:

1. Psychology (normal and abnormal)
2. Assessment (psychological and physiological)
3. Growth, development, and personality
4. Learning theory
5. Counseling theory and technique (group dynamics)
6. Human behavior
7. Sociology
8. Interpersonal relations
9. Change
10. Systems theory
11. Interdisciplinary team process

## 12. Organizational theory

## 13. Planning

These persons must have two years of documented supervised experience in providing mental health services; or

Is employed by a community mental health center or mental health service provider accredited by the commission and has less than a master's degree but at least a bachelor's degree and sufficient education and experience as determined by the chief administrative officer of the community mental health center, with the approval of the commission with coursework and experience focusing on diagnosis and evaluation and treatment of persons with mental health problems and mental illness.

All persons must hold a current license when required by Iowa law.

1. *"Psychiatrist"* means a doctor of medicine or osteopathic medicine and surgery who is certified by the American Board of Psychiatry and Neurology or who is eligible for certification.

2. *"Psychologist"* means a person who is licensed to practice psychology in the state of Iowa, or is certified by the Iowa department of education as a school psychologist, or is eligible for certification, or meets the requirements for eligibility for a license to practice psychology in the state of Iowa that were effective prior to July 1, 1985.

3. *"Social worker"* means a person who is licensed to practice social work in the state of Iowa, or who is eligible for licensure.

4. *"Psychiatric nurse"* means a person who meets the requirements of certified psychiatric-mental health nurse practitioner pursuant to 655—Chapter 7, Iowa Administrative Code, or is eligible for certification.

5. *"Mental health counselor"* means a person who is certified or eligible for certification as a mental health counselor by the National Academy of Certified Clinical Mental Health Counselors.

*"Resident"* means a person who has been admitted to the facility to receive care and services.

*"Seclusion"* means the isolation of the resident in a locked room which cannot be opened by the resident.

*"Self-care training services"* means those activities provided to assist a person to acquire or sustain the knowledge, habits, and skills essential to the daily needs of the person. The activities focus on personal hygiene, general health maintenance, mobility skills, and other activities of daily living.

*"Service"* means a set of interrelated activities provided to a resident pursuant to the IPP.

*"Sexual abuse"* means, but is not limited to, the exposing of pubes to a resident, the exposure of a resident's genitals, pubes, breasts or buttocks for sexual satisfaction, fondling or touching the inner thigh, groin, buttocks, anus or breast of a resident or the clothing covering these areas, sexually suggestive comments or remarks made to a resident, a genital to genital or oral to genital contact or the commission of a sexual offense under Iowa Code chapter 709 or Iowa Code section 726.2.

*"Short-term transitional residential care facility for persons with mental illness"* means a transitional setting to move the person toward independent living by helping the person gain mastery of independent living skills.

*"Support services"* means those activities provided to or on behalf of a person in the areas of personal care and assistance and property maintenance in order to allow a person to live in the least restrictive environment.

*"Transportation services"* means those activities designed to assist a person to travel from one place to another to obtain services or carry out life's activities.

*"Verbal abuse"* means, but is not limited to, the use of derogatory terms or names, undue voice volume and rude comments, orders, or responses to residents.

*"Vocational training services"* means those activities designed to familiarize a person with production or employment requirements and to maintain or develop the person's ability to function in a work setting. This service includes programming which allows or promotes the development of skills, attitudes, and personal attributes appropriate to the work setting.

*"Work"* means any activity during which a resident provides goods or services for wages.

*"Written, in writing or recorded"* means that an account or entry is made in a permanent form.

**481—62.2(135C) Application for license.**

**62.2(1) *Initial application and licensing.*** In order to obtain an initial license for a residential care facility for persons with mental illness, the applicant must meet all of the rules, regulations, and standards contained in Iowa Code chapter 135C, and Iowa Administrative Code 481—Chapters 60 and 62, and submit an application to the department which states the type and category of license for which the facility is applying.

- a.* Submit a résumé of care with a narrative which includes the following information:
- (1) The purpose of the facility.
  - (2) A description of the target population and limitations on resident eligibility.
  - (3) An identification and description of the services the facility will provide which shall minimally include specific and measurable goals and objectives for each of the services to be made available by the facility and a description of the resources needed to provide each of the services including staff, physical facilities and funds.
  - (4) A description of the human services system available in the area, including, but not limited to, social, public health, visiting nurse, vocational training, employment services, sheltered living arrangements, and services of private agencies.
  - (5) A description of working relationships with the human services agencies when applicable, which shall include at a minimum:
    1. A description of how the facility will coordinate with the human services to facilitate continuity of care and coordination of services to residents; and
    2. A description of how the facility will coordinate with those agencies to identify unnecessary duplication of services and plan for development and coordination of needed services.
- b.* Submit a floor plan of each floor of the facility drawn on 8½- x 11-inch paper showing room areas in proportion, room dimensions, room numbers for all rooms, including bathroom; and designation of the use to which room will be put and window and door location;
- c.* Submit a photograph of the front and side elevation of the facility;
- d.* Submit the statutory fee for a residential care facility license;
- e.* Show evidence of a certificate signed by the state fire marshal or deputy state fire marshal as to compliance with fire safety rules.

**62.2(2) *Renewal application or change of ownership.*** In order to obtain a renewal or change of ownership license of the residential care facility to serve persons with mental illness the applicant must:

- a.* Submit to the department the completed application form 30 days prior to annual license renewal or change of ownership date of the residential care facility license.
- b.* Submit the statutory license fee for a residential care facility for persons with mental illness with the application for renewal or change of ownership.
- c.* Have an approved current certificate signed by the state fire marshal or deputy state fire marshal as to compliance with fire safety rules.
- d.* Submit documentation of review of résumé of care pursuant to 62.2(1) “*a*” and a copy of any revisions to the plan.

This rule is intended to implement Iowa Code sections 135C.7 and 135C.9.

**481—62.3(135C) Licenses for distinct parts.**

**62.3(1)** Separate licenses may be issued for distinct parts which are clearly identifiable parts of a health care facility, containing contiguous rooms in a separate wing or building or on a separate floor of the facility and which provide care and services of separate categories.

**62.3(2)** The following requirements shall be met for a separate licensing of a distinct part:

- a.* The distinct part shall serve only residents who require the category of care and services immediately available to them within that part. (III)
- b.* The distinct part shall meet all the standards, rules, and regulations pertaining to the category for which a license is being sought.
- c.* The distinct part must be operationally and financially feasible.

*d.* A separate personal care staff with qualifications appropriate to the care and services being rendered must be regularly assigned and working in the distinct part under responsible management. (III)

*e.* Separately licensed distinct parts may have certain services such as management, building maintenance, laundry and dietary in common with each other.

**62.3(3)** Licenses are issued to the person or governmental unit which has responsibility for the operation of the facility and authority to comply with all applicable statutes, rules or regulations.

The person or governmental unit must be the owner of the facility or, if the facility is leased, the lessee.

This rule is intended to implement Iowa Code sections 135C.6(1) and 135C.6(2).

**481—62.4(135C) Variances.** Variances from these rules may be granted by the director of the department:

1. When the need for a variance has been established consistent with the résumé of care or the resident's individual program plan.

2. When there is no danger to the health, safety, welfare, or rights of any resident.

3. The variance will apply only to a specific residential care facility for the mentally ill.

4. Variances shall be reviewed at the time of each licensure survey by the department to see if the need for the variance is still acceptable.

**62.4(1)** To request a variance, the licensee must:

*a.* Apply in writing on a form provided by the department;

*b.* Cite the rule or rules from which a variance is desired;

*c.* State why compliance with the rule or rules cannot be accomplished;

*d.* Explain how the variance is consistent with the résumé of care or the individual program plan;

*e.* Demonstrate that the requested variance will not endanger the health, safety, welfare, or rights of any resident.

**62.4(2)** Upon receipt of a request for variance, the director shall:

*a.* Examine the rule from which the variance is requested;

*b.* Evaluate the requested variance against the requirement of the rule to determine whether the request is necessary to meet the needs of the residents;

*c.* Examine the effect of the requested variance on the health, safety, or welfare of the residents;

*d.* Consult with the applicant to obtain additional written information if required.

**62.4(3)** Based upon this information, approval of the variance will be either granted or denied within 120 days of receipt.

**481—62.5(135C) General requirements.**

**62.5(1)** The license shall be valid and be posted in each facility so the public can see it easily. (III)

**62.5(2)** The license shall be valid only for the premises and person named on the license and is not transferable.

**62.5(3)** The posted license shall accurately reflect the current status of the residential care facility for persons with mental illness. (III)

**62.5(4)** Licenses expire one year after the date of issuance or as indicated on the license.

**62.5(5)** There shall be no more beds erected than are stipulated on the license. (II, III)

**62.5(6)** Each citation or a copy of each citation issued by the department for a class I or class II violation shall be prominently posted by the facility in plain view of the residents, visitors, and persons inquiring about placement in the facility. The citation or copy of the citation shall remain posted until the violation is corrected to the satisfaction of the department. (III)

This rule is intended to implement Iowa Code section 135C.8.

**481—62.6(135C) Notification required by the department.** The department shall be notified:

Within 48 hours, by letter, of any reduction or loss of personal care or dietary staff lasting more than seven days which places the staff ratio below that required for licensing. No additional residents shall be admitted until the minimum staff requirements are achieved. (II, III)

Within 30 days of any proposed change in the résumé of care for the RCF/PMI. (II, III)

Thirty days before addition, alteration, or new construction is begun in the residential care facility or on the premises; (III)

Thirty days in advance of closure of the residential care facility for persons with mental illness; (III)

Within two weeks of any change of administrator; (II, III)

Within 30 days when any change in the category of license is sought. (III)

Prior to the purchase, transfer, assignment, or lease of a residential care facility the licensee shall:

1. Inform the department in writing of pending sale, transfer, assignment, or lease of the facility; (III)

2. Inform the department in writing of the name and address of the prospective purchaser, transferee, assignee, or lessee at least 30 days before the sale, transfer, assignment, or lease is completed; (III)

3. Submit a written authorization to the department permitting the department to release information of whatever kind from the department's files concerning the licensee's residential care facility to the named prospective purchaser, transferee, assignee, or lessee. (III)

After the authorization has been submitted to the department, the department shall upon request send or give copies of all recent licensure surveys and any other pertinent information relating to the facility's licensure status to the prospective purchaser, transferee, assignee or lessee. Costs for copies requested shall be paid by the prospective purchaser, transferee, assignee or lessee. No information personally identifying any resident shall be provided to prospective purchaser, transferee, assignee or lessee. (II, III)

This rule is intended to implement Iowa Code sections 135C.6(3) and 135C.16(2).

**481—62.7(135C) Administrator.** Each residential care facility for persons with mental illness shall have one person in charge, duly approved by the department or acting in a provisional capacity in accordance with these rules. (II, III)

**62.7(1)** The administrator shall be at least 21 years of age and shall meet at least one of the following conditions:

a. Be a licensed nursing home administrator, or a certified residential care administrator in Iowa. These individuals must have at least two years' experience in direct care or supervision of persons with mental illness, (II, III) or

b. Be a qualified mental health professional (QMHP) with at least one year of experience in an administrative capacity in a health care facility, (II, III) or

c. Have completed a one-year educational training program approved by the department with emphasis on serving the needs of persons with mental illness, and two years' experience in direct care or supervision of persons with mental illness. (II, III)

d. Those individuals currently employed as administrators on the effective date of these rules (March 30, 1988) shall not be required to meet the above criteria during their employment in the current facility.

**62.7(2)** The administrator shall be responsible for no more than 150 beds in total if the administrator is an administrator of more than one facility. (II, III)

a. The distance between the two farthest facilities shall be no greater than 50 miles. (II, III)

b. An administrator of more than one facility must designate an administrative staff person in each facility who shall be responsible for directing programs in the facility during the administrator's absence. (II, III)

**62.7(3)** The administrative staff person shall be designated in writing and immediately available to the facility on a 24-hour basis when the administrator is absent and residents are in the facility. (II, III)

The person(s) designated shall:

- a. Have at least two years' experience or training in a supervisory or direct care position in a mental health setting; (II, III)
- b. Be knowledgeable of the operation of the facility; (II, III)
- c. Have access to records concerned with the operation of the facility; (II, III)
- d. Be capable of carrying out administrative duties and of assuming administrative responsibilities; (II, III)
- e. Be at least 21 years of age; (III)
- f. Be empowered to act on behalf of the licensee during the administrator's absence concerning the health, safety, and welfare of the residents; (II, III)
- g. Have training to carry out assignments and take care of emergencies and sudden illnesses of residents. (II, III)

**62.7(4)** If an administrator serves more than one facility, a written plan shall be developed and available for review and approval by the department designating regular and specific times the administrator will be available to meet with the staff and residents to provide direction and supervision of resident care and services. (II, III)

**62.7(5)** The licensee may be the approved administrator providing the requirements set forth in these rules are met. (III)

**62.7(6)** When a facility has been unable to replace the administrator, through no fault of its own, a provisional administrator meeting the qualifications of the administrative staff person may be appointed on a temporary basis by the licensee to assume the administrative responsibilities for the facility. This person shall not serve more than three months. The department must be notified before the appointment of the provisional administrator. (III)

A facility applying for initial licensing shall not have a provisional administrator. (III)

This rule is intended to implement Iowa Code section 135C.14(2).

#### **481—62.8(135C) Administration.**

**62.8(1)** The licensee shall:

- a. Be responsible for the overall operation of the RCF/PMI. (III)
- b. Be responsible for compliance with all applicable laws and with the rules of the department. (II, III)
- c. Establish written policies, which shall be available for review by the department or other agencies designated by Iowa Code section 135C.16(3), for the operation of the RCF/PMI including but not limited to: (III)
  - 1. Personnel (III)
  - 2. Admission (III)
  - 3. Evaluation services (II, III)
  - 4. Programming and individual program plan (II, III)
  - 5. Crisis intervention (II, III)
  - 6. Discharge or transfer (III)
  - 7. Medication management (II)
  - 8. Resident property (II, III)
  - 9. Financial affairs (II, III)
  - 10. Records (III)
  - 11. Health and safety (II, III)
  - 12. Nutrition (III)
  - 13. Physical facilities and maintenance (III)
  - 14. Care review (III)
  - 15. Resident rights (II, III)
- d. Furnish statistical information concerning the operation of the facility to the department within 30 days of request. (III)

**62.8(2)** The administrator shall be responsible for the implementation of procedures to support the policies established by the licensee. (III)

This rule is intended to implement Iowa Code section 135C.14.

**481—62.9(135C) Personnel.**

**62.9(1)** The personnel policies and procedures shall include the following requirements: (III)

*a.* Written job descriptions for all employees or agreements for all consultants, which include duties and responsibilities; education, experience, or other requirements, and supervisory relationships. (III)

*b.* Annual performance evaluation of all employees and consultants which is dated and signed by the employee or consultant and the supervisor. (III)

*c.* Personnel records which are current, accurate, complete, and confidential to the extent allowed by law. The record shall contain documentation of how the employee's or consultant's education and experience are relevant to the position for which hired. (III)

*d.* Roles, responsibilities, and limitation of student interns and volunteers. (III)

*e.* An orientation program for all newly hired employees and consultants which includes an introduction to the facility's personnel policies and procedures, and a discussion of the facility's safety plan. (II, III)

*f.* A plan for a continuing education program with a minimum of eight in-service programs per year for all employees which shall include a written, individualized staff development plan for each employee. This includes, but is not limited to, the administrator, department heads, and direct care staff. The plan shall take into consideration the needs of the facility as identified in the résumé of care. The plan shall ensure that each employee has the opportunity to develop and enhance skills and to broaden and increase knowledge contributing to effective resident care, including but not limited to: (II, III)

(1) First aid. (II, III)

(2) Human needs and behavior. (II, III)

(3) Problems and needs of persons with mental illness. (II, III)

(4) Medication. (II, III)

(5) Crisis intervention. (II)

(6) Delivery of services in accordance with the principles of normalization. (III)

(7) Wellness. (III)

(8) Fire safety, disaster, and tornado preparation. (II, III)

*g.* Equal opportunity and affirmative action employment practices. (III)

*h.* Procedures to be used when disciplining an employee. (III)

*i.* Appropriate dress and personal hygiene for staff and residents. (III)

**62.9(2)** The facility shall require regular health examinations for all personnel, and examinations shall be required at the commencement of employment and thereafter at least every four years. The examination shall include, at a minimum, the health status of the employee. Screening and testing for tuberculosis shall be conducted pursuant to 481—Chapter 59. (III)

*a.* No person shall be allowed to provide services in a facility if the person has a disease:

(1) Which is transmissible through required workplace contact, (I, II, III)

(2) Which presents a significant risk of infecting others, (I, II, III)

(3) Which presents a substantial possibility of harming others, and (I, II, III)

(4) For which no reasonable accommodation can eliminate the risk. (I, II, III)

Refer to Guidelines for Infection Control in Hospital Personnel, Centers for Disease Control, U.S. Department of Health and Human Services, PB85-923402 to determine (1), (2), (3) and (4).

*b.* There shall be written policies for emergency medical care for employees in case of sudden illness or accident. These policies shall include the administrative individuals to be contacted. (III)

*c.* Health certificates for all employees shall be available for review by the department. (III)

**62.9(3)** Staffing. The facility shall establish, subject to approval of the department, the numbers and qualifications of the staff required in an RCF/PMI using as its criteria the services being offered as indicated on the résumé of care and as required for implementation of individual program plans. (II, III)

*a.* Personnel in an RCF/PMI shall provide 24-hour coverage for residential care services. Personnel shall be up and dressed at all times in facilities over 15 beds. In facilities with 15 or less beds, personnel shall be up and dressed when residents are awake. (II, III)

*b.* The policies and procedures shall provide for staff accessibility during normal sleeping hours in facilities with 15 beds or less. (I)

*c.* Direct care staff shall be present in the facility unless all residents are involved in activities away from the facility. The policies and procedures shall provide for an on-call staff person to be available when residents and staff are absent from the facility. (II, III)

(1) The on-call staff person shall be designated in writing.

(2) Residents shall be informed of how to call the on-call person.

*d.* The staffing plan shall ensure that at least one qualified direct care staff is on duty to carry out and implement the individual program plans. (II, III)

*e.* The RCF/PMI shall provide for services of a qualified mental health professional by direct employment or contract and whose responsibilities shall include, but not be limited to: (II, III)

(1) Approval of each resident's individual program plan; (II, III)

(2) Monitoring the implementation of each resident's individual program plan; (II, III)

(3) Recording each resident's progress; (II, III)

(4) Participation in a periodic review of each individual program plan pursuant to 62.12(4) "a" and "b." (II, III)

*f.* Each residential care facility with over 15 beds shall employ a person to direct the activity program both inside and outside the facility in accordance with each resident's individual program plan. (III)

*g.* Staff for the activity program shall be provided on a minimum basis of 45 minutes per licensed bed per week:

(1) The activity coordinator shall have completed the activity coordinator's orientation course approved by the department within six months of beginning employment or have comparable training and experience as approved by the department. (III)

(2) The activity coordinator shall attend workshops or educational programs which relate to activity programming. These shall total a minimum of ten contact hours per year. (III)

(3) There shall be a written plan for personnel coverage when the activity coordinator is absent during scheduled working hours. (III)

*h.* The activity coordinator shall have access to all residents' records excluding financial records; (III)

*i.* Responsibilities of the activity coordinator shall include:

(1) Coordinating all activities, including volunteer or auxiliary activities and religious services. (III)

(2) Keeping all necessary records including attendance, individual resident progress notes at least quarterly, and monthly calendars prepared one month in advance. (III)

(3) Coordinating the activity program with all other services in the facility. (III)

(4) Participating in the in-service training program in the facility. This shall include attending as well as presenting sessions. (III)

**62.9(4)** Personnel record. A personnel record shall be kept for each employee. (III)

*a.* The record shall include the employee's:

1. Name and address, (III)

2. Social security number, (III)

3. Date of birth, (III)

4. Date of employment, (III)

5. References, (III)

6. Position in the facility, (III)

7. Job description, (III)

8. Documentation of experience and education, (III)

9. Staff development plan, (III)

10. Annual performance evaluation, (II, III)
11. Documentation of disciplinary action, (II, III)
12. Date and reason for discharge or resignation, (III)
13. Current physical examination. (III)

*b.* The personnel records shall be made available to the long-term care resident's advocate/ombudsman of the department on aging in response to a complaint being investigated.

**62.9(5)** Employee criminal record checks, child abuse checks and dependent adult abuse checks and employment of individuals who have committed a crime or have a founded abuse. The facility shall comply with the requirements found in Iowa Code section 135C.33 as amended by 2013 Iowa Acts, Senate File 347, and rule 481—50.9(135C) related to completion of criminal record checks, child abuse checks, and dependent adult abuse checks and to employment of individuals who have committed a crime or have a founded abuse. (I, II, III)

This rule is intended to implement Iowa Code sections 135C.14(2) and 135C.14(6).  
 [ARC 0663C, IAB 4/3/13, effective 5/8/13; ARC 0903C, IAB 8/7/13, effective 9/11/13]

**481—62.10(135C) General admission policies.** There shall be admission policies which address the following:

1. No resident shall be admitted or retained who is in need of greater services than the facility can provide. (II, III)
2. Residents shall be admitted only on a written order signed by a physician certifying that the individual requires no more than personal care and supervision and does not require nursing care. (II, III)
3. A preplacement visit shall be completed prior to admission, except in case of an emergency admission or readmission, to familiarize the applicant with the facility and services offered. The policies and procedures may allow for waiving the requirement at the request of a person seeking admission when the completion of the visit would create a hardship for the person seeking admission. If the distance to be traveled makes it impossible to complete the visit in an eight-hour day, this may be considered to create a hardship. (III)
4. Prior to admission of an applicant, the facility shall obtain sufficient information to determine if its program is appropriate and adequate to meet the person's needs. (III)
5. Admission criteria shall include but not be limited to age, sex, diagnosis, from the American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders, substance abuse, dual diagnosis and criteria that are consistent with the résumé of care. (III)
6. Each facility shall maintain a waiting list with selection priorities identified. (III)
7. No RCF/PMI may admit more residents than the number of beds for which it is licensed. (II, III)
8. There shall be a written, organized orientation program for all residents which shall be planned and implemented to resolve or reduce personal, family, business, and emotional problems that may interfere with the health care, recovery, and rehabilitation of the individual and which shall be available for review by the department. (III)
9. Infants and children under the age of 18 shall not be admitted to an RCF/PMI for adults unless given prior written approval by the department. A distinct part of an RCF/PMI, segregated from the adult section, may be established based on a résumé of care submitted by the licensee or applicant which is commensurate with the needs of the residents of the health care facility and has received the department's review and approval. (III)

This rule is intended to implement Iowa Code sections 135C.3 and 135C.23.

**481—62.11(135C) Evaluation services.**

**62.11(1)** Each resident admitted shall have had a physical examination prior to admission and annually thereafter. (II, III)

*a.* If the resident is admitted directly from a hospital, a copy of the hospital admission physical and discharge summary may be part of the record in lieu of an additional physical examination. (II, III)

*b.* The record of the admission physical examination shall portray the current medical status of the resident and shall include the resident's name, sex, age, medical history, physical examination, diagnosis, statement of chief complaints, and results of any diagnostic procedure. (II, III)

*c.* Screening and testing for tuberculosis shall be conducted pursuant to 481—Chapter 59. (II, III)

**62.11(2)** Evaluation services shall be provided to each resident. An annual evaluation of each resident shall be completed no later than 12 months from the date of the last available evaluation. For residents who are on leave from a state mental health institution, the institution shall be responsible for the completion of the evaluation. The facility shall ensure the completion of the evaluation of all other residents. The annual evaluation shall identify physical health and current level of functioning and need for services. (II, III)

**62.11(3)** The portion of the evaluation to identify the resident's physical health shall:

*a.* Result in identification of current illness and disabilities and recommendations for physical and physiological treatment and services. (II, III)

*b.* Include an evaluation of the resident's ability for health maintenance. (III)

*c.* Be performed by a medical doctor or doctor of osteopathic medicine who holds a current license to practice medicine in the state of Iowa. If the evaluation is completed out of Iowa, it must be by a physician who holds a current license in the state in which the evaluation is performed. (II, III)

**62.11(4)** The portion of the evaluation to identify the resident's current functioning level and need for services shall:

*a.* Identify the resident's level of functioning and need for services in each of the following areas: self-care, community living skills, psychotherapeutic treatment, vocational skills, academic skills. (II, III)

*b.* Be of sufficient detail to determine the appropriateness of placement according to the skills and needs of the resident. (II, III)

*c.* Be made without regard to the availability of services. (III)

*d.* Be performed by a QMHP, in consultation with the interdisciplinary team. (II, III)

*e.* If an evaluation is available from the referral source, the evaluation shall be secured by the facility prior to the admission of the applicant. (III)

*f.* If an evaluation is not available, or does not contain all the required information, the facility shall ensure an evaluation to the extent necessary to determine if the applicant meets the criteria for admission. For those admitted, the remainder of the evaluation shall be performed prior to the development of an individual program plan. (III)

*g.* Results of all evaluations shall be in writing and maintained in the resident's record. Evaluations subsequent to the initial evaluation shall be performed in sufficient detail to determine changes in the resident's physical health, skills and need for services. (II, III)

**62.11(5)** A narrative social history shall be completed for each resident within 30 days of admission and approved by the qualified mental health professional prior to the development of the IPP. (III)

*a.* When the social history was secured from another provider, the information contained shall be reviewed within 30 days of admission. The date of the review, signature of the staff reviewing the history and a summary of significant changes in the information shall be entered in the resident's record. (III)

*b.* An annual review of the information contained within the social history shall be incorporated into the individual program plan progress note. (III)

*c.* The social history shall minimally address the following areas:

1. Referral source and reason for admission, (II, III)

2. Legal status, (II, III)

3. A description of previous living arrangements, (III)

4. A description of previous services received and summary of current service involvements, (II,

III)

5. A summary of significant medical conditions including, but not limited to, illnesses, hospitalizations, past and current drug therapies, and special diets, (II, III)

6. Substance abuse history, (II, III)

7. Work history, (III)

8. Educational history, (III)
9. Relationship with family, significant others, and other support systems, (III)
10. Cultural and ethnic background and religious affiliation, (II, III)
11. Hobbies and leisure time activities, (III)
12. Likes, dislikes, habits, and patterns of behavior, (II, III)
13. Impressions and recommendations.

This rule is intended to implement Iowa Code section 135C.14(7).

[ARC 0663C, IAB 4/3/13, effective 5/8/13]

#### **481—62.12(135C) Programming.**

**62.12(1)** Individual program plan. An individual program plan (IPP) for each resident shall be developed by an interdisciplinary team. Services to the resident shall be appropriate to address the short-term transitional or long-term residential needs of the resident. The resident or the resident's legal guardian has the ultimate authority to accept or reject the plan unless otherwise determined by the court. The IPP shall be approved and implementation monitored by the QMHP. (II, III)

*a.* The IPP shall be based on the individual service plan of the referring agency, if available, the information contained in the social history, the need for services identified in the evaluation, and any other pertinent information. (III)

*b.* The facility shall assist the resident in obtaining access to academic, community living skills training, legal, self-care training, support, transportation, treatment, and vocational training services to the resident as needed. These services may be provided by the facility or obtained from other providers. (III)

*c.* Services to the resident shall be provided in the least restrictive environment and shall incorporate the principle of normalization. (III)

*d.* If needed services are not available and accessible, the facility shall document the actions which were taken to locate and access or deliver those services. The documentation shall include the identification of the type of needs which will not be met due to the lack of available services. (III)

*e.* The IPP shall be developed within 30 days following admission to the facility and renewed at least annually. (II, III)

*f.* The IPP shall be in writing, dated, signed by the interdisciplinary team members, and maintained in the resident's record. (III)

*g.* Written notice of the meeting to develop an IPP shall be sent to all persons to be included in the interdisciplinary team conference in advance of the scheduled meeting. (III)

**62.12(2)** The IPP shall include the following:

1. Goals, (III)
2. Objectives, (III)
3. The specific service(s), including medication counseling, to be provided to achieve the objectives, the person(s) or agency(ies) responsible for providing the service(s), and the date of initiation and anticipated duration of service(s). (III)

**62.12(3)** The IPP shall state the evaluation procedure for determining if objectives are achieved which shall include the incorporation of a continuous process for review and revision. (III)

**62.12(4)** There shall be a review of the IPP by relevant staff, the resident, and appropriate others at least semiannually. (II, III)

*a.* The review shall include the development of a written report which addresses the following: summary of the resident's progress toward objectives; the need for continued services and any recommendation concerning alternative services or living arrangements; and any recommended change in guardianship or conservatorship status. The report shall reflect those involved in the review and the date of the review, and shall be maintained in the resident's record. (II, III)

*b.* The review shall be approved by the qualified mental health professional. (III)

**62.12(5)** There shall be procedures for recording the activities of each service provider toward assisting the resident in achieving the objectives in the IPP and the resident's response which shall include a mechanism for coordination with all service providers. (III)

- a. An entry into the resident's record shall be made by staff whenever possible at the time of service provision but no later than seven days from service provision. (III)
  - b. Entries shall be dated and signed by the person providing the service. (III)
  - c. When the service includes ongoing activities occurring more than once a week, a summarized entry may be made weekly by staff in the resident's record. (III)
  - d. Entries shall be written in terms of behavioral observations and specific activities. Entries that involve subjective interpretations of a resident's behavior or progress shall be clearly identified and shall be supplemented with the behavioral observations which served as the basis of the interpretation. (III)
- This rule is intended to implement Iowa Code section 135C.14.

**481—62.13(135C) Crisis intervention.**

**62.13(1)** There shall be written policies and procedures concerning crisis intervention. (II) These policies and procedures shall be:

- a. Directed to maximizing the growth and development of the individual by incorporating a hierarchy of available alternative methods that emphasize positive approaches; (II, III)
- b. Available in each program area and living unit; (II, III)
- c. Available to individuals and their families; and (II, III)
- d. Developed with the participation, as appropriate, of individuals served. (II, III)

**62.13(2)** Corporal punishment and verbal abuse (shouting, screaming, swearing, name-calling, or any other activity that would be damaging to an individual's self-respect) are prohibited by written policy. (II)

**62.13(3)** Medication shall not be used as punishment, for the convenience of staff, or as a substitute for a program. Direct care staff shall monitor residents on medication and notify the physician if a resident is too sedated to participate in IPP. (I, II)

**62.13(4)** Residents shall not be subjected to mechanical restraint. (I, II)

**62.13(5)** There shall be written policies that define the uses of seclusion and physical restraints, designate the staff member(s) who may authorize its use, and establish a mechanism for monitoring and controlling its use. (I, II) Temporary physical restraint and temporary seclusion of residents shall be used only under the following conditions: (I, II)

- a. An emergency to prevent injury to the resident or to others; or (I, II)
- b. For crisis intervention but shall not be used for punishment, for the convenience of staff or as a substitution for supervision or program; (I, II) and
- c. Seclusion may only be used in an RCF/PMI if a variance is granted. When a seclusion room is used, it shall meet the standards set out in 481—subrule 61.5(12). (I, II)

**62.13(6)** The physician and QMHP shall be notified immediately of the resident's need for placement in seclusion and a time-limited order for seclusion obtained from the physician. The order shall be for no more than one hour at a time. If the resident is placed in seclusion longer than one hour, the resident shall be visited and evaluated by the physician or qualified mental health professional before a continuation of the seclusion order can be obtained. If the evaluation is conducted by a QMHP, the physician shall be notified of the resident's condition and the physician shall see the resident within 24 hours of each incident of seclusion and sign the seclusion order. (I, II)

**62.13(7)** If orders for seclusion remain in force for more than a total of 3 hours in a 24-hour period, the facility shall make arrangements for immediate transfer of the resident to a higher level of care. (I, II)

**62.13(8)** Standing or PRN orders for seclusion are prohibited. (I, II)

**62.13(9)** Written documentation of the above information shall be kept as a part of each resident's record and the administrator shall be responsible for maintaining a daily record of seclusion usage which shall be kept available for review by the department. (II, III)

**62.13(10)** Written documentation shall be kept of each incident of seclusion to minimally include: (II)

- a. Explanation of less restrictive measures implemented prior to use of seclusion, (I, II)
- b. Record of visual observation of the resident every ten minutes or more frequently if needed, (I)

- c.* Description of the resident's activity at the time of observation to include verbal exchange and behavior, (I, II)
- d.* Description of safety procedures taken (removal of dangerous objects, etc.), (I)
- e.* Record of vital signs including blood pressure, pulse and respiration unless contraindicated by resident behavior and reasons documented, (I, II)
- f.* Record of intake of food and fluid, (II, III)
- g.* Record of rest room use, (II, III)
- h.* Record of numbers of hours and minutes in seclusion. (II)

**62.13(11)** The facility shall provide training by qualified professionals to the staff on physical restraint and seclusion theory and techniques. (I)

- a.* The facility shall keep a record of above training for review by the department and shall include attendance. (II, III)
- b.* Only staff who have documented training in physical restraint and seclusion theory and techniques shall be authorized to assist with seclusion or physical restraint of a resident. (I)
- c.* Under no circumstances shall a resident be allowed to actively or passively assist in the restraint of another resident. (I)

This rule is intended to implement Iowa Code section 135C.14.

**481—62.14(135C) Discharge or transfer.** Procedures for the discharge or transfer of the resident shall be established and followed: (II, III)

**62.14(1)** The decision to discharge a person and the plan for doing so shall be established through the participation of the resident, members of the interdisciplinary team and other resource personnel as appropriate for the welfare of the individual. (II, III)

- a.* Discharge planning shall begin within 30 days of admission and be carried out in accordance with the IPP. (II, III)
- b.* As changes occur in a resident's physical or mental condition, necessitating services or care which cannot be adequately provided by the facility, the resident shall be transferred promptly to another appropriate facility pursuant to 62.10(1) "a." (I, II)
- c.* Notification shall be made to the next of kin, legal representative, attending physician, and sponsoring agency, if any, prior to transfer or discharge of any resident. (III)
- d.* Proper arrangements shall be made for the welfare of the resident prior to the transfer or discharge in the event of an emergency or inability to reach the next of kin or legal representative. (III)
- e.* The licensee shall not refuse to discharge or transfer a resident when directed by the physician, resident, legal representative, or court. (II, III)
- f.* Advance notification by telephone shall be made to the receiving facility prior to the transfer of any resident. (III)
- g.* When a resident is transferred or discharged, the current evaluation and treatment plan and progress notes for the last 30 days, as set forth in these rules, shall accompany the resident. (II, III)
- h.* Prior to the transfer or discharge of a resident to another health care facility, arrangements to provide for continuity of care shall be made with the facility to which the resident is being sent. (II, III)
- i.* A discharge or transfer authorization and summary shall be prepared for each resident who has been discharged or transferred from the facility and shall be disseminated to appropriate persons to ensure continuity of care and in accordance with the requirements to ensure confidentiality. (II, III)
- j.* A transfer to a part of a facility that has a different license must be handled the same way as a transfer to another facility, and not as an intrafacility transfer.

**62.14(2)** Intrafacility transfer. Residents shall not be moved from room to room within a health care facility arbitrarily. (I, II)

*a.* Involuntary relocation may occur only to implement goals and objectives in the IPP and in the following situations:

- (1) Incompatibility with or behavior disturbing to roommates, as documented in the residents' records; (I, II)

(2) To allow a new admission to the facility which would otherwise not be possible due to separation of roommates by sex; (II, III)

(3) Reasonable and necessary administrative decisions regarding the use and functioning of the building. (II, III)

*b.* Unreasonable and unjustified reasons for changing a resident's room without the concurrence of the resident or legal guardian include:

(1) Punishment or behavior modification. (II)

(2) Discrimination on the basis of race or religion. (II)

*c.* If intrafacility relocation is necessary for reasons outlined in paragraph "a," the resident shall be notified at least 48 hours prior to the transfer and the reason shall be explained. The legal guardian shall be notified as soon as possible. The notification shall be documented in the resident's record and signed by the resident or legal guardian. (II)

*d.* If emergency relocation is required to protect the safety or health of the resident or other residents, the notification requirements may be waived. The conditions of the emergency shall be documented. The family and legal guardian shall be notified immediately, or as soon as possible, of the condition requiring emergency relocation and the notification shall be documented. (II)

**62.14(3)** Involuntary discharge or transfer. Residents shall be transferred or discharged from the facility in accordance with contract arrangements and requirements of Iowa Code chapter 135C which states that a resident shall be transferred or discharged only for the following:

*a.* Medical reasons which include:

(1) Acute stage of alcoholism, mental illness, or an active state of a communicable disease, (I, II)

or

(2) Need for medical procedures as determined by a physician, or services which cannot be or are not being carried out in the facility. (I, II)

*b.* Resident's welfare or welfare of other residents which includes a resident who is dangerous to the resident or other residents (I), or

*c.* Nonpayment except as prohibited by Medicaid. (II)

**62.14(4)** Involuntary transfer or discharge of a resident from a facility shall be preceded by a written notice to the resident or responsible party at least 30 days in advance of the proposed transfer or discharge. (II) The 30-day requirement shall not apply in any of the following instances:

*a.* If an emergency transfer or discharge is mandated by the resident's health care needs and is in accord with the written orders and written medical justification of the attending physician. Emergency transfers or discharges may also be mandated to protect the health, safety, or well-being of other residents and staff. (I, II)

*b.* If the transfer or discharge is subsequently agreed to by the resident or by the resident's legal guardian, and notification is given to the legal guardian, physician, and the person or agency responsible for the resident's placement, maintenance, and care in the facility. (II)

(1) The notice required by 62.14(4) shall contain all of the following information:

1. The stated reason for the proposed transfer or discharge. (II)

2. The effective date of the proposed transfer or discharge. (II)

3. The following statement must be included:

"You have a right to appeal the facility's decision to transfer or discharge you. If you think you should not have to leave this facility, you may request a hearing in writing or verbally with the Iowa state department of inspections and appeals (hereinafter referred to as department) within seven days after receiving this notice. You have a right to be represented at the hearing by an attorney or any other individual of your choice. If you request a hearing, it will be held no later than 14 days after receipt of your request by the department and you will not be transferred prior to a final decision. Provision may be made for extension of the 14-day requirement upon request to the department designee in emergency circumstances. If you lose the hearing, you will not be transferred before the expiration date of 30 days following receipt of the original notice of the discharge or transfer, or no sooner than 5 days following final decision of such hearing. To request a hearing or receive further information, call the department at (515)281-4115 or you may write to the department to the attention of: Administrator, Division of Health

Facilities, Iowa Department of Inspections and Appeals, Lucas State Office Building, Des Moines, Iowa 50319.” (II)

(2) A request for a hearing made under 62.14(4) “b”(1) shall stay a transfer or discharge pending a hearing or appeal decision. (II)

(3) The type of hearing shall be determined by a representative of the department. Notice of the date, time, and place of the hearing shall be sent by certified mail or delivered in person to the licensee, resident, legal guardian, and Iowa department on aging long-term care resident’s advocate/ombudsman of record, not later than five full business days after receipt of the request. This notice shall also inform the licensee, resident, or legal guardian that they have a right to appear at the hearing in person or be represented by their attorneys or other individual. The hearing shall be dismissed if neither party is present or represented at the hearing. If only one party appears or is represented, the hearing shall proceed with one party present. The Iowa department on aging’s long-term care resident’s advocate/ombudsman shall have the right to appear at the hearing. (II)

(4) The hearing shall be heard by a department of inspections and appeals hearing officer pursuant to department rules. The licensee or designee shall have the opportunity to present oral testimony or written materials to show by a preponderance of the evidence just cause why a transfer or discharge may be made. The resident and legal guardian shall also have an opportunity to present oral testimony or written material to show just cause why a transfer or discharge should not be made; the burden of proof rests on the party requesting the transfer or discharge. (II)

(5) Based upon all testimony and material submitted to the representative of the department, the representative shall issue, in accordance with Iowa Code chapter 17A, written findings of fact and conclusions of law and issue a decision and order in respect to the adverse action. This decision shall be mailed by regular mail to the licensee, resident, responsible party, and department on aging long-term care ombudsman within 10 working days after the hearing has been concluded. The representative shall have the power to issue fines and citations against the facility in appropriate circumstances.

A request for review of a proposed decision in which the department is the final decision maker shall be made within 15 days of issuance of the proposed decision, unless otherwise provided by statute. Requests shall be mailed or delivered by either party to the Director, Department of Inspections and Appeals, Lucas State Office Building, Des Moines, Iowa 50319-0083. Failure to request review will preclude judicial review unless the department reviews a proposed decision upon its own motion within 15 days of the issuance of the decision. (II)

(6) A copy of the notice required by 62.14(4) shall be personally delivered to the resident and a copy placed in the resident’s record. A copy shall also be transmitted to the department, the resident’s legal guardian, physician, the person or agency responsible for the resident’s placement, maintenance, and care in the facility, and the department on aging’s long-term care resident’s advocate/ombudsman. (II)

(7) If nonpayment is the basis for involuntary transfer or discharge, the resident shall have the right to make full payment up to the date that the discharge or transfer is to be made and then shall have the right to remain in the facility. (II)

(8) The involuntary transfer or discharge shall be discussed with the resident, legal guardian, and the person or agency responsible for the resident’s placement, maintenance, and care in the facility within 48 hours after notice of discharge has been received. The explanation and discussion of the reasons for involuntary transfer or discharge shall be given by the facility administrator or other appropriate facility representative as the administrator’s designee. The content of the discussion and explanation shall be summarized in writing and shall include the names of the individuals involved in the discussions and shall be made a part of the resident’s record. (II)

(9) The resident shall receive counseling services before (by sending facility) and after (by receiving facility) the involuntary transfer to minimize the possible adverse effects of the involuntary transfer. Counseling shall be documented in the resident’s record. Counseling shall be provided by a qualified individual who meets one of the following criteria: (II)

1. Has a bachelor’s or master’s degree in social work from an accredited college. (II)

2. Is a graduate of an accredited four-year college and has had at least one year of full-time paid employment in a social work capacity with a public or private agency. (II)

3. Has been employed in a social work capacity for a minimum of four years in a public or private agency. (II)

4. Is a licensed psychologist or psychiatrist. (II)

(10) The facility shall develop a plan to provide for the orderly and safe transfer or discharge of each resident to be discharged or transferred. (II)

(11) The receiving health care facility of a resident involuntarily discharged or transferred shall immediately formulate and implement a plan of care which takes into account possible adverse effects the transfer may cause. (II)

(12) In the case of an emergency transfer or discharge as outlined in 62.14(4) “a,” the resident must still be given a written notice prior to or within 48 hours following transfer or discharge. A copy of this notice must be placed in the resident’s file and it must contain all the information required by 62.14(4) “b”(1)“1” and “2.” In addition, the notice must contain a statement in not less than 12-point type, which reads:

“You have a right to appeal the facility’s decision to transfer or discharge you on an emergency basis. If you think you should not have to leave this facility, you may request a hearing in writing or verbally with the Iowa department of inspections and appeals within seven days after receiving this notice. You have the right to be represented at the hearing by an attorney or any other individual of your choice. If you request a hearing, it will be held no later than 14 days after receipt of your request by the department. You may be transferred or discharged before the hearing is held or before a final decision is rendered. If you win the hearing, you have the right to be transferred back into the facility. To request a hearing or receive further information, call the department at (515)281-4115 or you may write to the department to the attention of: Administrator, Division of Health Facilities, Department of Inspections and Appeals, Lucas State Office Building, Des Moines, Iowa 50319-0083.”

A hearing requested pursuant to this subrule shall be held in accordance with 62.14(4) “b”(3), (4) and (5). (II)

(13) Residents shall not have the right to a hearing to contest an involuntary discharge or transfer resulting from the revocation of the facility’s license by the department. In the case of a facility voluntarily closing, a period of 30 days must be allowed for an orderly transfer of residents to other facilities. (II)

This rule is intended to implement Iowa Code sections 135C.14(8), 135C.31, 135C.43, and 135C.46.

#### **481—62.15(135C) Medication management.**

**62.15(1)** Medications shall be prescribed on an individual basis by one who is authorized by Iowa law to prescribe. (I, II)

a. Medication orders shall be correctly implemented by qualified personnel. (II)

b. Qualified staff shall ensure that residents are able to take their own medication. (I, II)

c. Each physician order allowing a resident to take their own medications shall specify whether this self-medication shall be without supervision or under the supervision of qualified staff as defined in 62.15(2). (I, II)

**62.15(2)** Drug administration.

a. A properly trained person shall be charged with the responsibility of administering nonparenteral medications.

b. The individual shall have knowledge of the purpose of the drugs, their dangers, and contraindications.

c. This person shall be a licensed nurse or physician or shall have successfully completed a department-approved medication aide course or passed a department-approved medication aide challenge examination administered by an area community college.

d. Prior to taking a department-approved medication aide course, the individual shall:

(1) Successfully complete an approved residential aide course, nurse aide course, nurse aide training and testing program or nurse aide competency examination;

(2) Be employed in the same facility for at least six consecutive months prior to the start of the medication aide course. This requirement is not subject to waiver.

(3) Have a letter of recommendation for admission to the medication aide course from the employing facility.

*e.* A person who is a nursing student or a graduate nurse may take the challenge examination in place of taking a medication aide course. This individual shall do all of the following before taking the medication aide challenge examination:

(1) Complete a clinical or nursing theory course within six months before taking the challenge examination;

(2) Successfully complete a nursing program pharmacology course within one year before taking the challenge examination;

(3) Provide to the community college a written statement from the nursing program's pharmacology or clinical instructor indicating the individual is competent in medication administration.

*f.* A person who has written documentation of certification as a medication aide in another state may become a medication aide in Iowa by successfully completing a department-approved nurse aide competency examination and a medication aide challenge examination.

The requirements of paragraph "d" of this subrule do not apply to this individual.

*g.* Unit dose medication shall remain in the identifiable unit dose package until given to the resident. (II)

*h.* Medications that are not contained in unit dose packaging shall be set up and administered by the same person and must be administered within one hour of preparation. (II)

*i.* The person administering medications must observe and check to make sure the resident swallows oral medications and must record the date, time, amount and name of each medication given. (II)

*j.* Injectable medications shall be administered as permitted by Iowa law by a qualified nurse, physician, pharmacist, or physician assistant (PA).

*k.* Residents certified by their physician as capable of injecting their own insulin may do so. Insulin may be administered pursuant to "j" above or as otherwise authorized by the resident's physician. Authorization by the physician shall:

(1) Be in writing,

(2) Be maintained in the resident's record,

(3) Be renewed quarterly,

(4) Include the name of the individual authorized to administer the insulin,

(5) Include documentation by the physician that the authorized person is qualified to administer insulin to that resident.

*l.* Current and accurate records must be kept on the receipt and disposition of all Schedule II drugs. (II, III)

**62.15(3)** For each resident who is taking medication with or without supervision there shall be documentation on the individual's record to include:

*a.* Name of resident, (II, III)

*b.* Name of drug, dose, and schedule, (II, III)

*c.* Method of administration, (II, III)

*d.* Drug allergies and adverse reactions, (I, II)

*e.* Special precautions, (I, II)

*f.* Documentation of resident's continuing ability to administer own medication. (I, II)

**62.15(4)** Medication counseling shall be provided for all residents in accordance with the IPP on an ongoing basis and as part of discharge planning unless contraindicated in writing by the physician with reasons and pursuant to 62.12(2)"c." (II, III)

Each resident shall be given verbal and written information about all medications the resident is currently using, including over-the-counter medications. A suggested reference is "USPDI, Advice for the Patient." (II, III)

The information shall include:

- a. Name, reason for, and amount of medication to be taken; (II)
- b. Time medication is to be taken and the reason that schedule was established; (II)
- c. Possible benefits, risks and side effects of each medication including over-the-counter medications; (II)
- d. The names of people in the community qualified to answer questions about medications. (II, III)
- e. A list of available resources or agencies which may assist the resident to obtain medication after discharge. (III)

**62.15(5) Drug storage.**

a. Residents who have been certified in writing by the physician as capable of taking their own medications may retain these medications in their bedrooms. Individual locked storage shall be utilized. (II, III)

b. Drug storage for residents who are unable to take their own medications and require supervision shall meet the following requirements:

(1) Adequate size cabinet with lock which can be used for storage of drugs, solutions, and prescriptions. A locked drug cart may be used. (II, III)

(2) A bathroom shall not be used for drug storage. (II, III)

(3) The drug storage cabinet shall be kept locked when not in use. (II, III)

(4) The drug storage cabinet key shall be in the possession of the employee charged with the responsibility of administering medication. (III)

(5) Medications requiring refrigeration which are stored in a common refrigerator shall be kept in a locked box properly labeled, and separated from food and other items. (III)

(6) Drugs for external use shall be stored separately from drugs for internal use. External medications are those to be applied to the outside of the body and include but are not limited to salves, ointments, gels, pastes, soaps, baths, and lotions. Internal medications are those to be applied inside the body or ingested and include but are not limited to oral and injectable medications, eye drops, ear drops and suppositories. Also, eye drops and ear drops shall be separated from each other as well as from other internal and external medications. (II, III)

(7) All potent, poisonous, or caustic materials shall be stored in a separate room from the medications. (II, III)

(8) Inspection of the condition of stored drugs shall be made by the administrator and a licensed pharmacist not less than once every three months. The inspection shall be verified by a report signed by the administrator and the pharmacist and filed with the administrator. The report shall include, but need not be limited to, certifying absence of the following: expired drugs, deteriorated drugs, improper labeling, drugs for which there is no current order, and drugs improperly stored. (III)

(9) Double-locked storage of Schedule II drugs shall not be required under single unit package drug distribution systems in which the quantity stored does not exceed a seven-day supply and a missing dose can be readily detected but must be kept in a locked medication cabinet. Quantities in excess of a seven-day supply must be double-locked. (II)

c. Bulk supplies of prescription drugs shall not be kept. (III)

**62.15(6) Drug safeguards.**

a. All labels on medications must be legible. If labels are not legible, the medication shall be sent back to the dispenser as defined in Iowa Code section 147.107 for relabeling. (II, III)

b. The medication for each resident shall be kept or stored in the original dispensed containers. (II, III)

c. The facility shall adopt policies and procedures for the destruction of unused prescription drugs for residents who have died. The policies and procedures shall include, but not be limited to, the following: (III)

(1) Drugs shall be destroyed by the person in charge in the presence of the administrator or the administrator's designee;

(2) Notation of the destruction shall be made in the resident's chart, with signatures of the persons involved in the destruction;

(3) The manner in which the drugs are disposed of shall be identified (i.e., incinerator, sewer, landfill). (II, III)

*d.* The facility shall also adopt policies and procedures for the disposal of controlled substances dispensed to residents whose administration has been discontinued by the prescriber. These policies and procedures shall include, but not be limited to, the following:

(1) Procedures for obtaining a release from the resident;

(2) The manner in which the drugs were destroyed and by whom, including witnesses to the destruction;

(3) Mechanisms for recording the destruction;

(4) Procedures to be used when the resident or the conservator or guardian refuses to grant permission for destruction. (II, III)

*e.* The facility shall adopt policies and procedures for the disposal of unused discontinued medication. The procedures shall include but not be limited to:

(1) A specified time after which medication must be destroyed, sent back to the dispenser or placed in long-term storage;

(2) Procedures for obtaining permission of the resident, or the conservator or guardian;

(3) Procedures to be used when the resident or conservator or guardian refuses to grant permission for disposal;

(4) Unused discontinued medication shall be locked and shall be separate from current medication. (II, III)

*f.* All medication orders which do not specifically indicate the number of doses to be administered or the length of time the drug is to be administered shall be stopped automatically after a given time period. The automatic stop order may vary for different types of drugs. The facility, in consultation with a physician or pharmacist serving the home, shall institute policies and provide procedures. These shall be provided to all prescribers and pharmacists serving the facility and conveniently located for personnel administering medications. (III)

*g.* Residents shall not keep any prescription medication in their possession unless the attending physician has certified in writing on the resident's medical record that the resident is mentally and physically capable of doing so. Over-the-counter medications may be maintained provided they are in a locked container and pursuant to subrule 62.16(5). (I, II)

*h.* No prescription drugs shall be administered to a resident without a written order signed by a person qualified to prescribe the medication and renewed quarterly. (II)

*i.* Prescription drugs shall be reordered only with the permission of the attending prescriber. (II, III)

*j.* No medications prescribed for one resident may be administered to or allowed in the possession of another. (II)

*k.* Residents on prescribed medication may maintain over-the-counter medication pursuant to 62.15(6) "g" unless contraindicated by the physician. The facility shall request this information from the physician and document in the resident's record. (II)

**62.15(7)** Each facility shall have policies and procedures established to govern the administration of prescribed medications to residents on leave from the facility. (III)

*a.* Medication may be issued to residents who will be on leave from a facility for less than 24 hours. Non-child-resistant containers may be used. Each container may hold only one medication. A label on each container shall indicate the date, the resident's name, the facility, the medication, its strength, dose, and time of administration.

*b.* Medication for residents on leave from a facility longer than 24 hours shall be obtained in accordance with requirements established by the Iowa board of pharmacy examiners.

*c.* Medication distributed as above may be issued only by facility personnel responsible for administering medication.

**62.15(8)** Each RCF/PMI that administers controlled substances shall obtain annually a registration issued by the board of pharmacy pursuant to Iowa Code section 124.302(1). (III)

This rule is intended to implement Iowa Code section 135C.14.  
[ARC 1050C, IAB 10/2/13, effective 11/6/13]

**481—62.16(135C) Resident property.**

**62.16(1)** The admission of a resident does not give the facility or any employee of the facility the right to manage, use, or dispose of any property of the resident except with the written authorization of the resident or the resident's legal guardian. (II, III)

**62.16(2)** The admission of a resident shall not grant the RCF/PMI the authority or responsibility to manage the personal affairs of the resident except as may be necessary for the resident's safety and for safe and orderly management of the residential care facility as required by these rules and in accordance with the IPP. (III)

**62.16(3)** An RCF/PMI shall provide for the safekeeping of personal effects, funds, and other property of its residents. The facility may require that items of exceptional value or which would convey unreasonable responsibilities to the licensee be removed from the premises of the facility for safekeeping. (III)

**62.16(4)** Resident's funds held by the RCF/PMI shall be in a trust account and kept separate from funds of the facility. (III)

**62.16(5)** No administrator, employee or representative thereof shall act as guardian, trustee, or conservator for any resident or the resident's property, unless the resident is related to the person acting as guardian within the third degree of consanguinity. (III)

**62.16(6)** If a facility is a county care facility and upon the verified petition of the county board of supervisors, the district court may appoint the administrator of a county care facility as conservator or guardian or both of a resident of that county care facility without fee. The administrator may establish either separate or common bank accounts for cash funds of these residents. (III)

This rule is intended to implement Iowa Code section 135C.24.

**481—62.17(135C) Financial affairs.** Each resident who has not been assigned a guardian or conservator by the court may manage the resident's personal financial affairs, and to the extent, under written authorization by the resident that the facility assists in management, the management shall be carried out in accordance with Iowa Code section 135C.24. (II)

**62.17(1)** The facility shall maintain a written account of all the resident's funds received by or deposited with the facility. (II)

*a.* An employee shall be designated in writing to be responsible for resident accounts. (II)

*b.* The facility shall keep on deposit personal funds over which the resident has control.

*c.* If the resident requests these funds, they shall be given to the resident with a receipt maintained by the facility and a copy to the resident. If a conservator or guardian has been appointed for the resident, the conservator or guardian shall designate the method of disbursing the resident's funds. (II)

*d.* If the facility makes a financial transaction on a resident's behalf, the resident or the resident's legal guardian or conservator must receive or acknowledge having seen an itemized accounting of disbursements and current balances at least quarterly. A copy of this statement shall be maintained in the resident's financial or business record. (II)

*e.* A resident's personal funds shall not be used without the written consent of the resident or the resident's guardian. (II)

*f.* A resident's personal funds shall be returned to the resident when the funds have been used without the written consent of the resident or the resident's guardian. The department may report findings that resident funds have been used without written consent to the audits division or the local law enforcement agency, as appropriate. (II)

**62.17(2)** Contracts. There shall be a written contract between the facility and each resident which meets the following requirements:

- a.* State the base rate or scale per day or per month, the services included, and the method of payment; (III)
  - b.* Contain a complete schedule of all offered services for which a fee may be charged in addition to the base rate; (III)
  - c.* Stipulate that no further additional fees shall be charged for items not contained in complete schedule of services as set forth in subrule 62.17(2); (III)
  - d.* State the method of payment of additional charges; (III)
  - e.* Contain an explanation of the method of assessment of additional charges and an explanation of the method of periodic reassessment, if any, resulting in charging the additional charges; (III)
  - f.* State that additional fees may be charged to the resident for nonprescription drugs, other personal supplies, and services by a barber, beautician, etc. (III)
  - g.* Contain an itemized list of those services, with the specific fee the resident will be charged and method of payment, as related to the resident's current condition, based on the program assessment at the time of admission, which is determined in consultation with the administrator. (III)
  - h.* Include the total fee to be charged initially to the specific resident. (III)
  - i.* State the conditions whereby the facility may make adjustments to its overall fees for residential care as a result of changing costs. (III) Furthermore, the contract shall provide that the facility shall give:
    - (1) Written notification to the resident and responsible party, when appropriate, of changes in the overall rates of both base and additional charges at least 30 days prior to the effective date of changes; (III)
    - (2) Notification to the resident and payor when appropriate, of changes in additional charges based on a change in the resident's condition. Notification must occur prior to the date the revised additional charges begin. If notification is given orally, subsequent written notification must also be given within a reasonable time, not to exceed one week, listing specifically the adjustments made; (III)
    - (3) State the terms of agreement in regard to refund of all advance payments, in the event of transfer, death, or voluntary or involuntary discharge. (III)
  - j.* State the terms of agreement concerning the holding and charging for a bed when a resident is hospitalized or leaves the facility temporarily for recreational or therapeutic reasons. The terms shall contain a provision that the bed will be held at the request of the resident or the resident's legal representative.
    - (1) The facility shall ask the resident or legal representative if they want the bed held. This request shall be made before the resident leaves or within 48 hours after the resident leaves. The inquiry and the response shall be documented. (II)
    - (2) The facility shall reserve the bed when requested for as long as payments are made in accordance with the contract. (II)
  - k.* State the conditions under which the involuntary discharge or transfer of a resident would be effected; (III)
  - l.* State the conditions of voluntary discharge or transfer; (III)
  - m.* Set forth any other matters deemed appropriate by the parties to the contract. No contract or any provision shall be drawn or construed so as to relieve any health care facility of any requirement or obligation imposed upon it by this chapter or any standards or rules in force pursuant to this chapter; (III)
- 62.17(3)** Each party shall receive a copy of the signed contract. (III)
- This rule is intended to implement Iowa Code sections 135C.24 and 135C.23(1).

#### **481—62.18(135C) Records.**

**62.18(1)** *Resident record.* The licensee shall keep a permanent record about each resident with all entries current, dated, and signed. (II) The record shall include:

- a.* Name and previous address of resident; (III)
- b.* Birth date, sex, and marital status of resident; (III)
- c.* Church affiliation; (III)
- d.* Physician's name, telephone number, and address; (III)
- e.* Dentist's name, telephone number, and address; (III)

- f. Name, address and telephone number of next of kin or legal representative; (III)
- g. Name, address and telephone number of the person to be notified in case of emergency; (III)
- h. Funeral director, telephone number, and address; (III)
- i. Pharmacy name, telephone number, and address; (III)
- j. Results of evaluation pursuant to 62.11(135C); (III)
- k. Certification by the physician that the resident requires no more than personal care and supervision, but does not require nursing care; (III)
- l. Physician's orders for medication and treatments shall be in writing and signed by the physician quarterly; diet orders shall be renewed yearly; (III)
- m. A notation of yearly or other visits to physician or other professionals, all consultation reports and progress notes; (III)
- n. Any change in the resident's condition; (II, III)
- o. A notation describing the resident's condition on admission, transfer, and discharge; (III)
- p. In the event of a resident's death, notations in the resident's record shall include the date and time of the resident's death, the circumstances of the resident's death, the disposition of the resident's body, and the date and time that the resident's family and physician were notified of the resident's death; (III)
- q. A copy of instructions given to the resident, legal representative, or facility in the event of discharge or transfer; (III)
- r. Disposition of personal property; (III)
- s. Copy of IPP pursuant to 62.12(1); (III)
- t. Progress notes pursuant to 62.12(4) and 62.12(5). (III)

**62.18(2) Confidentiality of resident records.** The facility shall have policies and procedures providing that each resident shall be ensured confidential treatment of all information, including information contained in an automatic data bank. The resident's or the resident's legal guardian's written informed consent shall be required for the release of information to persons not otherwise authorized under law to receive it. (II)

A release of information form shall be used which includes to whom the information shall be released, the reason for the information being released, how the information is to be used, and the period of time for which the release is in effect. A third party, not requesting the release, shall witness the release of information form. (II)

a. The facility shall limit access to any resident records to staff and consultants providing professional service to the resident. Information shall be made available to staff only to the extent that the information is relevant to the staff person's responsibilities and duties. (II)

Only those personnel concerned with financial affairs of the residents may have access to the financial information. This is not meant to preclude access by representatives of state or federal regulatory agencies. (II)

b. The resident, or the resident's legal guardian, shall be entitled to examine all information and shall have the right to secure full copies of the record at reasonable cost upon request, unless the physician or QMHP determines the disclosure of the record or section is contraindicated in which case this information will be deleted prior to making the record available to the resident. This determination and the reasons for it must be documented in the resident's record by the physician or qualified mental health professional in collaboration with the resident's interdisciplinary team. (II)

**62.18(3) Incident records.**

a. Each RCF/PMI shall maintain an incident record report and shall have available incident report forms. (II, III)

b. The report of every incident shall be in detail on a printed incident report form. (II, III)

c. The person in charge at the time of the incident shall oversee the preparation and sign the report. (III)

d. A copy of the incident report shall be kept on file in the facility available for review and a part of administrative records. (III)

**62.18(4) Retention of records.**

*a.* Records shall be retained in the facility for five years following termination of services to the resident even when there is a change of ownership. (III)

*b.* When the facility ceases to operate, the resident's record shall be released to the facility to which the resident is transferred. If no transfer occurs, the record shall be released to the individual's physician. (III)

This rule is intended to implement Iowa Code section 135C.24.

**481—62.19(135C) Health and safety.**

**62.19(1) Physician.** Each resident shall have a designated licensed physician who may be called when needed. (III)

**62.19(2) Emergency care.** The facility shall have written policies and procedures for emergency medical or psychiatric care to include:

*a.* A written agreement with a hospital or psychiatric facility or documentation of attempt to obtain a written agreement for the timely admission of a resident who, in the opinion of the attending physician, requires inpatient services; (II, III)

*b.* Provisions consistent with Iowa Code chapter 229; (II, III)

*c.* Immediate notification by the person in charge to the physician or QMHP, as appropriate, of any accident, injury or adverse change in the resident's condition. (I, II)

**62.19(3) First-aid kit.** A first-aid emergency kit shall be available on each floor in every facility. (II, III)

**62.19(4) Infection control.** Each facility shall have a written and implemented infection control program addressing the following:

*a.* Techniques for hand washing consistent with Guidelines for Handwashing and Hospital Control, 1985, Centers for Disease Control, U.S. Department of Health and Human Services, PB85-923404; (I, II, III)

*b.* Techniques for handling of blood, body fluids, and body wastes consistent with Guideline for Isolation Precautions in Hospitals, Centers for Disease Control, U.S. Department of Health and Human Services, PB96-138102; (I, II, III)

*c.* Dressings, soaks, or packs; (I, II, III)

*d.* Infection identification; (I, II, III)

*e.* Resident care procedures to be used when there is an infection present consistent with Guideline for Isolation Precautions in Hospitals, Centers for Disease Control, U.S. Department of Health and Human Services, PB96-138102; (I, II, III)

*f.* Sanitation techniques for resident care equipment; (I, II, III)

*g.* Techniques for sanitary use and reuse of feeding syringes and single-resident use and reuse of urine collection bags; (I, II, III)

*h.* Techniques for use and disposal of needles, syringes, and other sharp instruments consistent with Guideline for Isolation Precautions in Hospitals, Centers for Disease Control, U.S. Department of Health and Human Services, PB96-138102; (I, II, III)

CDC Guidelines may be obtained from the U.S. Department of Commerce, Technology Administration, National Technical Information Service, 5285 Port Royal Rd., Springfield, Virginia 22161 (1-800-553-6847).

**62.19(5) Aseptic techniques.** If a resident needs any of the treatment or devices on the list below, written and implemented procedures regarding aseptic techniques shall be followed.

*a.* Intravenous or central line catheter consistent with Guideline for Prevention of Intravascular Device Related Infections, Centers for Disease Control, U.S. Department of Health and Human Services, PB97-130074, (I, II, III)

*b.* Urinary catheter, (I, II, III)

*c.* Respiratory suction, oxygen or humidification, (I, II, III)

*d.* Decubitus care, (I, II, III)

*e.* Tracheostomy, (I, II, III)

- f. Nasogastric or gastrostomy tubes, (I, II, III)
- g. Sanitary use and reuse of feeding syringes and single-resident use and reuse of urine collection bags. (I, II, III)

**62.19(6) Dental services.** Personnel shall assist residents to obtain regular and emergency dental services and provide necessary transportation. Dental services shall be performed only on the request of the resident or legal guardian. The resident's physician shall be advised of the resident's dental problems. (III)

**62.19(7) Safe environment.** The licensee of an RCF/PMI is responsible for the provision and maintenance of a safe environment for residents and personnel. (I, II) The RCF/PMI shall meet the fire and safety rules and regulations as promulgated by the state fire marshal. (I, II)

**62.19(8) Disaster.** The licensee shall have a written emergency plan to be followed in the event of fire, tornado, explosion, or other emergency. (II, III)

- a. The plan shall be posted. (II, III)
- b. Training shall be provided to ensure that all employees and residents are knowledgeable of the emergency plan. The training shall be documented. (II, III)
- c. Residents shall be permitted to smoke only in posted areas where proper facilities are provided. Smoking by residents considered to be careless shall be prohibited except under direct supervision and in accordance with the IPP. (II, III)

**62.19(9) Safety precautions.** The facility shall take reasonable measures to ensure the safety of residents and shall involve the residents in learning the safe handling of household supplies and equipment in accordance with the policies and procedures established by the facility. (II)

- a. All potent, poisonous, or caustic materials shall be plainly labeled and stored in a specific locked, well-illuminated cabinet, closet, or storeroom and made accessible only to authorized persons. (I, II)

- b. Residents shall have access to storage areas for cleaning and laundry supplies as appropriate to the activities being performed unless contraindicated in their IPP. (I, II)

**62.19(10) Hazards.** Entrances, exits, steps, and outside steps and walkways shall be kept free from ice, snow, and other hazards. (II, III)

**62.19(11) Laundry.** All soiled linens shall be collected in and transported to the laundry room in closed, leakproof laundry bags or covered, impermeable containers. (III)

- a. Except for related activities, the laundry room shall not be used for other purposes. (III)
- b. Resident's personal laundry shall be marked with an identification unless the resident is responsible for doing the resident's own laundry as indicated in the individual program plan. (III)
- c. There shall be an adequate supply of clean, stain-free linens so that each resident shall have at least three washcloths, hand towels, and bath towels. (III)
- d. Each bed shall be provided with clean, stain-free, washable bedspreads and sufficient lightweight serviceable blankets. A complete change of bed linens shall be available for each bed. (III)

**62.19(12) Supplies, equipment, and storage.**

- a. Each facility shall provide a variety of supplies and equipment of a nature calculated to fit the needs and interests of the residents. These may include: books (standard and large print), magazines, newspapers, radio, television, bulletin boards, board game, game equipment, songbooks, cards, craft supplies, record player, movie projector, piano, and outdoor equipment. Supplies and equipment shall be appropriate to the chronological age of the residents. (III)

- b. Storage shall be provided for recreational equipment and supplies. (III)

This rule is intended to implement Iowa Code section 135C.14(1).

#### **481—62.20(135C) Nutrition.**

**62.20(1)** There shall be policies and procedures written and implemented for dietary staffing.

- a. The person responsible for planning menus and monitoring the kitchens in each facility shall have completed training, approved by the department, in sanitation and food preparation. (III)

- b. In facilities licensed for over 15 beds, food service personnel shall be on duty during a 12-hour span extending from the preparation of breakfast through supper. (III)

*c.* There shall be written work schedules and time schedules covering each type of job in the food service department for facilities over 15 beds. These work and time schedules shall be posted or kept in a notebook which is available for use in the food service area. (III)

**62.20(2)** Nutrition and menu planning.

*a.* Residents shall be encouraged to the maximum extent possible to participate in meal planning, shopping, and in preparing and serving the meal and cleaning up. The facility shall be responsible for helping residents become knowledgeable of what constitutes a nutritionally adequate diet. (III)

*b.* Menus shall be planned and served to meet nutritional needs of residents in accordance with the physician's diet orders which shall be renewed yearly. Menus shall be planned and served to include foods and amounts necessary to meet the recommended daily dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences. (II) Other foods shall be included to meet energy requirements (calories) to add to the total nutrients and variety of meals. (III)

*c.* At least three meals or their equivalent shall be made available to each resident daily, consistent with those times normally existing in the community. (II, III)

(1) There shall be no more than a 14-hour span between the substantial evening meal and breakfast. (III)

(2) To the extent medically possible, bedtime nourishments, containing a protein source, shall be offered routinely to all residents. Special nourishments shall be available when ordered by the physician. (II, III)

*d.* Menus shall include a variety of foods prepared in various ways. The same menus shall not be repeated on the same day of the following week. (III)

*e.* If modified diets are ordered by the physician, the person responsible for writing the menus shall have completed department-approved training in simple therapeutic diets and a copy of a modified diet manual approved by the department and written within the past five years shall be available in the facility. (II, III)

*f.* Therapeutic diets shall be served accurately. (II)

*g.* Menus shall be written at least one week in advance. The current menu shall be located in an accessible place in the dietetic service department for easy use by persons purchasing, preparing, and serving food. (III)

*h.* Records of menus as served shall be filed and maintained for 30 days and shall be available for review by departmental personnel. When substitutions are necessary, they shall be of similar nutritive value and recorded on the menu or in a notebook. (III)

*i.* A file of tested recipes adjusted to the number of people to be fed in the facility shall be maintained. (III)

**62.20(3)** Dietary storage, food preparation, service.

*a.* The use of foods from salvaged, damaged, or unlabeled containers is prohibited. (II, III)

*b.* No perishable food shall be allowed to stand at room temperature any longer than is required to prepare and serve. (II, III)

*c.* Canning of food is prohibited. The facility may freeze fruits, vegetables, and meats provided strict sanitary procedures are followed and in accordance with recommendations in the "Food Service Manual" revised 1976, U.S. Department of Health, Education, and Welfare, Public Health Service, U.S. Government Printing Office, Washington, D.C. (II)

*d.* Supplies of staple foods for a minimum of a one-week period and of perishable foods for a minimum of a three-day period shall be maintained on the premises. (III)

*e.* If family-style service is used, all leftover prepared food that has been on the table shall be safely handled. (III)

*f.* Poisonous compounds shall not be kept in food storage or preparation areas except for a sanitizing agent which shall be kept in a locked cabinet. (II, III)

**62.20(4)** Sanitation in food preparation area.

*a.* The facility shall develop and implement policies and procedures to address sanitation, meal preparation and service in accordance with recommendations in the food service sanitation manual

pursuant to 62.20(2) “c,” and which shall be used as the established, nationally recognized reference for establishing and determining satisfactory compliance with the department’s food service and sanitation rules. (III)

- b. Residents shall be allowed in the food preparation area in accordance with their IPP. (III)
- c. In facilities licensed for over 15 beds, the kitchen shall not be used for serving meals to residents, food service personnel, or other staff. (III)
- d. All appliances and work areas shall be kept clean and sanitized. (III)
- e. There shall be written procedures established for cleaning all work and serving areas in facilities over 15 beds and a schedule of duties to be performed daily shall be posted in each food area. (III)
- f. The food service area shall be located so it will not be used as a passageway by residents, guests, or nonfood service staff in facilities over 15 beds. (III)
- g. Dirty linen shall not be carried through the food service area unless it is in sealed, leakproof containers. (III)
- h. Mops, scrub pails, and other cleaning equipment used in the resident areas shall not be stored or used in the dietary area. (III)

**62.20(5) Hygiene of food service personnel.**

- a. In the event food service employees are assigned duties outside the dietetic service, these duties shall not interfere with sanitation, safety, or time required for dietetic work assignments. (II, III)
  - b. Employees shall wear clean, washable uniforms that are not used for duties outside the food service area in facilities over 15 beds. (III)
  - c. Hairnets shall be worn by all food service personnel in facilities over 15 beds and effective hair restraints in facilities less than 15 beds. (III)
  - d. Persons handling food shall use correct hand-washing and food-handling techniques as identified in the food service sanitation manual. (III)
  - e. Persons handling dirty dishes shall not handle clean dishes without washing their hands. (III)
- This rule is intended to implement Iowa Code section 135C.14.

**481—62.21(135C) Physical facilities and maintenance.**

**62.21(1) Housekeeping.** The facility shall have written procedures for daily and weekly cleaning (III) to include but need not be limited to:

- a. All rooms including furnishings, all corridors, storage areas, linen closets, attics, and basements shall be kept in a clean, orderly condition, free of unserviceable furniture and equipment or accumulations of refuse. (III)
- b. All resident bedrooms, including furnishings, shall be cleaned and sanitized before use by another resident. (III)
- c. Polishes used on floors shall provide a slip-resistant finish. (III)

**62.21(2) Equipment.** Housekeeping and maintenance personnel shall be provided with well-constructed and properly maintained equipment appropriate to the function for which it is to be used. (III)

- a. All facilities shall be provided with clean and sanitary storage for cleaning equipment, supplies, and utensils. In facilities over 15 beds a janitor’s closet shall be provided. It shall be equipped with water for filling scrub pails and a janitor’s sink for emptying scrub pails. A hallway or corridor shall not be used for storage of equipment. (III)
- b. Sufficient numbers of noncombustible trash containers, which have covers, shall be available. (III)
- c. All containers for trash shall be watertight, rodent-proof, and have tight-fitting covers and shall be thoroughly cleaned each time a container is emptied. (III)
- d. All wastes shall be properly disposed of in compliance with the local ordinances and state codes. (III)

**62.21(3) Bedrooms.**

- a. Each resident shall be provided with a bed, substantially constructed and in good repair. Roll-away beds, metal cots, or folding beds are not acceptable. (III)

b. Each bed shall be equipped with the following: casters or glides; clean springs in good repair; a clean, comfortable, well-constructed mattress approximately 5 inches thick and standard in size for the bed; and clean, comfortable pillows of average bed size. (III)

c. There shall be a comfortable chair, either a rocking chair or arm chair, per resident bed. The resident's personal wishes shall be considered and documented. (III)

d. There shall be drawer space for each resident's clothing. In a multiple bedroom, drawer space shall be assigned each resident. (III)

e. There shall be a bedside table with a drawer and a reading lamp for each resident.

f. All furnishings and equipment shall be durable, cleanable, and appropriate to their function. (III)

g. All resident areas shall be decorated, painted, and furnished to provide a homelike atmosphere and in a manner which is age and culture appropriate. (III)

h. Upholstery materials shall be moisture- and soil-resistant, except on furniture which is provided by the resident and is the property of the resident. (III)

i. Beds and other furnishings shall not obstruct free passage to and through doorways. (III)

j. Beds shall not be placed with the side of the bed against a radiator or in close proximity to it unless the radiator is covered to protect the resident from contact with it or from excessive heat. (III)

**62.21(4) Bath and toilet facilities.** All lavatories shall have nonreusable towels and an available supply of soap. (III)

**62.21(5) Dining and living rooms.**

a. Every facility shall have a dining room and a living room easily accessible to all residents. (III)

b. Dining rooms and living rooms shall at no time be used as bedrooms. (III)

c. Dining rooms and living rooms shall be available for use by residents at appropriate times to allow social, diversional, individual, and group activities. (III)

d. A combination dining room and living room may be permitted if the space requirements of a multipurpose room as provided in 481—subrule 60.6(2) are met. (III)

e. Living rooms shall be suitably furnished and maintained for the use of residents and their visitors and may be used for recreational activities. (III)

f. Dining rooms shall be furnished with dining tables and chairs appropriate to the size and function of the facility. These rooms and furnishings shall be kept clean and sanitary. (III)

**62.21(6) Family and employee accommodations.**

a. The residents' bedrooms shall not be occupied by employees, family members of employees, or family members of the licensee. (III)

b. In facilities where the total occupancy of family, employees, and residents is five or less, one toilet and one tub or shower is the minimum requirement. (III)

c. In all health care facilities, if the family or employees live within the facility, living quarters shall be required for the family or employees separate from areas provided for residents. (III)

**62.21(7) Animals.** Animals shall be allowed within the facility with written approval of the department and under controlled conditions. (III)

**62.21(8) Maintenance.** Each facility shall establish a maintenance program to ensure continued maintenance of the facility, to promote good housekeeping procedures, and to ensure sanitary practices throughout the facility. In facilities over 15 beds, this program shall be in writing and be available for review by the department. (III)

a. The buildings, furnishing, and grounds shall be maintained in a clean, orderly condition and be in good repair. (III)

b. The buildings and grounds shall be kept free of flies, other insects, rodents, and their breeding areas. (III)

**62.21(9) Buildings, furnishings, and equipment.**

a. Battery-operated, portable emergency lights in good working condition shall be available at all times, at a ratio of one light per employee on duty from 6 p.m. to 6 a.m. (III)

b. All windows shall be supplied with curtains and shades or drapes which are kept in good repair. (III)

c. Wherever glass sliding doors or transparent panels are used, they shall be marked conspicuously and decoratively. (III)

**62.21(10) Water supply.** Every facility shall have an adequate water supply from an approved source. A municipal source of water shall be considered as meeting this requirement. (III) Private sources of water to a facility shall be tested annually and the report submitted with the annual application for license. (III)

a. A bacterially unsafe source of water shall be grounds for denial, suspension, or revocation of license. (III)

b. The department may require testing of private sources of water to a facility at its discretion in addition to the annual test. The facility shall supply reports of tests as directed by the department. (III)

This rule is intended to implement Iowa Code section 135C.14.

**481—62.22(135C) Care review committee.** Each facility shall have a care review committee in accordance with Iowa Code section 135C.25, which shall operate within the scope of the rules for care review committees promulgated by the department on aging. (II)

**62.22(1) Role of committee in complaint investigations.**

a. The department shall notify the facility's care review committee of a complaint from the public. The department shall not disclose the name of a complainant.

b. The department may refer complaints to the care review committee for initial evaluation or investigation by the committee pursuant to rules promulgated by the department on aging. Within ten days of completion of the investigation, the committee shall report to the department in writing the results of the evaluation of the investigation.

c. When the department investigates a complaint, upon conclusion of its investigation, it shall notify the care review committee and the department on aging of its findings, including any citations and fines issued.

d. Results of all complaint investigations addressed by the care review committee shall be forwarded to the department within ten days of completion of the investigation.

**62.22(2)** The care review committee shall, upon department request, be responsible for monitoring correction of substantiated complaints.

**62.22(3)** When requested, names, addresses and telephone numbers of family members shall be given to the care review committee, unless the family refuses. The facility shall provide a form on which a family member may refuse to have the member's name, address or telephone number given to the care review committee.

This rule is intended to implement Iowa Code section 135C.25.

**481—62.23(135C) Residents' rights in general.**

**62.23(1)** Each facility shall ensure that policies and procedures are written and implemented which include, at a minimum, all of the following provisions subrules (62.23(2) to 62.23(22)) and which govern all areas of service provided to staff, residents, their families or legal representatives and shall be available to the public and shall be reviewed annually. (II)

**62.23(2) Grievances.** Written policies and procedures shall include a method for submitting grievances and recommendations by residents or their responsible party and for ensuring a response and disposition by the facility. The written procedure shall ensure protection of the resident from any form of reprisal or intimidation and shall include:

a. An employee or an alternate designated to be responsible for handling grievances and recommendations; (II) and

b. Methods to investigate and assess the validity of a grievance or recommendation, resolve grievances, and take action. (II)

**62.23(3) Informed of rights.** Policies and procedures shall include a provision that each resident shall be fully informed of the resident's rights and responsibilities as a resident and of all rules governing resident conduct and responsibilities. This information must be provided upon admission, or in the case

of residents already in the facility, upon the facility's adoption or amendment of residents' rights policies and be posted in locations accessible to all residents. (II)

*a.* The facility shall make known to residents what they may expect from the facility and its staff, and what is expected from residents. The facility shall communicate these expectations during the period of not more than two weeks before or five days after admission. The communication shall be in writing, e.g., in a separate handout or brochure describing the facility, and interpreted verbally, e.g., as part of a preadmission interview, resident counseling, or in individual or group orientation sessions following admission. (II)

*b.* Resident's rights and responsibilities shall be presented in language understandable to the resident. If the facility serves residents who are not English-speaking or are deaf, steps shall be taken to translate the information into a foreign or sign language. In the case of blind residents, either Braille or a recording shall be provided. Residents shall be encouraged to ask questions about their rights and responsibilities and these questions shall be answered. (II)

*c.* A statement shall be signed by the resident and legal guardian, if applicable, indicating an understanding of these rights and responsibilities, and the statement shall be maintained in the record. The statement shall be signed no later than five days after admission, and a copy of the signed statement shall be given to the resident or legal guardian. (II)

*d.* All residents, next of kin, or legal guardian shall be advised within 30 days following changes made in the statement of residents' rights and responsibilities. Appropriate means shall be used to inform non-English-speaking, deaf or blind residents of changes. (II)

**62.23(4)** Informed of health condition. Each resident or legal guardian shall be fully informed by a physician of the resident's health and medical condition unless medically contraindicated as documented by a physician in the resident's record. (II)

**62.23(5)** Research. The resident or legal guardian shall make the decision as whether to participate in experimental research and then only upon written informed consent. (II, III)

Any clinical investigation involving residents must be under the sponsorship of an institution with a human subjects review board functioning in accordance with the requirement of Public Law 93-348, as implemented by Part 46 of Title 45 of the Code of Federal Regulations, as amended to December 1, 1981 (45 CFR 46). (III)

**62.23(6)** Resident work. Services performed by the resident for the facility shall be in accordance with the IPP. (II)

*a.* Residents shall not be used to provide a source of labor for the facility against the resident's will. Physician's approval is required for all work programs and must be renewed yearly. (II, III)

*b.* If the individual program plan requires activities for therapeutic or training reasons, the plan for these activities must be professionally developed and implemented. Therapeutic or training goals must be clearly stated and measurable and the plan shall be time-limited and reviewed at least quarterly. (II)

*c.* A resident engaged in work programs in the RCF/PMI shall be paid wages commensurate with wage and hour regulations for comparable work and productivity. (II)

*d.* The resident shall have the right to employment options commensurate with training and skills. (II)

**62.23(7)** Residents performing work shall not be used to replace paid employees in fulfilling staffing requirements. (II)

**62.23(8)** Encouragement to exercise rights. Each resident shall be encouraged and assisted throughout the resident's period of stay, to exercise resident and citizen rights and may voice grievances and recommend changes in policies and services to administrative staff or to outside representatives of the resident's choice, free from interference, coercion, discrimination, or reprisal. (II)

**62.23(9)** Posting of names. The facility shall post in a prominent area the name, telephone number, and address of the long-term care resident's advocate/ombudsman, survey agency, local law enforcement agency, care review committee members, Iowa Protection and Advocacy Services, Inc., and text of Iowa Code section 135C.46, to provide to residents another course of redress. (II)

**62.23(10)** Dignity preserved. Each resident shall be treated with consideration, respect, and full recognition of the resident's dignity and individuality, including privacy in treatment and in care of personal needs. (II)

*a.* Staff shall display respect for residents when speaking with, caring for, or talking about them, as constant affirmation of the individuality and dignity of human beings. (II)

*b.* Schedules of daily activities shall allow maximum flexibility for residents to exercise choice about what they will do and when they will do it. Residents' individual preferences regarding such things as menus, clothing, religious activities, friendships, activity programs, entertainment, sleeping, eating, and times to retire at night and arise in the morning shall be elicited and considered by the facility. The facility shall make every effort to match nonsmokers with other nonsmokers. (II)

*c.* Residents shall be examined and treated in a manner that maintains the privacy of their bodies. A closed door shall shield the resident from passersby. People not involved in the care of the residents shall not be present without the resident's consent while the resident is being examined or treated. (II)

*d.* Privacy for each person shall be maintained when residents are being taken to the toilet or being bathed and while they are being helped with other types of personal hygiene, except as needed for resident safety or assistance. (II)

*e.* Staff shall knock and be acknowledged before entering a resident's room unless the resident is not capable of a response. This does not apply under emergency conditions. (II)

**62.23(11)** Communications. Each resident may communicate, associate, and meet privately with persons of the resident's choice, unless to do so would infringe upon the rights of other residents. Each resident may send and receive personal mail unopened unless prohibited in the IPP which has explicit approval of the resident or legal guardian. (II)

**62.23(12)** Visiting hours. Subject to reasonable scheduling restrictions, visiting policies and procedures shall permit residents to receive visits from anyone they wish. Visiting hours shall be posted. (II)

*a.* Reasonable, regular visiting hours shall not be less than 12 hours per day and shall take into consideration the special circumstances of each visitor. A particular visitor(s) may be restricted by the facility for one of the following reasons:

- (1) The resident refuses to see the visitor(s). (II)
- (2) The visit would not be in accordance with the IPP. (II)
- (3) The visitor's behavior is unreasonably disruptive to the functioning of the facility.

Reasons for denial of visitation shall be documented in the resident's records. (II)

*b.* Decisions to restrict a visitor are reevaluated at least quarterly by the QMHP or at the resident's request. (II)

**62.23(13)** Privacy. Space shall be provided for residents to receive visitors in comfort and privacy. (II)

**62.23(14)** Telephone calls. Telephones consistent with ANSI standards 42 CFR 405.1134(c) (10-1-86) shall be available and accessible for residents to make and receive calls with privacy. Residents who need help shall be assisted in using the telephone. (II)

**62.23(15)** Arrangements shall be made to provide assistance to residents who require help in reading or sending mail. (II)

**62.23(16)** Residents shall be permitted to leave the facility and environs at reasonable times unless there are justifiable reasons established in writing by the attending physician, QMHP, or facility administrator for refusing permission. (II)

**62.23(17)** Residents shall not have their personal lives regulated beyond reasonable adherence to meal schedules, bedtime hours, and other written policies which may be necessary for the orderly management of the facility and as required by these rules; however, residents shall be encouraged to participate in recreational programs. (II)

**62.23(18)** Resident activities. Each resident may participate in activities of social, religious, and community groups as desired unless contraindicated for reasons documented by the attending physician or qualified mental health professional, as appropriate, in the resident's record. (II)

Residents who wish to meet with or participate in activities of social, religious or community groups in or outside the facility shall be informed, encouraged, and assisted to do so. (II)

**62.23(19)** Resident property. Each resident may retain and use personal clothing and possessions as space permits and provided use is not otherwise prohibited in these rules. (II)

*a.* Residents shall be permitted to keep reasonable amounts of personal clothing and possessions for their use while in the facility. The personal property shall be kept in a secure location which is convenient to the resident. (II)

*b.* Residents shall be advised, prior to or at the time of admission, of the kinds and amounts of clothing and possessions permitted for personal use, and whether the facility will accept responsibility for maintaining these items, e.g., cleaning and laundry. (II)

*c.* Any personal clothing or possessions retained by the facility for the resident shall be identified and recorded on admission and the record placed on the resident's chart. The facility shall be responsible for secure storage of items, and they shall be returned to the resident promptly upon request or upon discharge from the facility. (II)

*d.* A resident's personal property shall not be used without the written consent of the resident or the resident's guardian. (II)

*e.* A resident's personal property shall be returned to the resident when it has been used without the written consent of the resident or the resident's guardian. The department may report findings that a resident's property has been used without written consent to the local law enforcement agency, as appropriate. (II)

**62.23(20)** Sharing rooms. Residents, including spouses staying in the same facility, shall be permitted to share a room, if available, if requested by both parties, unless contraindicated in the IPP and when the reasons for denial are documented in the resident's record. (II)

**62.23(21)** Choice of physician and pharmacy. Each resident shall be permitted free choice of a physician and a pharmacy. The facility may require the pharmacy selected to use a drug distribution system compatible with the system currently used by the facility. (II)

**62.23(22)** Incompetent residents.

*a.* Each facility shall provide that all rights and responsibilities of the resident devolve to the resident's legal guardian when a resident is adjudicated incompetent in accordance with state law or, in the case of a resident who has not been adjudicated incompetent under the laws of the state, in accordance with 42 CFR 483.10. This paragraph is not intended to limit the authority of any individual acting pursuant to Iowa Code chapter 144A. (II)

*b.* The fact that a resident has been adjudicated incompetent does not absolve the facility from advising the resident of these rights to the extent the resident is able to understand them. The facility shall also advise the legal guardian, if any, and acquire a statement indicating an understanding of resident's rights. (II)

**62.23(23)** Resident abuse prohibited. Each resident shall receive kind and considerate care at all times and shall be free from physical, sexual, mental and verbal abuse, exploitation, and physical injury. (I, II)

**62.23(24)** Upon a claim of dependent adult abuse of a resident being reported, the administrator of the facility shall separate the victim and accused abuser immediately and maintain the separation until the abuse investigation is completed. (I, II)

**62.23(25)** Pursuant to Iowa Code chapter 235B, a mandatory reporter of dependent adult abuse is any person who, in the course of employment, examines, attends, counsels, or treats a dependent adult and reasonably believes the dependent adult has suffered abuse. This includes a member of the staff or employee of a health care facility. (II, III)

If a staff member or employee is required to report pursuant to this subrule, the staff member or employee shall immediately notify the person in charge of the facility or the person's designated agent, and the person in charge or the designated agent shall make the report to the department of human services. (II, III)

This rule is intended to implement Iowa Code sections 135C.14(8) and 135C.24.

**481—62.24(135C) County care facilities.** In addition to Chapter 62 licensing rules, county care facilities licensed as residential care facilities for persons with mental illness must also comply with department of human services rules, 441—Chapter 37. Violation of any standard established by the department of human services is a class II violation pursuant to 481—56.2(135C).

This rule is intended to implement Iowa Code section 227.4.

**481—62.25(135C) Another business or activity in a facility.** A facility is allowed to have another business or activity in a health care facility or in the same physical structure of the facility, if the other business or activity is under the control of and is directly related to and incidental to the operation of the health care facility, or the business or activity is approved by the department and the state fire marshal.

To obtain the approval of the department and the state fire marshal, the facility must submit to the department a written request for approval which identifies the service(s) to be offered by the business and addresses the factors outlined in paragraphs “a” through “j” of this rule. (I, II, III)

**62.25(1)** The following factors will be considered by the department in determining whether a business or activity will interfere with the use of the facility by residents, interfere with services provided to residents, or be disturbing to residents:

- a. Health and safety risks for residents;
- b. Compatibility of the proposed business or activity with the facility program;
- c. Noise created by the proposed business or activity;
- d. Odors created by the proposed business or activity;
- e. Use of entrances and exits for the business or activity in regard to safety and disturbance of residents and interference with delivery of services;
- f. Use of the facility’s corridors or rooms as thoroughfares to the business or activity in regard to safety and disturbance of residents and interference with delivery of services;
- g. Proposed staffing for the business or activity;
- h. Sharing of services and staff between the proposed business or activity and the facility;
- i. Facility layout and design; and
- j. Parking area utilized by the business or activity.

**62.25(2)** Approval of the state fire marshal shall be obtained before approval of the department will be considered.

**62.25(3)** A business or activity conducted in a health care facility or in the same physical structure as a health care facility shall not reduce space, services or staff available to residents below minimums required in these rules and 481—Chapter 60. (I, II, III)

This rule will become effective July 1, 1992.

**481—62.26(135C) Respite care services.** Respite care services means an organized program of temporary supportive care provided for 24 hours or more to a person in order to relieve the usual caregiver of the person from providing continual care to the person. A facility which chooses to provide respite care services must meet the following requirements related to respite care services and must be licensed as a health care facility.

**62.26(1)** A facility which chooses to provide respite care services is not required to obtain a separate license or pay a license fee.

**62.26(2)** Rules regarding involuntary discharge or transfer rights do not apply to residents who are being cared for under a respite care contract.

**62.26(3)** The facility shall have a contract with each resident in the facility. When the resident is there for respite care services, the contract shall specify the time period during which the resident will be considered to be receiving respite care services. At the end of that period, the contract may be amended to extend that period of time. The contract shall specifically state the resident may be involuntarily discharged while being considered as a respite care resident. The contract shall meet other requirements for contracts between a health care facility and resident, except the requirements concerning the holding and charging for a bed when a resident is hospitalized or leaves the facility temporarily for recreational or therapeutic reasons.

**62.26(4)** Respite care services shall not be provided by a facility to persons requiring a level of care which is higher than the level of care the facility is licensed to provide.

These rules are intended to implement Iowa Code sections 135C.2(6), 135C.4, 135C.6(1) to 135C.6(3), 135C.7, 135C.8, 135C.14, 135C.16(2), 135C.23 to 135C.25, 135C.31, 135C.36, and 227.4.

[Filed 2/5/88, Notice 10/7/87—published 2/24/88, effective 3/30/88]

[Filed 5/26/88, Notice 4/20/88—published 6/15/88, effective 7/20/88]

[Filed 9/30/88, Notice 8/24/88—published 10/19/88, effective 11/23/88]

[Filed 12/9/88, Notices 8/24/88, 10/5/88—published 12/28/88, effective 2/1/89]

[Filed 4/14/89, Notice 2/8/89—published 5/3/89, effective 6/7/89]

[Filed 6/23/89, Notice 5/17/89—published 7/12/89, effective 8/16/89]

[Filed 7/20/89, Notice 6/14/89—published 8/9/89, effective 9/13/89]

[Filed 8/16/89, Notices 4/19/89, 7/12/89—published 9/6/89, effective 10/11/89]

[Filed 3/14/91, Notice 9/19/90—published 4/3/91, effective 5/8/91]

[Filed 1/31/92, Notice 11/13/91—published 2/19/92, effective 7/1/92]

[Filed 3/12/92, Notice 12/11/91—published 4/1/92, effective 5/6/92]

[Filed 1/15/93, Notice 11/25/92—published 2/3/93, effective 3/10/93]

[Filed 5/16/95, Notice 3/15/95—published 6/7/95, effective 7/12/95]

[Filed 11/30/95, Notice 9/13/95—published 12/20/95, effective 1/24/96]

[Filed 7/11/97, Notice 4/23/97—published 7/30/97, effective 9/3/97]

[Filed emergency 7/25/97—published 8/13/97, effective 7/25/97]

[Filed emergency 11/14/97—published 12/3/97, effective 11/14/97]

[Filed 11/14/97, Notice 8/13/97—published 12/3/97, effective 1/7/98]

[Filed 3/31/98, Notice 12/3/97—published 4/22/98, effective 5/27/98]

[Filed 7/9/98, Notice 4/22/98—published 7/29/98, effective 9/2/98]

[Filed 1/15/04, Notice 10/1/03—published 2/4/04, effective 3/10/04]

[Filed 1/15/04, Notice 12/10/03—published 2/4/04, effective 3/10/04]

[Filed 9/20/06, Notice 8/2/06—published 10/11/06, effective 11/15/06]

[Filed ARC 0663C (Notice ARC 0513C, IAB 12/12/12), IAB 4/3/13, effective 5/8/13]

[Filed ARC 0903C (Notice ARC 0776C, IAB 5/29/13), IAB 8/7/13, effective 9/11/13]

[Filed ARC 1050C (Notice ARC 0907C, IAB 8/7/13), IAB 10/2/13, effective 11/6/13]



CHAPTER 63  
RESIDENTIAL CARE FACILITIES FOR THE  
INTELLECTUALLY DISABLED  
[Prior to 7/15/87, Health Department[470] Ch 63]

**481—63.1(135C) Definitions.** For the purpose of these rules, the following terms shall have the meaning indicated in this chapter. The definitions set out in Iowa Code section 135C.1 shall be considered to be incorporated verbatim in the rules. The use of the words “shall” and “must” indicate those standards are mandatory. The use of the words “should” and “could” indicate those standards are recommended.

**63.1(1)** “*Accommodation*” means the provision of lodging, including sleeping, dining, and living areas.

**63.1(2)** “*Administrator*” means a person who administers, manages, supervises, and is in general administrative charge of a residential care facility for the intellectually disabled, whether or not such individual has an ownership interest in such facility, and whether or not the functions and duties are shared with one or more individuals.

**63.1(3)** “*Alcoholic*” means a person in a state of dependency resulting from excessive or prolonged consumption of alcoholic beverages as defined in Iowa Code section 125.2.

**63.1(4)** “*Ambulatory*” means a person who immediately and without aid of another, is physically and mentally capable of traveling a normal path to safety, including the ascent and descent of stairs.

**63.1(5)** “*Basement*” means that part of a building where the finish floor is more than 30 inches below the finish grade.

**63.1(6)** “*Board*” means the regular provision of meals.

**63.1(7)** “*Communicable disease*” means a disease caused by the presence of virus or microbial agents within a person’s body, which agents may be transmitted either directly or indirectly to other persons.

**63.1(8)** “*Department*” means the state department of inspections and appeals.

**63.1(9)** “*Distinct part*” means a clearly identifiable area or section within a residential care facility for the intellectually disabled, consisting of at least a residential unit, wing, floor, or building containing contiguous rooms.

**63.1(10)** “*Drug addiction*” means a state of dependency, as medically determined, resulting from excessive or prolonged use of drugs as defined in Iowa Code chapter 124.

**63.1(11)** “*Interdisciplinary team*” means persons drawn from, or representing such of the professions, disciplines, or services required for the care of the resident.

**63.1(12)** “*Medication*” means any drug including over-the-counter substances ordered and administered under the direction of the physician.

**63.1(13)** “*Nonambulatory*” means a person who immediately and without the aid of another is not physically and mentally capable of traveling a normal path to safety, including the ascent and descent of stairs.

**63.1(14)** “*Personal care*” means assistance with the activities of daily living which the recipient can perform only with difficulty. Examples are help in getting in and out of bed, assistance with personal hygiene and bathing, help with dressing and feeding, and supervision over medications which can be self-administered.

**63.1(15)** “*Program of care*” means all services being provided for a resident in a health care facility.

**63.1(16)** “*Qualified intellectual disabilities professional*” means a psychologist, physician, registered nurse, educator, social worker, physical or occupational therapist, speech therapist or audiologist who meets the educational requirements for the profession, as required in the state of Iowa, and having one year’s experience working with the intellectually disabled.

**63.1(17)** “*Rate*” means that daily fee charged for all residents equally and shall include the cost of all minimum services required in these regulations.

**63.1(18)** “*Responsible party*” means the person who signs or cosigns the admission agreement required in 481—63.14(135C) or the resident’s guardian or conservator if one has been appointed. In the event that a resident has neither a guardian, conservator nor person who signed or cosigned the

resident's admission agreement, the term "responsible party" shall include the resident's sponsoring agency, e.g., the department of social services, Veterans Administration, religious groups, fraternal organizations, or foundations that assume responsibility and advocate for their client patients and pay for their health care.

**63.1(19)** "*Restraints*" means the measures taken to control a resident's physical activity for the resident's own protection or for the protection of others.

[ARC 0765C, IAB 5/29/13, effective 7/3/13]

**481—63.2(135C) Variances.** Variances from these rules may be granted by the director of the department of inspections and appeals for good and sufficient reason when the need for variance has been established; no danger to the health, safety, or welfare of any resident results; alternate means are employed or compensating circumstances exist and the variance will apply only to an individual residential care facility for the intellectually disabled. Variances will be reviewed at the discretion of the director of the department of inspections and appeals.

**63.2(1)** To request a variance, the licensee must:

- a. Apply for variance in writing, on a form provided by the department;
- b. Cite the rule or rules from which a variance is desired;
- c. State why compliance with the rule or rules cannot be accomplished;
- d. Explain alternate arrangement or compensating circumstances which justify the variance;
- e. Demonstrate that the requested variance will not endanger the health, safety, or welfare of any resident.

**63.2(2)** Upon receipt of a request for variance, the director of the department of inspections and appeals will:

- a. Examine the rule from which variance is requested to determine that the request is necessary and reasonable;
- b. If the request meets the above criteria, evaluate the alternate arrangements or compensating circumstances against the requirement of the rules;
- c. Examine the effect of the requested variance on the health, safety, or welfare of the residents;
- d. Consult with the applicant if additional information is required.

**63.2(3)** Based upon these studies, approval of the variance will be either granted or denied within 120 days of receipt.

[ARC 0765C, IAB 5/29/13, effective 7/3/13]

**481—63.3(135C) Application for licensure.**

**63.3(1)** Initial application and licensing. In order to obtain an initial residential care facility for the intellectually disabled license for a residential care facility for the intellectually disabled which is currently licensed, the applicant must:

- a. Meet all of the rules, regulations, and standards contained in 481—Chapters 60 and 63;
- b. Submit a letter of intent and a written résumé of the resident care program and other services provided which reflect the services indicated in individualized programs of care for each resident for departmental review and approval;
- c. Make application at least 30 days prior to the change of ownership of the facility on forms provided by the department;
- d. Submit a floor plan of each floor of the facility drawn on 8½- × 11-inch paper showing room areas in proportion, room dimensions, room numbers for all rooms, including bathrooms, and designation of the use to which each room will be put and window and door location;
- e. Submit a photograph of the front and side elevation of the facility;
- f. Submit the statutory fee for a residential care facility for the intellectually disabled for which licensure application is made;
- g. Comply with all other local statutes and ordinances in existence at the time of licensure;
- h. Have a certificate signed by the state fire marshal or deputy state fire marshal as to compliance with fire safety rules and regulations.

**63.3(2)** In order for a facility not currently licensed as a residential care facility for the intellectually disabled to obtain an initial license as a residential care facility for the intellectually disabled, the applicant must:

- a.* Meet all of the rules, regulations, and standards contained in 481—Chapters 60 and 63 (exceptions noted in 60.3(2) shall not apply);
- b.* Submit a letter of intent and a written résumé of the resident care program and other services provided for departmental review and approval;
- c.* Make application at least 30 days prior to the proposed opening date of the facility on forms provided by the department;
- d.* Submit a floor plan of each floor of the residential care facility for the intellectually disabled, drawn on 8½- × 11-inch paper showing room areas in proportion, room dimensions, room numbers for all rooms, including bathrooms, and designation of the use to which the room will be put and window and door locations;
- e.* Submit a photograph of the front and side elevation of the residential care facility for the intellectually disabled;
- f.* Submit the statutory fee for a residential care facility for the intellectually disabled;
- g.* Comply with all other local statutes and ordinances in existence at the time of licensure;
- h.* Have a certificate signed by the state fire marshal or deputy state fire marshal as to compliance with fire safety rules and regulations.

**63.3(3)** Renewal application. In order to obtain a renewal of the residential care facility for the intellectually disabled license, the applicant must:

- a.* Submit the completed application form 30 days prior to annual license renewal date of residential care facility for the intellectually disabled license;
- b.* Submit the statutory license fee for a residential care facility for the intellectually disabled with the application for renewal;
- c.* Have an approved current certificate signed by the state fire marshal or deputy state fire marshal as to compliance with fire safety rules and regulations;
- d.* Submit appropriate changes in the résumé to reflect any changes in the resident care program and other services.

**63.3(4)** Deemed status.

*a.* The department shall recognize, in lieu of its own inspection, the comparable inspection and inspection findings of the Accreditation Council for Service for Mentally Retarded and Other Developmentally Disabled Persons (AC—MR/DD), if the department is given copies of all requested materials relating to the comparable inspection process, is notified of the scheduled comparable inspection not less than 30 days in advance of the inspection, and is given the opportunity to monitor the comparable inspection. The department may verify the findings of 10 percent of the comparable inspections, selected annually on a random basis, in order to ensure compliance with minimum residential care standards established pursuant to this chapter.

*b.* The above accreditation will be accepted in lieu of the department's yearly licensure inspection for each year of the AC—MR/DD accreditation period up to two years.

**63.3(5)** Licenses are issued to the person or governmental unit which has responsibility for the operation of the facility and authority to comply with all applicable statutes, rules or regulations.

The person or governmental unit must be the owner of the facility or, if the facility is leased, the lessee.

This rule is intended to implement Iowa Code sections 135C.6(1) and 135C.9.  
[ARC 0765C, IAB 5/29/13, effective 7/3/13]

**481—63.4(135C) General requirements.**

**63.4(1)** The license shall be displayed in a conspicuous place in the facility which is viewed by the public. (III)

**63.4(2)** The license shall be valid only in the possession of the licensee to whom it is issued.

**63.4(3)** The posted license shall accurately reflect the current status of the residential care facility for the intellectually disabled. (III)

**63.4(4)** Licenses expire one year after the date of issuance, or as indicated on the license.

**63.4(5)** Each citation or a copy of each citation issued by the department for a class I or class II violation shall be prominently posted by the facility in plain view of the residents, visitors, and persons inquiring about placement in the facility. The citation or copy of the citation shall remain posted until the violation is corrected to the satisfaction of the department. (III)

[ARC 0765C, IAB 5/29/13, effective 7/3/13]

**481—63.5(135C) Notifications required by the department.** The department shall be notified:

**63.5(1)** Within 48 hours, by letter, of any reduction or loss of personal care or dietary staff lasting more than seven days which places the staffing ratio below that required for licensing. No additional residents shall be admitted until the minimum staffing requirements are achieved; (III)

**63.5(2)** Of any proposed change in the residential care facility for the intellectually disabled's functional operation or addition or deletion of required services; (III)

**63.5(3)** Thirty days before addition, alteration, or new construction is begun in the residential care facility for the intellectually disabled, or on the premises; (III)

**63.5(4)** Thirty days in advance of closure of the residential care facility for the intellectually disabled; (III)

**63.5(5)** Within two weeks of any change in administrator; (III)

**63.5(6)** When any change in the category of license is sought; (III)

**63.5(7)** Prior to the purchase, transfer, assignment, or lease of a residential care facility for the intellectually disabled, the licensee shall:

*a.* Inform the department of the pending sale, transfer, assignment, or lease of the facility; (III)

*b.* Inform the department of the name and address of the prospective purchaser, transferee, assignee, or lessee at least 30 days before the sale, transfer, assignment, or lease is completed; (III)

*c.* Submit a written authorization to the department permitting the department to release all information of whatever kind from the department's files concerning the licensee's residential care facility for the intellectually disabled to the named prospective purchaser, transferee, assignee, or lessee; (III)

**63.5(8)** Pursuant to the authorization submitted to the department by the licensee prior to the purchase, transfer, assignment, or lease of a residential care facility for the intellectually disabled, the department shall upon request, send or give copies of all recent licensure surveys and of any other pertinent information relating to the facility's licensure status to the prospective purchaser, transferee, assignee, or lessee; costs for such copies shall be paid by the prospective purchaser.

[ARC 0765C, IAB 5/29/13, effective 7/3/13]

**481—63.6(135C) Witness fees.** Rescinded IAB 3/30/94, effective 5/4/94. See 481—subrule 50.6(4).

**481—63.7(135C) Licenses for distinct parts.**

**63.7(1)** Separate licenses may be issued for distinct parts of a health care facility which are clearly identifiable, containing contiguous rooms in a separate wing or building or on a separate floor of the facility and which provide care and services of separate categories.

**63.7(2)** The following requirements shall be met for a separate licensing of a distinct part:

*a.* The distinct part shall serve only residents who require the category of care and services immediately available to them within that part; (III)

*b.* The distinct part shall meet all the standards, rules, and regulations pertaining to the category for which a license is being sought;

*c.* A distinct part must be operationally and financially feasible;

*d.* A separate staff with qualifications appropriate to the care and services being rendered must be regularly assigned and working in the distinct part under responsible management; (III)

*e.* Separately licensed distinct parts may have certain services such as management, building maintenance, laundry, and dietary in common with each other.

**481—63.8(135C) Administrator.** Each residential care facility for the intellectually disabled shall have one person in charge, duly approved by the department or acting in a provisional capacity in accordance with these regulations. (III)

**63.8(1)** The administrator shall be at least 18 years of age and shall have a high school diploma or equivalent. (III) In addition this person shall meet at least one of the following conditions:

*a.* Be a licensed nursing home administrator who is also a qualified intellectual disabilities professional; (III) or

*b.* Be a qualified intellectual disabilities professional with at least one year of experience in an administrative capacity in a health care facility; (III) or

*c.* Have completed a one-year educational training program approved by the department for residential care facility for the intellectually disabled. (III)

**63.8(2)** The administrator may act as an administrator for not more than two residential care facilities for the intellectually disabled. (II)

*a.* The distance between the two facilities shall be no greater than 50 miles. (II)

*b.* The administrator shall spend the equivalent of three full eight-hour days per week in each facility. (II)

*c.* The administrator may be responsible for no more than 150 beds in total if the administrator is an administrator of more than one facility. (II)

**63.8(3)** The licensee may be the approved administrator providing the licensee meets the requirements as set forth in these regulations and devotes the required time to administrative duties. Residency in the facility does not in itself meet the requirement. (III)

**63.8(4)** A provisional administrator may be appointed on a temporary basis by the residential care facility for the intellectually disabled licensee to assume the administrative responsibilities for a residential care facility for the intellectually disabled for a period not to exceed six months when, through no fault of its own, the home has lost its administrator and has not been able to replace the administrator, provided the department has been notified prior to the date of the administrator's appointment. (III)

**63.8(5)** In the absence of the administrator, a responsible person shall be designated in writing to the department to be in charge of the facility. (III) The person designated shall:

*a.* Be knowledgeable of the operation of the facility; (III)

*b.* Have access to records concerned with the operation of the facility; (III)

*c.* Be capable of carrying out administrative duties and of assuming administrative responsibilities; (III)

*d.* Be at least 18 years of age; (III)

*e.* Be empowered to act on behalf of the licensee during the administrator's absence concerning the health, safety, and welfare of the residents; (III)

*f.* Have had training to carry out assignments and take care of emergencies and sudden illnesses of residents. (III)

**63.8(6)** The licensee shall:

*a.* Assume the responsibility for the overall operation of the residential care facility for the intellectually disabled; (III)

*b.* Be responsible for compliance with all applicable laws and with the rules of the department; (III)

*c.* Establish written policies, which shall be available for review, for the operation of the residential care facility for the intellectually disabled. (III)

**63.8(7)** The administrator shall:

*a.* Be responsible for the selection and direction of competent personnel to provide services for the resident care program; (III)

*b.* Be responsible for the arrangement for all department heads to annually attend a minimum of ten contact hours of educational programs to increase skills and knowledge needed for the position; (III)

*c.* Be responsible for a monthly in-service educational program for all employees and to maintain records of programs and participants; (III)

*d.* Make available the residential care facility for the intellectually disabled payroll records for departmental review as needed. (III)  
[ARC 0765C, IAB 5/29/13, effective 7/3/13]

**481—63.9(135C) General policies.**

**63.9(1)** There shall be written personnel policies in facilities of more than 15 beds to include hours of work, and attendance at educational programs. (III)

**63.9(2)** There shall be a written job description developed for each category of worker in facilities. The job description shall include title of job, job summary, age range, qualifications (formal education and experience), skills needed, physical requirements, and responsibilities. (III)

**63.9(3)** There shall be written personnel policies for each facility. Personnel policies shall include the following requirements:

- a.* Employees shall have a physical examination before employment. (I, II, III)
- b.* Employees shall have a physical examination at least every four years. (I, II, III)
- c.* Screening and testing for tuberculosis shall be conducted pursuant to 481—Chapter 59. (I, II, III)

**63.9(4)** Health certificates for all employees shall be available for review. (III)

**63.9(5)** Rescinded IAB 10/19/88, effective 11/23/88.

**63.9(6)** There shall be written policies for emergency medical care for employees and residents in case of sudden illness or accident which includes the individual to be contacted in case of emergency. (III)

**63.9(7)** The facility shall have a written agreement with a hospital for the timely admission of a resident who, in the opinion of the attending physician, requires hospitalization. (III)

**63.9(8)** The residential care facility for the intellectually disabled shall have established policies concerning the control, investigation, and prevention of infections within the facility. (III)

**63.9(9)** Each facility licensed as a residential care facility for the intellectually disabled shall provide an organized continuous 24-hour program of care commensurate with the needs of the residents of the home and under the direction of an administrator whose combined training and supervisory experience is such as to ensure adequate and competent care. (III)

**63.9(10)** Each facility shall have a written and implemented infection control program addressing the following:

*a.* Techniques for hand washing consistent with Guidelines for Handwashing and Hospital Control, 1985, Centers for Disease Control, U.S. Department of Health and Human Services, PB85-923404; (I, II, III)

*b.* Techniques for handling of blood, body fluids, and body wastes consistent with Guideline for Isolation Precautions in Hospitals, Centers for Disease Control, U.S. Department of Health and Human Services, PB96-138102; (I, II, III)

*c.* Dressings, soaks, or packs; (I, II, III)

*d.* Infection identification; (I, II, III)

*e.* Resident care procedures to be used when there is an infection present consistent with Guideline for Isolation Precautions in Hospitals, Centers for Disease Control, U.S. Department of Health and Human Services, PB96-138102; (I, II, III)

*f.* Sanitation techniques for resident care equipment; (I, II, III)

*g.* Techniques for sanitary use and reuse of feeding syringes and single-resident use and reuse of urine collection bags; (I, II, III)

*h.* Techniques for use and disposal of needles, syringes, and other sharp instruments consistent with Guideline for Isolation Precautions in Hospitals, Centers for Disease Control, U.S. Department of Health and Human Services, PB96-138102; (I, II, III)

CDC Guidelines may be obtained from the U.S. Department of Commerce, Technology Administration, National Technical Information Service, 5285 Port Royal Rd., Springfield, Virginia 22161 (1-800-553-6847).

**63.9(11)** Aseptic techniques. If a resident needs any of the treatments or devices on the list below, written and implemented procedures regarding aseptic techniques shall be followed.

*a.* Intravenous or central line catheter consistent with Guideline for Prevention of Intravascular Device Related Infections, Centers for Disease Control, U.S. Department of Health and Human Services, PB97-130074, (I, II, III)

*b.* Urinary catheter, (I, II, III)

*c.* Respiratory suction, oxygen or humidification, (I, II, III)

*d.* Decubitus care, (I, II, III)

*e.* Tracheostomy, (I, II, III)

*f.* Nasogastric or gastrostomy tubes, (I, II, III)

*g.* Sanitary use and reuse of feeding syringes and single-resident use and reuse of urine collection bags. (I, II, III)

**63.9(12)** Prior to the removal of a deceased resident/patient from a facility, the funeral director or person responsible for transporting the body shall be notified by the facility staff of any special precautions that were followed by the facility having to do with the mode of transmission of a known or suspected communicable disease. (III)

[ARC 0663C, IAB 4/3/13, effective 5/8/13; ARC 0765C, IAB 5/29/13, effective 7/3/13]

**481—63.10** Rescinded, effective 7/14/82.

**481—63.11(135C) Personnel.**

**63.11(1)** *General qualifications.*

*a.* No person with a current record of habitual alcohol intoxication or addiction to the use of drugs shall serve in a managerial role of a residential care facility for the intellectually disabled. (II)

*b.* No person under the influence of alcohol or intoxicating drugs shall be permitted to provide services in a residential care facility for the intellectually disabled. (II)

*c.* No person shall be allowed to provide services in a facility if the person has a disease:

(1) Which is transmissible through required workplace contact, (I, II, III)

(2) Which presents a significant risk of infecting others, (I, II, III)

(3) Which presents a substantial possibility of harming others, and (I, II, III)

(4) For which no reasonable accommodation can eliminate the risk. (I, II, III)

Refer to Guidelines for Infection Control in Hospital Personnel, Centers for Disease Control, U.S. Department of Health and Human Services, PB85-923402 to determine (1), (2), (3) and (4).

*d.* Reserved.

*e.* Individuals with either physical or mental disabilities may be employed for specific duties, but only if that disability is unrelated to that individual's ability to perform the duties of the job. (III)

**63.11(2)** *Supervision and staffing.*

*a.* The department shall establish on an individual facility basis the numbers and qualifications of the staff required in a residential care facility for the intellectually disabled, using as its criteria the services being offered as indicated on the résumé program of care and, as required for individual care plans, the needs of the resident. (II, III)

*b.* Personnel in a residential care facility for the intellectually disabled shall provide 24-hour coverage for residential care services for the intellectually disabled. Personnel shall be up and dressed at all times in facilities with more than 15 beds. In facilities with 15 or fewer beds, personnel shall be up and dressed when residents are awake. (II, III)

*c.* Direct care staff shall be present in the facility unless all residents are involved in activities away from the facility. (II, III)

*d.* Physician's orders shall be implemented by qualified personnel. (II, III)

**63.11(3)** *Employee criminal record checks, child abuse checks and dependent adult abuse checks and employment of individuals who have committed a crime or have a founded abuse.* The facility shall comply with the requirements found in Iowa Code section 135C.33 as amended by 2013 Iowa Acts, Senate File 347, and rule 481—50.9(135C) related to completion of criminal record checks, child abuse

checks, and dependent adult abuse checks and to employment of individuals who have committed a crime or have a founded abuse. (I, II, III)

[ARC 0765C, IAB 5/29/13, effective 7/3/13; ARC 0903C, IAB 8/7/13, effective 9/11/13]

**481—63.12(135C) Resident care and personal services.**

**63.12(1)** Beds shall be made daily and adjusted as necessary. A complete change of linen shall be made at least once a week and more often if necessary. (III)

**63.12(2)** Residents shall receive sufficient supervision so that their personal cleanliness is maintained. (II, III)

**63.12(3)** Residents shall have clean clothing as needed to present a neat appearance, be free of odors, and to be comfortable. Clothing shall be appropriate to their activities and to the weather. (III)

**63.12(4)** Rescinded, effective 7/14/82.

**63.12(5)** Residents shall be encouraged to leave their rooms and make use of the recreational room or living room of the facility. (III)

**63.12(6)** Residents shall not be required to pass through another's bedroom to reach a bathroom, living room, dining room, corridor, or other common areas of the facility. (III)

**63.12(7)** Rescinded, effective 7/14/82.

**63.12(8)** Uncontrollable residents shall be transferred or discharged from the facility in accordance with contract arrangements and requirements of Iowa Code chapter 135C. (II, III)

**63.12(9)** Residents shall be required to bathe at least twice a week. (II, III)

**481—63.13(135C) Admission, transfer, and discharge.**

**63.13(1)** *General admission policies.*

*a.* No resident who is in need of greater services than the facility can provide shall be admitted or retained in a residential care facility for the intellectually disabled. (II, III)

*b.* No residential care facility for the intellectually disabled shall admit more residents than the number of beds for which it is licensed. (II, III)

*c.* There shall be no more beds erected than is stipulated on the license. (II, III)

*d.* There shall be no more beds erected in a room than its size and other characteristics will permit. (II, III)

*e.* The admission of a resident to a residential care facility for the intellectually disabled shall not give the facility or any employee of the facility the right to manage, use, or dispose of any property of the resident except with the written authorization of the resident or the resident's legal representative. (III)

*f.* The admission of a resident shall not grant the residential care facility for the intellectually disabled the authority or responsibility to manage the personal affairs of the resident except as may be necessary for the safety of the resident and safe and orderly management of the residential care facility for the intellectually disabled as required by these rules. (III)

*g.* A residential care facility for the intellectually disabled shall provide for the safekeeping of personal effects, funds, and other property of its residents. The facility may require that items of exceptional value or which would convey unreasonable responsibilities to the licensee be removed from the premises of the facility for safekeeping. (III)

*h.* Rescinded, effective 7/14/82.

*i.* Funds or properties received by the residential care facility for the intellectually disabled, belonging to or due a resident, expendable for the resident's account, shall be trust funds. (III)

*j.* Infants and children under the age of 16 shall not be admitted to health care facilities for adults unless given prior written approval by the department. A distinct part of a health care facility, segregated from the adult section, may be established based on a program of care submitted by the licensee or applicant which is commensurate with the needs of the residents of the health care facility and has received the department's review and approval. (III)

*k.* No health care facility, and no owner, administrator, employee or representative thereof shall act as guardian, trustee, or conservator for any resident's property, unless such resident is related to the person acting as guardian within the third degree of consanguinity. (III)

*l.* Upon the verified petition of the county board of supervisors, the district court may appoint the administrator of a county care facility as conservator or guardian or both of a resident of such county care facility. Such administrator shall serve as conservator or guardian or both without fee. The administrator may establish either separate or common bank accounts for cash funds of such resident wards. (III)

**63.13(2) Discharge or transfer.**

*a.* Prior notification shall be made to the next of kin, legal representative, attending physician, and sponsoring agency, if any, prior to transfer or discharge of any resident. (III)

*b.* Proper arrangements shall be made by the residential care facility for the intellectually disabled for the welfare of the resident prior to transfer or discharge in the event of an emergency or inability to reach the next of kin or legal representative. (III)

*c.* The licensee shall not refuse to discharge or transfer a resident when the physician, family, resident, or legal representative requests such transfer or discharge. (II, III)

*d.* Advance notification by telephone will be made to the receiving facility prior to the transfer of any resident. (III)

*e.* When a resident is transferred or discharged, the appropriate record as set forth in 63.17(1) of these rules will accompany the resident. (II, III)

*f.* Prior to the transfer or discharge of a resident to another health care facility, arrangements to provide for continuity of care shall be made with the facility to which the resident is being sent. (II, III)  
[ARC 0765C, IAB 5/29/13, effective 7/3/13]

**481—63.14(135C) Contracts.** Each party shall receive a copy of the signed contract. Each contract for residents shall:

**63.14(1)** State the base rate or scale per day or per month, the services included, and the method of payment; (III)

**63.14(2)** Contain a complete schedule of all offered services for which a fee may be charged in addition to the base rate. (III) Furthermore, the contract shall:

*a.* Stipulate that no further additional fees shall be charged for items not contained in complete schedule of services as set forth in subrule 63.14(2); (III)

*b.* State the method of payment of additional charges; (III)

*c.* Contain an explanation of the method of assessment of such additional charges and an explanation of the method of periodic reassessment, if any, resulting in changing such additional charges; (III)

*d.* State that additional fees may be charged to the resident for nonprescription drugs, other personal supplies, and services by a barber, beautician, etc. (III)

**63.14(3)** Contain an itemized list of those services, with the specific fee the resident will be charged and method of payment, as related to the resident's current condition, based on a preadmission evaluation assessment which is determined in consultation with the administrator; (III)

**63.14(4)** Include the total fee to be charged initially to the resident; (III)

**63.14(5)** State the conditions whereby the facility may make adjustments to its overall fees for resident care as a result of changing costs. (III) Furthermore, the contract shall provide that the facility shall give:

*a.* Written notification to the resident or responsible party, when appropriate, of changes in the overall rates of both base and additional charges at least 30 days prior to effective date of such changes; (III)

*b.* Notification to the resident or responsible party, when appropriate, of changes in additional charges, based on a change in the resident's condition. Notification must occur prior to the date such revised additional charges begin. If notification is given orally, subsequent written notification must also be given within a reasonable time, not to exceed one week, listing specifically the adjustments made; (III)

**63.14(6)** State the terms of agreement in regard to refund of all advance payments in the event of transfer, death, voluntary or involuntary discharge; (III)

**63.14(7)** State the terms of agreement concerning the holding and charging for a bed when a resident is hospitalized or leaves the facility temporarily for recreational or therapeutic reasons. The terms shall contain a provision that the bed will be held at the request of the resident or the resident's responsible party:

*a.* The facility shall ask the resident or responsible party if they want the bed held. This request shall be made before the resident leaves or within 48 hours after the resident leaves. The inquiry and the response shall be documented; (II)

*b.* The facility shall reserve the bed when requested for as long as the resident can ensure payment in accordance with the contract; (II)

**63.14(8)** State the conditions under which the involuntary discharge or transfer of a resident would be effected; (III)

**63.14(9)** State the conditions of voluntary discharge or transfer; (III)

**63.14(10)** Set forth any other matters deemed appropriate by the parties to the contract. No contract or any provision thereof shall be drawn or construed so as to relieve any health care facility of any requirement or obligation imposed upon it by this chapter or any standards or rules in force pursuant to this chapter. (III)

#### **481—63.15(135C) Physical examinations.**

**63.15(1)** Each resident in a residential care facility for the intellectually disabled shall have a designated licensed physician, who may be called when needed. (III)

**63.15(2)** Each resident admitted to a residential care facility for the intellectually disabled shall have had a physical examination prior to admission. (II, III)

*a.* If the resident is admitted directly from a hospital, a copy of the hospital admission physical and discharge summary may be a part of the record in lieu of an additional physical examination. A record of the examination, signed by the physician, shall be a part of the resident's record. (II, III)

*b.* The record of the admission physical examination and medical history shall portray the current medical status of the resident and shall include the resident's name, sex, age, medical history, physical examination, diagnosis, statement of chief complaints, and results of any diagnostic procedures. (II, III)

*c.* Screening and testing for tuberculosis shall be conducted pursuant to 481—Chapter 59. (II, III)

**63.15(3)** Arrangements shall be made to have a physician available to furnish medical care in case of emergency. (II, III)

**63.15(4)** Rescinded, effective 7/14/82.

**63.15(5)** The person in charge shall immediately notify the physician of any accident, injury, or adverse change in the resident's condition. (I, II, III)

**63.15(6)** Each resident shall be visited by or shall visit the resident's physician at least annually. The year period shall be measured from the date of admission and is not to include preadmission physicals. Any required physician task or visit in a residential care facility for the intellectually disabled may also be performed by an advanced registered nurse practitioner, clinical nurse specialist, or physician assistant who is working in collaboration with the physician. (III)

**63.15(7)** Residents shall be admitted to a residential care facility for the intellectually disabled only on a written order signed by a physician certifying that the individual being admitted requires no more than personal care and supervision but does not require nursing care. (III)

This rule is intended to implement Iowa Code section 135C.23(2).

[ARC 0663C, IAB 4/3/13, effective 5/8/13; ARC 0765C, IAB 5/29/13, effective 7/3/13]

#### **481—63.16(135C) Dental services.**

**63.16(1)** The residential care facility for the intellectually disabled personnel shall assist residents to obtain regular and emergency dental services. (III)

**63.16(2)** Transportation arrangements shall be made when necessary for the resident to be transported to the dentist's office. (III)

**63.16(3)** Dental services shall be performed only on the request of the resident, responsible relative, or legal representative. The resident's physician shall be advised of the resident's dental problems. (III)

**63.16(4)** All dental reports or progress notes shall be included in the clinical record. (III)

**63.16(5)** Personal care staff shall assist the resident in carrying out dentist's recommendations. (III)

**63.16(6)** Dentists shall be asked to participate in the in-service program of the facility. (III)

[ARC 0765C, IAB 5/29/13, effective 7/3/13]

**481—63.17(135C) Records.**

**63.17(1) Resident record.** The licensee shall keep a permanent record on all residents admitted to a residential care facility for the intellectually disabled with all entries current, dated, and signed. (III)  
The record shall include:

- a. Name and previous address of resident; (III)
- b. Birth date, sex, and marital status of resident; (III)
- c. Church affiliation; (III)
- d. Physician's name, telephone number, and address; (III)
- e. Dentist's name, telephone number, and address; (III)
- f. Name, address, and telephone number of next of kin or legal representative; (III)
- g. Name, address, and telephone number of person to be notified in case of emergency; (III)
- h. Mortician's name, telephone number, and address; (III)
- i. Pharmacist's name, telephone number, and address; (III)
- j. Physical examination and medical history; (III)
- k. Certification by the physician that the resident requires no more than personal care and supervision, but does not require nursing care; (III)
- l. Physician's orders for medication, treatment, and diet in writing and signed by the physician; (III)
- m. A notation of yearly or other visits to physician or other professional services; (III)
- n. Any change in the resident's condition; (II, III)
- o. If the physician has certified that the resident is capable of taking prescribed medications, the resident shall be required to keep the administrator advised of current medications, treatments, and diet. The administrator shall keep a listing of medication, treatments, and diet prescribed by the physician for each resident; (III)
- p. If the physician has certified that the resident is not capable of taking prescribed medication, it must be administered by a qualified person of the facility. A qualified person shall be defined as either a registered or licensed practical nurse or an individual who has completed the state-approved training course in medication administration; (II)
- q. Medications administered by an employee of the facility shall be recorded on a medication record by the individual who administers the medication; (II, III)
- r. A notation describing condition on admission, transfer, and discharge; (III)
- s. In the event of a resident's death, notations in the resident's record shall include the date and time of the resident's death, the circumstances of the resident's death, the disposition of the resident's body, and the date and time that the resident's family and physician were notified of the resident's death; (III)
- t. A copy of instructions given to the resident, legal representative, or facility in the event of discharge or transfer; (III)
- u. Disposition of valuables. (III)

**63.17(2) Incident record.**

- a. Each residential care facility for the intellectually disabled shall maintain an incident record report and shall have available incident report forms. (III)
- b. Report of incidents shall be in detail on a printed incident report form. (III)
- c. The person in charge at the time of the incident shall oversee the preparation and sign the incident report. (III)
- d. The report shall cover all accidents where there is apparent injury or where hidden injury may have occurred. (III)

*e.* The report shall cover all accidents or unusual occurrences within the facility or on the premises affecting residents, visitors, or employees. (III)

*f.* A copy of the incident report shall be kept on file in the facility. (III)

**63.17(3) Retention of records.**

*a.* Records shall be retained in the facility for five years following termination of services. (III)

*b.* Records shall be retained within the facility upon change of ownership. (III)

*c.* Rescinded, effective 7/14/82.

*d.* When the facility ceases to operate, the resident's record shall be released to the facility to which the resident is transferred. If no transfer occurs, the record shall be released to the individual's physician. (III)

**63.17(4) Reports to the department.** The licensee shall furnish statistical information concerning the operation of the facility to the department on request. (III)

**63.17(5) Personnel record.**

*a.* An employment record shall be kept for each employee consisting of the following information: name and address of employee, social security number of employee, date of birth of employee, date of employment, experience and education, references, position in the home, date and reason for discharge or resignation. (III)

*b.* The personnel records shall be made available for review upon request by the department. (III)  
[ARC 0765C, IAB 5/29/13, effective 7/3/13]

**481—63.18(135C) Drugs.**

**63.18(1) Drug storage.**

*a.* Residents who have been certified in writing by the physician as capable of taking their own medications may retain these medications in their bedroom but locked storage must be provided. (III)

*b.* Drug storage for residents who are unable to take their own medications and require supervision shall meet the following requirements:

(1) A cabinet with a lock shall be provided which can be used for storage of drugs, solutions, and prescriptions; (III)

(2) A bathroom shall not be used for drug storage; (III)

(3) The drug storage cabinet shall be kept locked; (III)

(4) Schedule II drugs, as defined by Iowa Code chapter 124, shall be kept in a locked box within the locked medication cabinet; (II)

(5) The medicine cabinet key shall be in the possession of the employee charged with the responsibility of administering medications; (II, III)

(6) Medications requiring refrigeration shall be kept in a refrigerator and separated from food and other items; (III)

(7) Drugs for external use shall be stored separately from drugs for internal use; (III)

(8) All potent, poisonous, or caustic materials shall be stored separately from drugs. They shall be plainly labeled and stored in a specific, well-illuminated cabinet, closet, or storeroom and made accessible only to authorized persons; (I, II)

(9) The drug cabinet shall have a work counter, both the counter and cabinet shall be well-lighted; (III)

(10) Running water shall be available in the room in which the medicine cabinet is located or in an adjacent room; (III)

(11) Inspection of drug storage condition shall be made by the administrator and a registered pharmacist not less than once every three months. The inspection shall be verified by a report signed by the administrator and the pharmacist and filed with the administrator. The report shall include, but not be limited to, certifying absence of the following: expired drugs, deteriorated drugs, improper labeling, drugs for which there is no current physician's order, and drugs improperly stored. (III)

*c.* Bulk supplies of prescription drugs shall not be kept in a residential care facility for the intellectually disabled unless a licensed pharmacy is established in the facility under the direct supervision and control of a pharmacist. (III)

**63.18(2) Drug safeguards.**

*a.* All prescribed medications shall be clearly labeled indicating the resident's full name, physician's name, prescription number, name and strength of drug, dosage, directions for use, date of issue, and name and address and telephone number of pharmacy or physician issuing the drug. Where unit dose is used, prescribed medications shall, as a minimum, indicate the resident's full name, physician's name, name and strength of drug, and directions for use. Standard containers shall be utilized for dispensing drugs. Paper envelopes shall not be considered standard containers. (III)

*b.* Medication containers having soiled, damaged, illegible or makeshift labels shall be returned to the issuing pharmacist, pharmacy, or physician for relabeling or disposal. (III)

*c.* The medications of each resident shall be kept or stored in the originally received containers. (II, III)

*d.* When a resident is discharged or leaves the facility, the unused prescription shall be sent with the resident or with a legal representative only upon the written order of a physician. (III)

*e.* Unused prescription drugs prescribed for residents who have died shall be destroyed by the person in charge with a witness and notation made on the resident's record, or, if a unit dose system is used, such drugs shall be returned to the supplying pharmacist. (III)

*f.* Prescriptions shall be refilled only with the permission of the attending physician. (II, III)

*g.* No medications prescribed for one resident may be administered to or allowed in the possession of another resident. (II)

*h.* Instructions shall be requested of the Iowa board of pharmacy examiners concerning disposal of unused Schedule II drugs prescribed for residents who have died or for whom the Schedule II drug was discontinued. (III)

*i.* There shall be a formal routine for the proper disposal of discontinued medications within a reasonable but specified time. These medications shall not be retained with the resident's current medications. Discontinued drugs shall be destroyed by the responsible person with a witness and notation made to that effect or returned to the pharmacist for destruction or resident credit. Drugs listed under the Schedule II drugs shall be disposed of in accordance with the provisions of the Iowa board of pharmacy examiners. (II, III)

*j.* All medication orders which do not specifically indicate the number of doses to be administered or the length of time the drug is to be administered shall be stopped automatically after a given time period. The automatic stop order may vary for different types of drugs. The personal physician of the resident, in conjunction with the pharmacist, shall institute these policies and provide procedures for review and endorsement. (II, III)

*k.* No resident shall be allowed to keep in the resident's possession any medications unless the attending physician has certified in writing on the resident's medical record that the resident is mentally and physically capable of doing so. (II)

*l.* No medications or prescription drugs shall be administered to a resident without a written order signed by the attending physician. (II)

*m.* Each facility shall establish a policy cooperating with a licensed pharmacist to govern distributing prescribed medication to residents who are on leave from a facility. (III)

(1) Medication may be issued to residents who will be on leave from a facility for less than 24 hours. Notwithstanding the prohibition against paper envelopes in 63.18(2) "a," non-child-resistant containers may be used. Each container may hold only one medication. A label on each container shall indicate the date, the resident's name, the facility, the medication, its strength, dose, and time of administration.

(2) Medication for residents on leave from a facility longer than 24 hours shall be obtained in accordance with requirements established by the Iowa board of pharmacy examiners.

(3) Medication distributed as above may be issued only by facility personnel responsible for administering medication.

**63.18(3) Drug administration.**

*a.* A properly trained person shall be charged with the responsibility of administering nonparenteral medications.

*b.* The individual shall have knowledge of the purpose of the drugs, their dangers, and contraindications.

*c.* This person shall be a licensed nurse or physician or shall have successfully completed a department-approved medication aide course or passed a department-approved medication aide challenge examination administered by an area community college.

*d.* Prior to taking a department-approved medication aide course, the individual shall:

(1) Successfully complete an approved residential aide course, nurse aide course, nurse aide training and testing program or nurse aide competency examination;

(2) Be employed in the same facility for at least six consecutive months prior to the start of the medication aide course. This requirement is not subject to waiver.

(3) Have a letter of recommendation for admission to the medication aide course from the employing facility.

*e.* A person who is a nursing student or a graduate nurse may take the challenge examination in place of taking a medication aide course. This individual shall do all of the following before taking the medication aide challenge examination:

(1) Complete a clinical or nursing theory course within six months before taking the challenge examination;

(2) Successfully complete a nursing program pharmacology course within one year before taking the challenge examination;

(3) Provide to the community college a written statement from the nursing program's pharmacology or clinical instructor indicating the individual is competent in medication administration.

*f.* In an RCF/ID facility licensed for 15 or fewer beds, a person who has successfully completed a state-approved medication manager course may administer medications.

*g.* A person who has written documentation of certification as a medication aide in another state may become a medication aide in Iowa by successfully completing a department-approved nurse aide competency examination and a medication aide challenge examination.

The requirements of paragraph “*d*” of this subrule do not apply to this individual.

*h.* Unless the unit dose system is used, the person assigned the responsibility of medication administration must complete the procedure by personally preparing the dose, observing the actual act of swallowing the oral medication, and charting the medication. (II) In facilities where the unit dose system is used, the person assigned the responsibility must complete the procedure by observing the actual act of swallowing the medication and charting the medication. Medications shall be prepared on the same shift of the same day they are administered, (II) unless the unit dose system is used.

*i.* Injectable medications shall be administered as permitted by Iowa law by a qualified nurse, physician, pharmacist, or physician assistant (PA).

*j.* Residents certified by their physician as capable of injecting their own insulin may do so. Insulin may be administered pursuant to “*i*” above or as otherwise authorized by the resident's physician. Authorization by the physician shall:

(1) Be in writing,

(2) Be maintained in the resident's record,

(3) Be renewed quarterly,

(4) Include the name of the individual authorized to administer the insulin,

(5) Include documentation by the physician that the authorized person is qualified to administer insulin to that resident.

*k.* An individual inventory record shall be maintained for each Schedule II drug prescribed for each resident. (II)

[ARC 0765C, IAB 5/29/13, effective 7/3/13; ARC 1050C, IAB 10/2/13, effective 11/6/13]

#### **481—63.19(135C) Dietary.**

##### **63.19(1) Dietary staffing.**

*a.* In facilities licensed for over 15 beds, persons in charge of meal planning and food preparation shall complete the home study course on sanitation and food preparation offered by the department. (III)

b. In facilities licensed for over 15 beds, food service personnel shall be on duty during a 12-hour span extending from the preparation of breakfast through supper. (III)

c. There shall be written work schedules and time schedules covering each type of job in the food service department. These work and time schedules shall be posted or kept in a notebook which is available for use in the food service area in facilities over 15 beds. (III)

**63.19(2) Nutrition and menu planning.**

a. Menus shall be planned and followed to meet nutritional needs of residents in accordance with the physician's orders. (II)

b. Menus shall be planned and served to include foods and amounts necessary to meet the recommended daily dietary allowances of the food and nutrition board of the National Research Council, National Academy of Sciences. (II) Recommended daily dietary allowances are:

- (1) Milk—two or more cups served as beverage or used in cooking;
- (2) Meat group—two or more servings of meat, fish, poultry, eggs, cheese or equivalent; at least four to five ounces edible portion per day;
- (3) Vegetable and fruit group—four or more servings (two cups). This shall include a citrus fruit or other fruit and vegetable important for vitamin C daily, a dark green or deep yellow vegetable for vitamin A at least every other day, and other fruits and vegetables, including potatoes;
- (4) Bread and cereal group—four or more servings of whole-grain, enriched or restored;
- (5) Foods other than those listed will usually be included to meet daily energy requirements (calories) to add to the total nutrients and variety of meals.

c. At least three meals or their equivalent shall be served daily, at regular hours. (II)

(1) There shall be no more than a 14-hour span between substantial evening meal and breakfast. (II, III)

(2) To the extent medically possible, bedtime nourishments shall be offered routinely to all residents. Special nourishments shall be available when ordered by physician. (II, III)

d. Menus shall include a variety of foods prepared in various ways. The same menu shall not be repeated on the same day of the following week. (III)

e. Menus shall be written at least one week in advance. The current menu shall be located in an accessible place in the dietetic service department for easy use by persons purchasing, preparing, and serving food. (III)

f. Records of menus as served shall be filed and maintained for 30 days and shall be available for review by departmental personnel. When substitutions are necessary, they shall be of similar nutritive value and recorded on the menu or in a notebook. (III)

g. A file of tested recipes adjusted to the number of people to be fed in the facility shall be maintained. (III)

**63.19(3) Dietary storage, food preparation, and service.**

a. All food and drink shall be clean, wholesome, free from spoilage, and safe for human consumption. (II, III)

b. The use of food from salvaged, damaged, or unlabeled containers shall be prohibited. (III)

c. All perishable or potentially hazardous food shall be stored at safe temperatures of 45°F (7°C) or below, or 140°F (60°C) or above. (III)

d. No perishable food shall be allowed to stand at room temperature any longer than is required to prepare and serve. (III)

e. Supplies of staple foods for a minimum of a one-week period and or perishable foods for a minimum of a two-day period shall be maintained on the premises. Minimum food portion requirements for a low-cost plan shall conform to information supplied by the nutrition section of the department of health. (II, III)

f. Table service shall be attractive. Dishes shall be free of cracks, chips, and stains. (III)

g. If family-style service is used, all leftover prepared food that has been on the table shall be properly handled. (III)

h. Poisonous compounds shall not be kept in food storage or preparation areas. (II)

**63.19(4) Sanitation in food preparation area.**

a. "Food Service Sanitation Manual," revised 1976, U.S. Department of Health, Education, and Welfare, Public Health Service, U.S. Government Printing Office, Washington, D.C., shall be used as the established, nationally recognized reference for establishing and determining satisfactory compliance with food service sanitation.

b. Residents shall not be allowed in the food preparation area, unless indicated in their individualized care plans. (III)

c. In facilities licensed for over 15 beds, the kitchen shall not be used for serving meals to residents, food service personnel, or other staff. (III)

d. All foods, while being stored, prepared, displayed, served, or transported shall be protected against contamination from dust, flies, rodents, and other vermin. (II, III)

e. Food shall be protected from unclean utensils and worn surfaces, unnecessary handling, coughs and sneezes, flooding, drainage, and overhead leakage. (II, III)

f. All appliances and work areas shall be kept clean. (III)

g. There shall be written procedures established for cleaning all work and serving areas in facilities over 15 beds. (III)

h. A schedule for duties to be performed daily shall be posted in each food area. (III)

i. All cooking stoves in facilities of 15 or more beds shall be provided with a properly sized exhaust system and hood to eliminate excess heat, moisture, and odors from the kitchen. (III)

j. Spillage and breakage shall be cleaned up immediately. (III)

k. All garbage not mechanically disposed of shall be kept in nonabsorbent, cleanable containers pending disposal. All filled containers shall be covered and stored in a sanitary manner. (III)

l. The food service area shall be located so it will not be used as a passageway by residents, guests, or nonfood service staff. (III)

m. The walls, ceilings, and floors of all rooms in which food is prepared and served shall be in good repair, smooth, washable, and shall be kept clean. (III)

n. There shall be no washing, ironing, sorting, or folding of laundry in the food service area. Dirty linen shall not be carried through the food service area unless it is in sealed, leakproof containers. (III)

o. Ice shall be stored and handled in such a manner as to prevent contamination. Ice scoops should be sanitized daily and kept in a clean container. (III)

p. There shall be no animals or birds in the food preparation area. (III)

q. No dishes or cooking utensils shall be towel dried. (III)

r. In facilities of over 15 beds directions for the dishwashing procedure shall be posted and available to all kitchen personnel. (III)

s. If there is a dishwashing machine, it must provide a wash temperature of 140°F (60°C) to 160°F (71°C) and a rinse temperature of 170°F (70°C) to 180°F (82°C). (III)

t. The washing and sanitizing of dishes and utensils shall meet approved sanitation procedures and practices. In facilities of 15 or more beds, a mechanical dishwashing machine or three-compartment sink shall be used for washing dishes; a booster heater for the third compartment or sanitizing agent shall be used. (III)

u. All dishes, silverware, and cooking utensils shall be stored above the floor in a sanitary manner, in a clean, dry place protected from flies, splashes, dust, and other contaminants. (III)

v. Procedures for washing and handling dishes shall be followed in order to protect the welfare of the residents and employees. Persons handling dirty dishes shall not handle clean dishes without washing their hands. (III)

w. Dishes, silverware, and cooking utensils shall be properly cleaned by prerinsing or scraping, washing, sanitizing, and air-drying. (III)

**63.19(5) Hygiene of food service personnel.**

a. Food service personnel shall be free of communicable diseases and practice hygienic food-handling techniques. In the event food service employees are assigned duties outside the dietetic service, these duties shall not interfere with sanitation, safety, or time required for dietetic work assignments. Personnel recovering from a diagnosed intestinal infection shall submit a report from their

physician showing freedom from infection before returning to work in the food service department. (II, III)

*b.* Staff employees who are full-time food service personnel shall wear clean, washable uniforms that are not used for duties outside the food service area. In all facilities, employees shall wear clean, washable clothing when in the food service area. (III)

*c.* Hairnets shall be worn by all staff food service personnel. Total enclosure of facial hair shall be provided for staff personnel. (III)

*d.* Clean aprons and hairnets shall be available for use by other personnel in emergency situations. (III)

*e.* Persons handling food shall be knowledgeable of good hand-washing techniques. A hand-wash sink shall be provided in or adjacent to the food service area. Continuous on-the-job training on sanitation shall be encouraged. (III)

*f.* The use of tobacco shall be prohibited in the kitchen. (III)

**63.19(6) Food and drink.** All food and drink consumed within the facility shall be clean and wholesome and comply with local ordinances and applicable provisions of state and federal laws. (II, III)

**481—63.20(135C) Orientation program.**

**63.20(1)** The administrator or designee shall be responsible for developing a written, organized orientation program for all residents. (III)

**63.20(2)** The program shall be planned and implemented to resolve or reduce personal, family, business, and emotional problems that may interfere with the medical or health care, recovery, and rehabilitation of the individual. (III)

**481—63.21(135C) Individualized program of care.**

**63.21(1)** The individualized program of care, including specific goals and regular evaluation of progress, shall incorporate the social services, psychological, educational activities, and medical needs of the residents, and shall be designed by an interdisciplinary team. (II)

**63.21(2)** Each residential care facility for the intellectually disabled shall provide an organized resident activity program for the group and for the individual resident which shall include suitable activities for evenings and weekends. (III)

*a.* The activity program shall be designed to meet the needs and interests of each resident and to assist residents in continuing normal activities within limitations set by the resident's physician. This shall include helping residents continue in their individual interests or hobbies. (III)

*b.* The program shall include individual goals for each resident. (III)

*c.* The activity program shall include both group and individual activities. (III)

*d.* Residents shall be encouraged, but not forced, to participate in the activity program. (III)

**63.21(3) Coordination of activities program.**

*a.* Each residential care facility for the intellectually disabled with over 15 beds shall employ a person to direct the activities program. (III)

*b.* <sup>1</sup>Staffing for the activity program shall be <sup>2</sup>provided on the minimum basis of 45 minutes per licensed bed per week. (II, III)

*c.* The activity coordinator shall have completed the activity coordinators' orientation course offered through the department within six months of employment or have comparable training and experience as approved by the department. (III)

*d.* The activity coordinator shall attend workshops or educational programs which relate to activity programming. These shall total a minimum of ten contact hours per year. These programs shall be approved by the department. (III)

*e.* There shall be a written plan for personnel coverage when the activity coordinator is absent during scheduled working hours. (III)

**63.21(4) Duties of activity coordinator.** The activity coordinator shall:

*a.* Have access to all residents' records excluding financial records; (III)

- b.* Coordinate all activities, including volunteer or auxiliary activities and religious services; (III)
- c.* Keep all necessary records including:
  - (1) Attendance; (III)
  - (2) Individual resident progress notes recorded at regular intervals (at least every three months).
- (III)
  - (3) Monthly calendars, prepared in advance. (III)
- d.* Coordinate the activity program with all other services in the facility; (III)
- e.* Participate in the in-service training program in the facility. This shall include attending as well as presenting sessions. (III)

**63.21(5) Supplies, equipment, and storage.**

*a.* Each facility shall provide a variety of supplies and equipment of a nature calculated to fit the needs and interests of the residents. (III) These may include: books (standard and large print), magazines, newspapers, radio, television, and bulletin boards. Also appropriate would be box games, game equipment, songbooks, cards, craft supplies, record player, movie projector, piano, outdoor equipment, etc.

*b.* Storage shall be provided for recreational equipment and supplies. (III)

*c.* Locked storage should be available for potentially dangerous items such as scissors, knives, and toxic materials. (III)

[ARC 0765C, IAB 5/29/13, effective 7/3/13]

<sup>1</sup> Emergency, pursuant to Iowa Code section 17A.5(2)“b”(2).

<sup>2</sup> Objection filed 2/14/79; see Objection following 481—Ch 57.

**481—63.22(135C) Care review committee.** Each facility shall have a care review committee in accordance with Iowa Code section 135C.25, which shall operate within the scope of the rules for care review committees promulgated by the department on aging. (II)

**63.22(1) Role of committee in complaint investigations.**

*a.* The department shall notify the facility’s care review committee of a complaint from the public. The department shall not disclose the name of a complainant.

*b.* The department may refer complaints to the care review committee for initial evaluation or investigation by the committee pursuant to rules promulgated by the department on aging. Within ten days of completion of the investigation, the committee shall report to the department in writing the results of the evaluation of the investigation.

*c.* When the department investigates a complaint, upon conclusion of its investigation, it shall notify the care review committee and the department on aging of its findings, including any citations and fines issued.

*d.* Results of all complaint investigations addressed by the care review committee shall be forwarded to the department within ten days of completion of the investigation.

**63.22(2)** The care review committee shall, upon department request, be responsible for monitoring correction of substantiated complaints.

**63.22(3)** When requested, names, addresses and telephone numbers of family members shall be given to the care review committee, unless the family refuses. The facility shall provide a form on which a family member may refuse to have the member’s name, address or telephone number given to the care review committee.

**481—63.23(135C) Safety.** The licensee of a residential care facility for the intellectually disabled shall be responsible for the provision and maintenance of a safe environment for residents and personnel. (III)

**63.23(1) Fire safety.**

*a.* All residential care facilities for the intellectually disabled shall meet the fire safety rules and regulations as promulgated by the state fire marshal. (I, II)

*b.* The size and condition of the facility and needs of the residents shall be taken into consideration in evaluating safety precautions and practices.

**63.23(2) *Safety duties of administrator.*** The administrator shall have a written emergency plan to be followed in the event of fire, tornado, explosion, or other emergency which shall be rehearsed at least quarterly. (III)

*a.* The plan shall be available for review upon request. (III)

*b.* In-service shall be provided to ensure that all employees are knowledgeable of the emergency plan. (III)

**63.23(3) *Resident safety.***

*a.* Residents shall be permitted to smoke only where proper facilities are provided. Smoking shall not be permitted in bedrooms. Smoking by residents considered to be careless shall be prohibited except when the resident is under direct supervision. (II, III)

*b.* Smoking is prohibited in all rooms where oxygen is being administered or in rooms where oxygen is stored. (II, III)

*c.* Whenever full or empty tanks of oxygen are being used or stored, they shall be securely supported in an upright position. (II, III)

*d.* Smoking shall be permitted only in designated areas. (II, III)

*e.* Residents shall receive adequate supervision to ensure against hazards from themselves, others, or elements in the environment. (II, III)

**63.23(4) *Restraints.***

*a.* Residents shall not be kept behind locked doors.

*b.* Temporary seclusion of residents shall be used only in an emergency to prevent injury to the resident or to others pending transfer to appropriate placements.

*c.* A divided door equipped with a securing device that may be readily opened by personnel shall be considered an appropriate means of temporarily confining a resident in the resident's room.

*d.* Divided doors shall be of such type that when the upper half is closed the lower section shall close.

[ARC 0765C, IAB 5/29/13, effective 7/3/13]

#### **481—63.24(135C) Housekeeping.**

**63.24(1)** Written procedures shall be established and implemented for daily and weekly cleaning schedules. (III)

**63.24(2)** Each resident unit shall be cleaned on a routine schedule. (III)

**63.24(3)** All rooms, corridors, storage areas, linen closets, attics, and basements shall be kept in a clean, orderly condition, free of unserviceable furniture and equipment and accumulations of refuse. (III)

**63.24(4)** A hallway or corridor shall not be used for storage of equipment. (III)

**63.24(5)** All odors shall be kept under control by cleanliness and proper ventilation. (III)

**63.24(6)** Clothing worn by personnel shall be clean and washable. (III)

**63.24(7)** Housekeeping and maintenance personnel shall be provided with well-constructed and properly maintained equipment appropriate to the function for which it is to be used. (III)

**63.24(8)** All furniture, bedding, linens, and equipment shall be cleaned periodically and before use by another resident. (III)

**63.24(9)** Polishes used on floors shall provide a nonslip finish. (III)

**63.24(10)** Throw or scatter rugs shall not be permitted. (III)

**63.24(11)** Entrances, exits, steps, and outside walkways shall be kept free from ice, snow, and other hazards. (II, III)

**63.24(12)** Cleaning agents, bleaches, insecticides, or any other poisonous, dangerous, or flammable materials shall not be accessible to residents except as indicated in individualized programs of care. (II, III)

**63.24(13)** Sufficient numbers of noncombustible trash containers, which have covers, shall be available. (III)

**481—63.25(135C) Maintenance.**

**63.25(1)** Each facility shall establish a maintenance program to ensure the continued maintenance of the facility, to promote good housekeeping procedures, and to ensure sanitary practices throughout the facility. In facilities over 15 beds, this program shall be established in writing and available for review by the department. (III)

**63.25(2)** The building, grounds, and other buildings shall be maintained in a clean, orderly condition and in good repair. (III)

**63.25(3)** Draperies and furniture shall be clean and in good repair. (III)

**63.25(4)** Cracks in plaster, peeling wallpaper or paint, and tears or splits in floor coverings shall be promptly repaired or replaced in a professional manner. (III)

**63.25(5)** The electrical systems, including appliances, cords, and switches, shall be maintained to guarantee safe functioning and comply with the National Electrical Code. (III)

**63.25(6)** All plumbing fixtures shall function properly and comply with the state plumbing code. (III)

**63.25(7)** Yearly inspections of the heating and cooling systems shall be made to guarantee safe operation. (III)

**63.25(8)** The building, grounds, and other buildings shall be kept free of breeding areas for flies, other insects, and rodents. (III)

**63.25(9)** The facility shall be kept free of flies, other insects, and rodents. (III)

**63.25(10)** Janitor closet.

*a.* Facilities shall be provided with storage for cleaning equipment, supplies, and utensils. (III)

*b.* Mops, scrub pails, and other cleaning equipment used in the resident areas shall not be stored or used in the dietary area. (III)

*c.* In facilities licensed for over 15 beds, a janitor's closet shall be provided. It shall be equipped with water for filling scrub pails and janitor's sink for emptying scrub pails. (III)

**481—63.26(135C) Laundry.**

**63.26(1)** All soiled linens shall be collected in and transported to the laundry room in closed, leakproof laundry bags or covered, impermeable containers. (III)

**63.26(2)** Except for related activities, the laundry room shall not be used for other purposes. (III)

**63.26(3)** Procedures shall be written for the proper handling of wet, soiled, and contaminated linens. (III)

**63.26(4)** Residents' personal laundry shall be marked with an identification. (III)

**63.26(5)** Bed linens, towels, washcloths, and residents' clothing shall be clean and stain-free. (III)

**63.26(6)** If laundry is done in the facility, the following shall be provided:

*a.* A clean, dry, well-lighted area to accommodate a washer and dryer of adequate size to serve the needs of the facility. (III)

*b.* In facilities of over 15 beds, the laundry room shall be divided into separate areas, one for sorting soiled linen and one for sorting and folding clean linen. (III)

**481—63.27(135C) Garbage and waste disposal.**

**63.27(1)** All garbage shall be gathered, stored, and disposed of in a manner that will not permit transmission of disease, create a nuisance, or provide a breeding or feeding place for vermin or insects. (III)

**63.27(2)** All containers for refuse shall be watertight, rodent-proof, and have tight-fitting covers. (III)

**63.27(3)** All containers shall be thoroughly cleaned each time the containers are emptied. (III)

**63.27(4)** All wastes shall be properly disposed of in compliance with local ordinances and state codes. (III)

**63.27(5)** Special provision shall be made for the disposal of soiled dressings and similar items in a safe, sanitary manner. (III)

**481—63.28(135C) Buildings, furnishings, and equipment.****63.28(1) Buildings—general requirements.**

a. For purposes of computation of usable floor space in bedrooms and other living areas of the facility, that part of the room having no less than 7 feet of ceiling height shall be used. Usable floor space may include irregularities in the rooms such as alcoves and offsets with approval of the department. Usable floor space shall not include space needed for corridor door swings or wardrobes being used as a substitute for closet space. (III)

b. Battery-operated, portable emergency lights in good working condition shall be available at all times, at a ratio of one light per one employee on duty from 6 p.m. to 6 a.m. (III)

c. All windows shall be supplied with curtains and shades or drapes which are kept clean and in good repair. (III)

d. Light fixtures shall be so equipped to prevent glare and to prevent hazards to the residents. (III)

e. Exposed heating pipes, hot water pipes, or radiators in rooms and areas used by residents and within reach of residents shall be covered or protected to prevent injury or burns to residents. (II, III)

f. All fans located within 7 feet of the floor shall be protected by screen guards of not more than ¼-inch mesh. (III)

g. Whenever glass sliding doors or transparent panels are used, they shall be marked conspicuously. (III)

h. The facility shall meet the equivalent requirements of the appropriate group occupancy of the state building code. (III)

i. No part of any room shall be enclosed, subdivided, or partitioned unless such part is separately lighted and ventilated and meets such other requirements as its usage and occupancy dictates, except closets used for the storage of resident's clothing. (III)

j. All stairways in resident-occupied areas shall have substantial handrails on both sides. (III)

k. Each stairway shall have protective barriers. (III)

l. Screens of 16 mesh per square inch shall be provided at all hold-open openings. (III)

m. Screen doors shall swing outward and be self-closing. At the discretion of the state fire marshal, screens for fire doors may swing in. (III)

n. All resident rooms shall have a door. (III)

o. All rooms in resident-occupied areas shall have general lighting switched at the entrance to each room. (III)

**63.28(2) Furnishings and equipment.**

a. All furnishings and equipment shall be durable, cleanable, and appropriate to its function and in accordance with the department's approved program of care. (III)

b. All resident areas shall be decorated, painted, and furnished to provide a homelike atmosphere. (III)

c. Upholstery materials shall be moisture- and soil-resistant, except on furniture provided by the resident and the property of the resident. (III)

d. Night lights may be required in corridors, at stairways, attendant's stations and resident's bedrooms, and hazardous areas with no less than 1 foot-candle throughout the area at all times. (III)

**63.28(3) Dining and living rooms.**

a. Every facility over 15 beds shall have a dining room and a living room easily accessible to all residents. (III)

b. Dining rooms and living rooms shall at no time be used as bedrooms. (III)

c. Dining rooms and living rooms shall be available for use by residents at appropriate times to provide periods of social and diversional individual and group activities. (III)

d. A combination dining room and living room may be permitted if the space requirements of a multipurpose room as provided in 63.28(3) "e" of the rules are met. (III)

e. Multipurpose rooms. When space is provided for multipurpose dining and activities and recreational purposes, the area shall total at least 30 square feet per licensed bed for the first 100 beds and 27 square feet per licensed bed for all beds in excess of 100. An open area of sufficient size shall

be provided to permit group activities such as religious meetings or presentation of demonstrations or entertainment. (III)

*f.* Living rooms.

(1) Living rooms shall be maintained for the use of residents and their visitors and may be used for recreational activities. (III)

(2) Living rooms shall be suitably furnished. (III)

(3) When space is provided to be used only for activities and recreational purposes, the area shall be at least 15 square feet per licensed bed. At least 50 percent of the required area must be in one room. (III)

*g.* Dining rooms.

(1) Dining rooms shall be furnished with dining tables and chairs appropriate to the size and function of the facility. These rooms and furnishings shall be kept clean and sanitary. (III)

(2) When space is provided to be used only for dining, the area shall total at least 15 square feet per licensed bed. (III)

**63.28(4) Bedrooms.**

*a.* Each resident shall be provided with a standard, single, or twin bed, substantially constructed and in good repair. Rollaway beds, metal cots, or folding beds are not acceptable. (III)

*b.* Each bed shall be equipped with the following: casters or glides; clean springs in good repair; a clean, comfortable, well-constructed mattress approximately five inches thick and standard in size for the bed; clean, comfortable pillows of average bed size. (III)

*c.* Each resident shall have a bedside table with a drawer to accommodate personal possessions. (III)

*d.* There shall be a comfortable bedside chair per resident bed. The resident's personal wishes shall be considered. (III)

*e.* There shall be drawer space for each resident's clothing. In a multiple bedroom, drawer space shall be assigned each resident. (III)

*f.* Walls, ceilings, and floors shall have easily cleanable surfaces and shall be kept clean and in good repair. (III)

*g.* Beds and other furnishings shall not obstruct free passage to and through doorways. (III)

*h.* There shall be a wardrobe or closet in each resident's room. Minimum clear dimensions shall be 1 foot 10 inches deep by 1 foot 8 inches wide with full hanging space and provide a clothes rod and shelf. In a multiple bedroom, closet or wardrobe space shall be assigned each resident sufficient for the resident's needs. (III)

*i.* Beds shall not be placed with the head of the bed in front of a window or radiator. (III)

*j.* Beds shall not be placed in such a manner that the side of the bed is against the radiator or in close proximity to it unless it is covered so as to protect the resident from contact with it or from excessive heat. (III)

*k.* Reading lamps shall be provided each resident in the resident's room. (III)

*l.* Each room shall have sufficient accessible mirrors to serve residents' needs. (III)

*m.* Usable floor space of a room shall be no less than 8 feet in any major dimension. (III)

*n.* Bedrooms shall have a minimum of 80 square feet of usable floor space per bed. (III)

*o.* There shall be no more than four residents per room. (III)

*p.* Each resident room shall be provided with light and ventilation by means of a window or windows with an area equal to one-eighth of the total floor area. The windows shall be openable. (III)

**63.28(5) Bath and toilet facilities.**

*a.* Provision shall be made for bars to hold individual towels and washcloths. (III)

*b.* In facilities of over 15 beds all lavatories shall have paper towel dispensers and an available supply of soap. (III)

*c.* Minimum numbers of toilet and bath facilities shall be one lavatory, one toilet for each five residents, and one tub or shower for each ten residents or fraction thereof. (III)

*d.* There shall be a minimum of one bathroom with tub or shower, toilet stool and lavatory on each floor in multistory buildings for facilities licensed for over 15 beds. Separate toilets for the sexes shall be provided. (III)

*e.* Grab bars shall be provided at all toilet stools, tubs, and showers. Grab bars, accessories, and anchorage shall have sufficient strength to sustain a deadweight of 250 pounds for five minutes. (III)

*f.* Each toilet room shall have a door. (III)

*g.* All toilet, bath, and shower facilities shall be supplied with adequate safety devices appropriate to the needs of the individual residents. Raised toilet seats shall be available for residents who are aged or infirm. (III)

*h.* Toilet and bath facilities shall have an aggregate outside window area of at least 4 square feet. Facilities having a system of mechanical ventilation are exempt from this regulation. (III)

*i.* Every facility shall provide a toilet with grab bars and lavatory for the public and staff. (III)

**63.28(6) Heating.** A centralized heating system capable of maintaining a minimum temperature of 78°F (26°C) shall be provided. Portable units or space heaters are prohibited from being used in the facility except in an emergency. (III)

**63.28(7) Water supply.**

*a.* Every facility shall have an adequate water supply from an approved source. A municipal source of supply shall be considered as meeting this requirement. (III)

*b.* Private sources of supply shall be tested annually and the report submitted with the annual application for license. (III)

*c.* A bacterially unsafe source of supply shall be grounds for denial, suspension, or revocation of license. (III)

*d.* The department may require testing of private sources of supply at its discretion in addition to the annual test. The facility shall supply reports of such tests as directed by the department. (III)

*e.* Hot and cold running water under pressure shall be available in the facility. (III)

*f.* Prior to construction of a new facility or new water source, private sources of supply shall be surveyed and shall comply with the requirements of the department. (III)

**63.28(8) Sewage system.**

*a.* Sewage shall be collected and disposed of in a manner approved by the department. Disposal into a municipal system will be considered as meeting this requirement. (III)

*b.* Private sewage systems shall conform to the rules and regulations of the department of environmental quality, state health department, and the natural resources council. (III)

*c.* Every facility shall have an interior plumbing system complete with flushing device. (III)

**63.28(9) Attendant's station.** In facilities over 15 beds, an attendant's station with a minimum of 40 square feet shall be provided which is centrally located in the resident area and shall have a well-lighted desk with the necessary equipment for the keeping of required records and supplies. (III)

#### **481—63.29(135C) Family and employee accommodations.**

**63.29(1)** Children under 14 years of age shall not be allowed into the service areas in facilities of more than 15 beds. (III)

**63.29(2)** The residents' bedrooms shall not be occupied by employees, family members of employees, or family members of the licensee. (III)

**63.29(3)** In facilities where the total occupancy of family, employees, and residents is five or less, one toilet and one tub or shower shall be the minimum requirement. (III)

**63.29(4)** In facilities where the total occupancy of family, employees, and residents is more than five, separate bathing and toilet facilities shall be required for the family or employees distinct from such areas provided for residents. (III)

**63.29(5)** In facilities of more than 15 beds, if the family or employees live within the facility, separate living quarters and recreation facilities shall be required for the family or employees distinct from such areas provided for residents. (III)

**481—63.30(135C) Animals.** No animals shall be allowed within the facility except with written approval of the department and under controlled conditions. (III)

**481—63.31(135C) Environment and grounds.**

**63.31(1)** A residential care facility for the intellectually disabled shall be constructed in a neighborhood free from excessive noise, dirt, polluted or odorous air, or similar disturbances. (III)

**63.31(2)** There shall be an area available for outdoor activities calculated at 25 square feet per licensed bed. (III) Open-air porches may be included in meeting such requirement.

[ARC 0765C, IAB 5/29/13, effective 7/3/13]

**481—63.32(135C) Supplies.**

**63.32(1) Linen supplies.**

*a.* There shall be an adequate supply of linen so that each resident shall have at least three washcloths, hand towels, and bath towels per week. (III)

*b.* A complete change of bed linens shall be available in the linen storage area for each bed. (III)

*c.* Sufficient lightweight, clean, serviceable blankets shall be available. All blankets shall be laundered as often as necessary for cleanliness and freedom from odors. (III)

*d.* Each bed shall be provided with clean, washable bedspreads. There shall be a supply available when changes are necessary. (III)

*e.* Uncrowded and convenient storage shall be provided for linens, pillows, and bedding. (III)

**63.32(2) First-aid kit.** A first-aid emergency kit shall be available on each floor in every facility. (II, III)

**63.32(3) General supplies.**

*a.* All equipment shall be properly cleaned and sanitized before use by another resident. (III)

*b.* Clean and sanitary storage shall be provided for equipment and supplies. (III)

**481—63.33(135C) Residents' rights in general.**

**63.33(1)** Each facility shall ensure that policies and procedures are written and implemented which include, at a minimum, all of the following provisions subrules (63.33(2) to 63.33(6)) and which govern all areas of service provided by the facility. These policies and procedures shall be available to staff, residents, their families or legal representatives and the public and shall be reviewed annually. (II)

**63.33(2)** Policies and procedures regarding the admission, transfer, and discharge of residents shall ensure that:

*a.* Only those persons are accepted whose needs can be met by the facility directly or in cooperation with community resources or other providers of care with which it is affiliated or has contracts. (II)

*b.* As changes occur in residents' physical or mental condition, necessitating services or care which cannot be adequately provided by the facility, they are transferred promptly to other appropriate facilities. (II)

**63.33(3)** Policies and procedures regarding the use of chemical and physical restraints shall define the use of restraints and identify the individual who may authorize the application of physical restraints in emergencies, and describe the mechanism for monitoring and controlling their use. (II)

**63.33(4)** Policies and procedures shall include a method for submitting complaints and recommendations by residents or their responsible party and for ensuring a response and disposition by the facility. (II)

**63.33(5)** Policies and procedures shall include provisions governing access to, duplication of, and dissemination of information from the residents' records. (II)

**63.33(6)** Policies and procedures shall include a provision that each resident shall be fully informed of the resident's rights and responsibilities as a resident and of all rules governing resident conduct and responsibilities. The information must be provided upon admission or in the case of residents already in the facility upon the facility's adoption or amendment of resident right policies.

*a.* The facility shall make known to residents what they may expect from the facility and its staff, and what is expected from them. The facility shall communicate these expectations during the period of not more than two weeks before or five days after admission. The communication shall be in writing, e.g., in a separate handout or brochure describing the facility, and interpreted verbally, e.g., as part of a preadmission interview, resident counseling, or in individual or group orientation sessions following admission. (II)

*b.* Residents' rights and responsibilities shall be presented in language understandable to the resident. If the facility serves residents who are non-English-speaking or deaf, steps shall be taken to translate the information into a foreign or sign language. In the case of blind residents, either Braille or a recording shall be provided. Residents shall be encouraged to ask questions about their rights and responsibilities and these questions shall be answered. (II)

*c.* A statement shall be signed by the resident, or responsible party, indicating an understanding of these rights and responsibilities, and shall be maintained in the record. The statement shall be signed no later than five days after admission, and a copy of the signed statement shall be given to the resident or responsible party, if applicable. In the case of an intellectually disabled resident, the signature shall be witnessed by a person not associated with or employed by the facility. The witness may be a parent, guardian, Medicaid agency representative, etc. (II)

*d.* In order to ensure that residents continue to be aware of these rights and responsibilities during their stay, a written copy shall be prominently posted in a location that is available to all residents. (II)

*e.* All residents shall be advised within 30 days following changes made in the statement of residents' rights and responsibilities. Appropriate means shall be utilized to inform non-English-speaking, deaf, or blind residents of such changes. (II)

**63.33(7)** Each resident or responsible party shall be fully informed in a contract as required in rule 481—63.14(135C), prior to or at the time of admission and during the resident's stay, of services available in the facility, and of related charges not covered by the facility's basic per diem rate. (II)

**63.33(8)** Each resident or responsible party shall be fully informed by a physician of the resident's health and medical condition unless medically contraindicated (as documented by a physician in the resident's record). Each resident shall be afforded the opportunity to participate in the planning of the resident's total care and medical treatment, which may include, but is not limited to, nursing care, nutritional care, rehabilitation, restorative therapies, activities, and social work services. Each resident only participates in experimental research conducted under the U.S. Department of Health and Human Services' protection from research risks policy and then only upon the resident's informed written consent. Each resident has the right to refuse treatment except as provided by Iowa Code chapter 229. In the case of a confused or intellectually disabled individual, the responsible party shall be informed by the physician of the resident's medical condition and be afforded the opportunity to participate in the planning of the resident's total care and medical treatment, to be informed of the medical condition, and to refuse to participate in experimental research. (II)

*a.* The requirement that residents shall be informed of their conditions, involved in the planning of their care, and advised of any significant changes in either, shall be communicated to every physician responsible for the medical care of residents in the facility. (II)

*b.* The administrator or designee shall be responsible for working with attending physicians in the implementation of this requirement. (II)

*c.* If the physician determines or in the case of a confused or intellectually disabled resident the responsible party determines that informing the resident of the resident's condition is contraindicated, this decision and reasons for it shall be documented in the resident's record by the physician. (II)

*d.* Any clinical investigation involving residents must be under the sponsorship of an institution with a human subjects review board functioning in accordance with the requirements of Public Law 93-348, as implemented by Part 46 of Title 45 of the Code of Federal Regulations, as amended December 1, 1981 (45 CFR 46). A resident being considered for participation in experimental research must be fully informed of the nature of the experiment, e.g., medication, treatment, and understand

the possible consequences of participating or not participating. The resident's (or responsible party's) written informed consent must be received prior to participation. (II)

[ARC 0765C, IAB 5/29/13, effective 7/3/13]

**481—63.34(135C) Involuntary discharge or transfer.**

**63.34(1)** A facility shall not involuntarily discharge or transfer a resident from a facility except: for medical reasons; for the resident's welfare or that of other residents; for nonpayment for the resident's stay (as contained in the contract for the resident's stay), and by reason of action pursuant to Iowa Code chapter 229. (I, II)

*a.* "Medical reasons" for transfer or discharge are based on the resident's needs and are determined and documented in the resident's record by the attending physician. Transfer or discharge may be required to provide a different level of care. (II)

*b.* "Welfare" of a resident or that of other residents refers to their social, emotional, or physical well-being. A resident might be transferred or discharged because the resident's behavior poses a continuing threat to the resident (e.g., suicidal) or to the well-being of other residents or staff (e.g., the resident's behavior is incompatible with their needs and rights). Evidence that the resident's continued presence in the facility would adversely affect the resident's own welfare or that of other residents shall be made by the administrator or designee and shall be in writing and shall include specific information to support this determination. (II)

*c.* Involuntary transfer or discharge of a resident from a facility shall be preceded by a written notice to the resident or responsible party at least 30 days in advance of the proposed transfer or discharge. The 30-day requirement shall not apply in any of the following instances:

(1) If an emergency transfer or discharge is mandated by the resident's health care needs and is in accord with the written orders and medical justification of the attending physician. Emergency transfers or discharges may also be mandated to protect the health, safety, or well-being of other residents and staff from the resident being transferred. (II)

(2) If the transfer or discharge is subsequently agreed to by the resident or the resident's responsible party, and notification is given to the responsible party, physician, and the person or agency responsible for the resident's placement, maintenance, and care in the facility. (II)

*d.* The notice required by paragraph "*c*" shall contain all of the following information:

(1) The stated reason for the proposed transfer or discharge. (II)

(2) The effective date of the proposed transfer or discharge. (II)

(3) A statement in not less than 12-point type (elite), which reads: "You have a right to appeal the facility's decision to transfer or discharge you. If you think you should not have to leave this facility, you may request a hearing in writing or verbally with the Iowa state department of inspections and appeals (hereinafter referred to as "department") within 7 days after receiving this notice. You have a right to be represented at the hearing by an attorney or any other individual of your choice. If you request a hearing, it will be held no later than 14 days after receipt of your request by the department and you will not be transferred prior to a final decision. Provision may be made for extension of the 14-day requirement upon request to the department of inspections and appeals designee in emergency circumstances. If you lose the hearing, you will not be transferred before the expiration of 30 days following receipt of the original notice of the discharge or transfer, or no sooner than 5 days following final decision of such hearing. To request a hearing or receive further information, call the department at (515)281-4115 or you may write to the department to the attention of: Administrator, Division of Health Facilities, Department of Inspections and Appeals, Lucas State Office Building, Des Moines, Iowa 50319-0083." (II)

*e.* A request for a hearing made under 63.34(1) "*d*"(3) shall stay a transfer or discharge pending a hearing or appeal decision. (II)

*f.* The type of hearing shall be determined by a representative of the department. Notice of the date, time, and place of the hearing shall be sent by certified mail or delivered in person to the licensee, resident, responsible party, and Iowa department on aging long-term care ombudsman of record not later than five full business days after receipt of the request. This notice shall also inform the licensee, resident or responsible party, that they have a right to appear at the hearing in person or be represented by their

attorneys or other individual. The hearing shall be dismissed if neither party is present or represented at the hearing. If only one party appears or is represented, the hearing shall proceed with one party present. The Iowa department on aging long-term care ombudsman shall have the right to appear at the hearing.

*g.* The hearing shall be heard by a department of inspections and appeals designee pursuant to Iowa Code chapter 17A. (The hearing shall be public unless the resident or the resident's representative requests in writing that it be closed.) The licensee or designee shall have the opportunity to present to the representative of the department any oral testimony or written materials to show by a preponderance of the evidence just cause why a transfer or discharge may be made. The resident and responsible party shall also have an opportunity to present to the representative of the department any oral testimony or written material to show just cause why a transfer or discharge should not be made. In a determination as to whether a transfer or discharge is authorized, the burden of proof rests on the party requesting the transfer or discharge.

*h.* Based upon all testimony and materials submitted to the representative of the department, the representative shall issue, in accordance with Iowa Code chapter 17A, written findings of fact and conclusions of law and issue a decision and order in respect to the adverse action. This decision shall be mailed by certified mail to the licensee, resident, responsible party, and department on aging long-term care ombudsman within 10 working days after the hearing has been concluded. The representative shall have the power to issue fines and citations against the facility in appropriate circumstances.

A request for review of a proposed decision in which the department is the final decision maker shall be made within 15 days of issuance of the proposed decision, unless otherwise provided by statute. Requests shall be mailed or delivered by either party to the Director, Department of Inspections and Appeals, Lucas State Office Building, Des Moines, Iowa 50319-0083. Failure to request review will preclude judicial review unless the department reviews a proposed decision upon its own motion within 15 days of the issuance of the decision.

*i.* A copy of the notice required by paragraph "c" shall be personally delivered to the resident and a copy placed in the resident's record. A copy shall also be transmitted to the department, the resident's responsible party, physician, the person or agency responsible for the resident's placement, maintenance, and care in the facility, and the department on aging long-term care ombudsman.

*j.* If nonpayment is the basis for involuntary transfer or discharge, the resident shall have the right to make full payment up to the date that the discharge or transfer is to be made and then shall have the right to remain in the facility. (II)

*k.* The involuntary transfer or discharge shall be discussed with the resident, the resident's responsible party, and the person or agency responsible for the resident's placement, maintenance, and care in the facility within 48 hours after notice of discharge has been received. The explanation and discussion of the reasons for involuntary transfer or discharge shall be given by the facility administrator or other appropriate facility representative as the administrator's designee. The content of the discussion and explanation shall be summarized in writing and shall include the names of the individuals involved in the discussions and made a part of the resident's record. (II)

*l.* The resident shall receive counseling services before (by the sending facility) and after (by the receiving facility) the involuntary transfer to minimize the possible adverse effects of the involuntary transfer. Counseling shall be documented in the resident's record. (II)

- (1) Counseling shall be provided by a qualified individual who meets one of the following criteria:
  1. Has a bachelor's or master's degree in social work from an accredited college. (II)
  2. Is a graduate of an accredited four-year college and has had at least one year of full-time paid employment in a social work capacity with public or private agency. (II)
  3. Has been employed in a social work capacity for a minimum of four years in a public or private agency. (II)
  4. Is a licensed psychologist or psychiatrist. (II)
  5. Is any other person of the resident's choice. (II)
- (2) The facility shall develop a plan to provide for the orderly and safe transfer or discharge of each resident to be discharged or transferred. (II)

(3) The receiving health care facility of a resident involuntarily discharged or transferred shall immediately formulate and implement a plan of care which takes into account possible adverse effects the transfer may cause. (II)

*m.* In the case of an emergency transfer or discharge as outlined in 63.34(1) “c”(1), the resident must still be given a written notice prior to or within 48 hours following transfer or discharge. A copy of this notice must be placed in the resident’s file and it must contain all the information required by 63.34(1) “d”(1) and (2). In addition, the notice must contain a statement in not less than 12-point type (elite), which reads: “You have a right to appeal the facility’s decision to transfer or discharge you on an emergency basis. If you think you should not have to leave this facility, you may request a hearing in writing or verbally with the Iowa state department of inspections and appeals within 7 days after receiving this notice. If you request a hearing, it will be held no later than 14 days after receipt of your request by the department. You may be transferred or discharged before the hearing is held or before a final decision is rendered. If you win the hearing, you have the right to be transferred back into the facility. To request a hearing or receive further information, call the department at (515)281-4115 or you may write to the department to the attention of: Administrator, Division of Health Facilities, Department of Inspections and Appeals, Lucas State Office Building, Des Moines, Iowa 50319-0083.” A hearing requested pursuant to this subrule shall be held in accordance with paragraphs “f,” “g,” and “h.” (II)

*n.* Residents shall not have the right to a hearing to contest an involuntary discharge or transfer resulting from the revocation of the facility’s license by the department of inspections and appeals. In the case of a facility voluntarily closing, a period of 30 days must be allowed for an orderly transfer of residents to other facilities.

**63.34(2) Intrafacility transfer:**

*a.* Residents shall not be relocated from room to room within a licensed health care facility arbitrarily. (I, II) Involuntary relocation may occur only in the following situations and such situation shall be documented in the resident’s record.

(1) Incompatibility with or disturbing to other roommates, as documented in the resident’s record.  
 (2) For the welfare of the resident or other residents of the facility.  
 (3) For medical, nursing or psychosocial reasons, as documented in the resident’s record, as judged by the attending physician, nurse or social worker in the case of a facility which groups residents by medical, nursing or psychosocial needs.

(4) To allow a new admission to the facility which would otherwise not be possible due to separation of roommates by sex.

(5) In the case of a resident whose source of payment was previously private, but who now is eligible for Title XIX assistance, the resident may be transferred from a private room to a semiprivate room or from one semiprivate room to another.

(6) Reasonable and necessary administrative decisions regarding the use and functioning of the building.

*b.* Unreasonable and unjustified reasons for changing a resident’s room without the concurrence of the resident, or responsible party include:

- (1) Change from private pay status to Title XIX, except as outlined in 63.34(2) “a”(5). (II)
- (2) As punishment or behavior modification (except as specified in 63.34(2) “a”(1). (II)
- (3) Discrimination on the basis of race or religion. (II)

*c.* If intrafacility relocation is necessary for reasons outlined in paragraph “a,” the resident shall be notified at least 48 hours prior to the transfer and the reason therefor shall be explained. The responsible party shall be notified as soon as possible. Notification shall be documented in the resident’s record and signed by the resident or responsible party. (II)

*d.* If emergency relocation is required to protect the safety or health of the resident or other residents, the notification requirements may be waived. The conditions of the emergency shall be documented. The family or responsible party shall be notified immediately or as soon as possible of the condition requiring emergency relocation and the notification shall be documented. (II)

**481—63.35(135C) Resident rights.** Each resident shall be encouraged and assisted throughout the resident's period of stay, to exercise the resident's rights as a resident and as a citizen and may voice grievances and recommend changes in policies and services to administrative staff or to outside representatives of the resident's choice, free from interference, coercion, discrimination, or reprisal. (II)

**63.35(1)** The facility shall provide ongoing opportunities for residents to be aware of and to exercise their rights as residents. Residents shall be kept informed of issues or pending decisions of the facility that affect them and their views shall be solicited prior to action. (II)

**63.35(2)** The facility shall implement a written procedure for registering and resolving grievances and recommendations by residents or their responsible party. The procedure shall ensure protection of the resident from any form of reprisal or intimidation. The written procedure shall include:

- a. Designation of an employee responsible for handling grievances and recommendations. (II)
- b. A method of investigating and assessing the validity of a grievance or recommendation. (II)
- c. Methods of resolving grievances. (II)
- d. Methods of recording grievances and actions taken. (II)

**63.35(3)** The facility shall post in a prominent area the name, telephone number, and address of the ombudsman, survey agency, local law enforcement agency, care review committee members, the text of Iowa Code section 135C.46, etc., to provide to residents a further course of redress. (II)

**481—63.36(135C) Financial affairs—management.** Each resident, who has not been assigned a guardian or conservator by the court, may manage personal financial affairs, and to the extent, under written authorization by the resident that the facility assists in management, the management shall be carried out in accordance with Iowa Code section 135C.24. (II)

**63.36(1)** The facility shall maintain a written account of all residents' funds received by or deposited with the facility. (II)

**63.36(2)** An employee shall be designated in writing to be responsible for resident accounts. (II)

**63.36(3)** The facility shall keep on deposit personal funds over which the resident has control in accordance with Iowa Code section 135C.24(2). Should the resident request these funds, they shall be given to the resident on request with receipts maintained by the facility and a copy to the resident. In the case of a confused or intellectually disabled resident, the resident's responsible party shall designate a method of disbursing the resident's funds. (II)

**63.36(4)** If the facility makes financial transactions on a resident's behalf, the resident must receive or acknowledge having seen an itemized accounting of disbursements and current balances at least quarterly. A copy of this statement shall be maintained in the resident's financial or business record. (II)

**63.36(5)** A resident's personal funds shall not be used without the written consent of the resident or the resident's guardian. (II)

**63.36(6)** A resident's personal funds shall be returned to the resident when the funds have been used without the written consent of the resident or the resident's guardian. The department may report findings that resident funds have been used without written consent to the audits division or the local law enforcement agency, as appropriate. (II)

[ARC 0765C, IAB 5/29/13, effective 7/3/13]

**481—63.37(135C) Resident abuse prohibited.** Each resident shall receive kind and considerate care at all times and shall be free from mental and physical abuse. Each resident shall be free from chemical and physical restraints, except in an emergency for the shortest amount of time necessary to protect the resident from injury to the resident or to others, pending the immediate transfer to an appropriate facility. The decision to use restraints on an emergency basis shall be made by the designated charge person who shall promptly report the action taken to the physician and the reasons for using restraints shall be documented in the resident's record. Mechanical supports used in normative situations to achieve proper body position and balance shall not be considered to be a restraint. (II)

**63.37(1)** Mental abuse includes, but is not limited to, humiliation, harassment, and threats of punishment or deprivation. (II)

**63.37(2)** Physical abuse includes, but is not limited to, corporal punishment and the use of restraints as punishment. (II)

**63.37(3)** Drugs such as tranquilizers may not be used as chemical restraints to limit or control resident behavior for the convenience of staff or as a substitute for program. (II)

**63.37(4)** Upon a claim of dependent adult abuse of a resident being reported, the administrator of the facility shall separate the victim and accused abuser immediately and maintain that separation until the abuse investigation is completed. (I, II)

**63.37(5)** Suspected abuse reports. The department shall investigate all complaints of dependent adult abuse which are alleged to have happened in a health care facility. The department shall inform the department of human services of the results of all evaluations and dispositions of dependent adult abuse investigations.

**63.37(6)** Pursuant to Iowa Code chapter 235B, a mandatory reporter of dependent adult abuse is any person who, in the course of employment, examines, attends, counsels, or treats a dependent adult and reasonably believes the dependent adult has suffered abuse. This includes a member of the staff or employee of a health care facility. (II, III)

If a staff member or employee is required to report pursuant to this subrule, the staff member or employee shall immediately notify the person in charge of the facility or the person's designated agent, and the person in charge or the designated agent shall make the report to the department of human services. (II, III)

This rule is intended to implement Iowa Code subsections 235B.3(1) and 235B.3(11).

**481—63.38(135C) Resident records.** Each resident shall be ensured confidential treatment of all information contained in the resident's records, including information contained in an automatic data bank. The resident's written consent shall be required for the release of information to persons not otherwise authorized under law to receive it. (II)

**63.38(1)** The facility shall limit access to any medical records to staff and consultants providing professional service to the resident. This is not meant to preclude access by representatives of state and federal regulatory agencies. (II)

**63.38(2)** Similar procedures shall safeguard the confidentiality of residents' personal records, e.g., financial records and social services records. Only those personnel concerned with the financial affairs of the residents may have access to the financial records. This is not meant to preclude access by representatives of state and federal regulatory agencies. (II)

**63.38(3)** The resident, or the resident's responsible party, shall be entitled to examine all information contained in the resident's record and shall have the right to secure full copies of the record at reasonable cost upon request, unless the physician determines the disclosure of the record or section thereof is contraindicated in which case this information will be deleted prior to making the record available to the resident or responsible party. This determination and the reasons for it must be documented in the resident's record. (II)

**481—63.39(135C) Dignity preserved.** The resident shall be treated with consideration, respect, and full recognition of the resident's dignity and individuality, including privacy in treatment and in care for the resident's personal needs. (II)

**63.39(1)** Staff shall display respect for residents when speaking with, caring for, or talking about them, as constant affirmation of their individuality and dignity as human beings. (II)

**63.39(2)** Schedules of daily activities shall allow maximum flexibility for residents to exercise choice about what they will do and when they will do it. Residents' individual preferences regarding such things as menus, clothing, religious activities, friendships, activity programs, entertainment, sleeping and eating, also times to retire at night and arise in the morning shall be elicited and considered by the facility. (II)

**63.39(3)** Residents shall be examined and treated in a manner that maintains the privacy of their bodies. A closed door or a drawn curtain shall shield the resident from passersby. People not involved

in the care of the residents shall not be present without the resident's consent while the resident is being examined or treated. (II)

**63.39(4)** Privacy of a resident's body also shall be maintained during toileting, bathing, and other activities of personal hygiene, except as needed for resident safety or assistance. (II)

**63.39(5)** Staff shall knock and be acknowledged before entering a resident's room unless the resident is not capable of a response. This shall not apply under emergency conditions. (II)

**481—63.40(135C) Resident work.** No resident may be required to perform services for the facility, except as provided by Iowa Code sections 35D.14 and 347B.5. (II)

**63.40(1)** Residents may not be used to provide a source of labor for the facility against their will. Physician's approval is required for all work programs. (I, II)

**63.40(2)** If the plan of care requires activities for therapeutic or training reasons, the plan for these activities shall be professionally developed and implemented. Therapeutic or training goals must be clearly stated and measurable and the plan shall be time-limited and reviewed at least quarterly. (II)

**63.40(3)** Residents who perform work for the facility must receive remuneration unless such work is part of their approved training program. Persons on the resident census performing work shall not be used to replace paid employees in fulfilling staff requirements. (II)

**481—63.41(135C) Communications.** Each resident may communicate, associate, and meet privately with persons of the resident's choice, unless to do so would infringe upon the rights of other residents, and may send and receive personal mail unopened. (II)

**63.41(1)** Subject to reasonable scheduling restrictions, visiting policies and procedures shall permit residents to receive visits from anyone they wish. Visiting hours shall be posted. (II)

**63.41(2)** Reasonable, regular visiting hours shall not be less than 12 hours per day and shall take into consideration the special circumstances of each visitor. A particular visitor(s) may be restricted by the facility for one of the following reasons:

*a.* The resident refuses to see the visitor. (II)

*b.* The resident's physician documents specific reasons why such a visit would be harmful to the resident's health. (II)

*c.* The visitor's behavior is unreasonably disruptive to the functioning of the facility (this judgment must be made by the administrator and the reasons shall be documented and kept on file). (II)

**63.41(3)** Decisions to restrict a visitor are reviewed and reevaluated: each time the medical orders are reviewed by the physician; at least quarterly by the facility's staff; or at the resident's request. (II)

**63.41(4)** Space shall be provided for residents to receive visitors in reasonable comfort and privacy. (II)

**63.41(5)** Telephones consistent with ANSI standards (405.1134(c)) shall be available and accessible for residents to make and receive calls with privacy. Residents who need help shall be assisted in using the telephone. (II)

**63.41(6)** Arrangements shall be made to provide assistance to residents who require help in reading or sending mail. (II)

**63.41(7)** Residents shall be permitted to leave the facility and environs at reasonable times unless there are justifiable reasons established in writing by the attending physician, qualified intellectual disabilities professional or facility administrator for refusing permission. (II)

**63.41(8)** Residents shall not have their personal lives regulated beyond reasonable adherence to meal schedules, bedtime hours, and other written policies which may be necessary for the orderly management of the facility and as required by these rules. However, residents shall be encouraged to participate in recreational programs. (II)

[ARC 0765C, IAB 5/29/13, effective 7/3/13]

**481—63.42(135C) Resident activities.** Each resident may participate in activities of social, religious, and community groups at the resident's discretion unless contraindicated for reasons documented by

the attending physician or qualified intellectual disabilities professional as appropriate in the resident's record. (II)

**63.42(1)** Residents who wish to meet with or participate in activities of social, religious, or other community groups in or outside of the facility shall be informed, encouraged, and assisted to do so. (II)

**63.42(2)** All residents shall have the freedom to refuse to participate in these activities. (II)  
[ARC 0765C, IAB 5/29/13, effective 7/3/13]

**481—63.43(135C) Resident property.** Each resident may retain and use personal clothing and possessions as space permits and provided such use is not otherwise prohibited by these rules. (II)

**63.43(1)** Residents shall be permitted to keep reasonable amounts of personal clothing and possessions for their use while in the facility. The personal property shall be kept in a safe location which is convenient to the resident. (II)

**63.43(2)** Residents shall be advised, prior to or at the time of admission, of the kinds and amounts of clothing and possessions permitted for personal use, and whether the facility will accept responsibility for maintaining these items, e.g., cleaning and laundry. (II)

**63.43(3)** Any personal clothing or possessions retained by the facility for the resident during the resident's stay shall be identified and recorded on admission and a record placed on the resident's chart. The facility shall be responsible for secure storage of such items, and they shall be returned to the resident promptly upon request or upon discharge from the facility. (II)

**63.43(4)** A resident's personal property shall not be used without the written consent of the resident or the resident's guardian. (II)

**63.43(5)** A resident's personal property shall be returned to the resident when it has been used without the written consent of the resident or the resident's guardian. The department may report findings that a resident's property has been used without written consent to the local law enforcement agency, as appropriate. (II)

**481—63.44(135C) Family visits.** Each resident, if married, shall be ensured privacy for visits by the resident's spouse; if both are residents in the facility, they shall be permitted to share a room, if possible. (II)

**63.44(1)** The facility shall provide for needed privacy in visits between spouses. (II)

**63.44(2)** Spouses who are residents in the same facility shall be permitted to share a room, if available, unless one of their attending physicians documents in the medical record those specific reasons why an arrangement would have an adverse effect on the health of the resident. (II)

**63.44(3)** Family members shall be permitted to share a room, if available, if requested by both parties, unless one of their attending physicians documents in the medical record those specific reasons why such an arrangement would have an adverse effect on the health of the resident. (II)

**481—63.45(135C) Choice of physician.** Each resident shall be permitted free choice of a physician and a pharmacy, if accessible. The facility may require the pharmacy selected to utilize a drug distribution system compatible with the system currently used by the facility. (II)

**481—63.46(135C) Incompetent resident.**

**63.46(1)** Each facility shall provide that all rights and responsibilities of the resident devolve to the resident's responsible party when a resident is adjudicated incompetent in accordance with state law or, in the case of a resident who has not been adjudicated incompetent under the laws of the state, in accordance with 42 CFR 483.10. This subrule is not intended to limit the authority of any individual acting pursuant to Iowa Code chapter 144A. (II)

**63.46(2)** The fact that a resident has been adjudicated incompetent does not absolve the facility from advising the resident of these rights to the extent the resident is able to understand them. The facility shall also advise the responsible party, if any, and acquire a statement indicating an understanding of residents' rights. (II)

**481—63.47(135C) Specialized license for three- to five-bed facilities.** The specialized license is for residential care facilities which serve persons with intellectual disabilities, chronic mental illness and other developmental disabilities having five or fewer residents as specified in Iowa Code section 225C.26. The facility is exempt from Iowa Code section 135.63. For this specialized license, all rules of 481—Chapter 63 apply except those which are deleted or amended, as indicated in subsequent rules.

**63.47(1)** The provider may apply for a specialized license from the department of inspections and appeals. Before the license is granted, the provider shall meet all of the following requirements:

*a.* Compliance with program requirements pursuant to Iowa Code chapter 135C and administrative rules relating to residential care facilities adopted by the state board of health, or standards adopted by the Accreditation Council for Services for Persons with Mental Retardation and Other Developmental Disabilities (1984). The program of care shall emphasize an age-appropriate and least restrictive program.

*b.* The facility shall be located in areas zoned for single- or multiple-family housing, or be located in an unincorporated area, and shall be constructed in compliance with applicable local housing codes and rules adopted for this classification of license by the state fire marshal. (II, III)

*c.* The facility shall be appropriately accessible to residents who have disabilities. (II, III)

*d.* Written plans shall demonstrate that the facility meets the needs of the residents pursuant to individual program plans meeting age-appropriate and least restrictive program requirements. (II)

*e.* Written plans shall demonstrate the residents have reasonable access to employment for job-related training, education, generic community resources, or integrated opportunities to promote community interaction. (II)

*f.* Unless documented as appropriate within the residents' individual program plans, populations with primary diagnosis of chronic mental illness or intellectual disability/developmental disability may not be residents of the same specialized license facility. (II, III)

**63.47(2)** The housing for persons with intellectual disabilities, chronic mental illness, and other developmental disabilities, developed pursuant to this rule shall be eligible for funding utilized by licensed residential care facilities for the intellectually disabled.

**63.47(3)** Rescinded IAB 6/27/90, effective 8/1/90.

**63.47(4)** Rescinded IAB 6/27/90, effective 8/1/90.

**63.47(5)** The director of the department of inspections and appeals shall appoint a specialized license committee not to exceed nine members. This committee shall monitor the program rules and procedures adopted for this classification of license.

**63.47(6)** All conditions and criteria in 481—Chapter 63 apply to the specialized license with the exception of the following deletions: 481—63.7(135C), 63.8(2)“b,” 63.8(7)“b,” 63.13(1)“l,” 63.18(1)“b”(9), 63.19(1)“a,” “b,” “c,” 63.19(2)“c”(1), “e,” “g,” 63.19(4)“a,” “b,” “c,” “g,” “h,” “i,” “l,” “n,” “p,” “q,” “r,” “t,” 63.19(5)“b,” “c,” “d,” 63.21(1), (2), (3)“a” to “e,” (4)“a,” “b,” “c”(1) to (3), “d,” “e,” 63.21(5)“c,” 63.23(3)“c,” 63.23(4)“c,” “d,” 63.24(1), (7), (10), 63.25(10)“b,” 63.26(1) to (4), (6)“b,” 63.27(3) to (5), 63.28(1)“a,” “b,” “f,” “g,” “k,” “l,” “m,” “o,” 63.28(2)“c,” 63.28(3)“a,” “d,” “e,” “f”(3), “g”(2), 63.28(5)“b,” “i,” 63.28(9), 63.29(1), (4), (5), 63.33(6)“d.”

**63.47(7)** The following rules in Chapter 63 are amended for this specialized license as follows:

1. 63.3(1)“a” and 63.3(2)—Delete all references to 481—Chapter 60.

2. 63.8(1)“a”—Add “or qualified mental health professional (III)” after “qualified intellectual disabilities professional”. (III)

3. 63.8(2)—Add “For purposes of the specialized license, the administrator may act as an administrator for not more than three residential care facilities for the intellectually disabled, chronic mentally ill, and developmentally disabled.” (II)

4. 63.9(1)—Add “For purposes of the specialized license there shall be written personnel policies in all facilities to include hours of work and attendance at the education program.” (III)

5. 63.11(1)“a”—Delete the words “a managerial role of” in line 2.

6. 63.11(2)“b”—Delete the second sentence and “with 15 or less beds” in the third sentence.

7. 63.14(5)“b”—Add “or guardian” after “resident” in the first line.

8. 63.17(1)—Add a new paragraph: “v. Current Individual Program Plans (IPP)”.

9. 63.17(5) “a” —Add “For the specialized license, a job description shall be in the individual’s personnel file.” (III)
10. 63.19(2) “b” —Delete from the end “Recommended daily dietary allowances are:” Also delete subparagraphs (1) to (5).
11. 63.19(2) “f” —Delete the second sentence.
12. 63.19(3) “e” —Delete “for a minimum of a one-week period” in the first line.
13. 63.19(4) “m” —Delete “smooth, washable,” in the second line.
14. 63.19(4) “o” —Delete the second sentence.
15. 63.19(4) “s” —Add “and rinse” after “wash” in the first line and then delete the rest of the sentence after “(60°C)”.
16. 63.19(4) “w” —Change “or” to “and” in the first line and delete “,washing, sanitizing, and air-drying”.
17. 63.19(5) “b” —Delete the second sentence.
18. 63.19(5) “f” —Add “during food preparation” after “kitchen”.
19. 63.24(9) —Change “nonslip” to “slip-resistant” in the first sentence.
20. 63.25(1) —Delete the second sentence.
21. 63.28(1) “j” —Change “on both sides” in the first line to “on at least one side”.
22. 63.28(4) “n” —Change to read “Bedrooms shall have a minimum of 60 square feet for double, 80 square feet for single, and 100 square feet physical (wheelchair).” (III)
23. 63.28(4) “o” —Change “four” to “two”.
24. 63.28(5) “c” —Amend to read: “Minimum numbers of toilets and bath facilities shall be one for each five residents.” (III)
25. 63.28(5) “d” —Amend to read: “There shall be a minimum of one bathroom with tub or shower, toilet stool, and lavatory on each floor in the multistory buildings.” (III)
26. 63.28(5) “e” —Amend to read: “Grab bars shall be provided as needed.” (III)
27. 63.33(8) —Change any reference of “responsible party” to “legal guardian”.
28. 63.33(8) “c” —Delete “in the case of a confused or intellectually disabled resident”. Change any reference of “responsible party” to “legal guardian”.
29. 63.33(8) “d” —Change any reference of “responsible party” to “legal guardian”.
30. 63.46(1) —Change any reference of “responsible party” to “legal guardian” and delete the rest of the paragraph after “state law”.

**63.47(8)** “Qualified mental health professional” is a person who:

- a. Holds a master’s degree from an accredited educational institution with coursework relevant to the position for which the person is hired;
- b. Has at least two years’ relevant experience supervised by a qualified mental health professional in assessing mental health problems and needs of persons in providing appropriate mental health services for those persons;
- c. Holds a current Iowa license when required by Iowa licensure law.

**63.47(9)** “Intellectual disabilities” as used in this chapter shall also include the chronically mentally ill and the developmentally disabled for purposes of this specialized license.

a. For the specialized license, “persons with intellectual disabilities” means persons with significantly subaverage general intellectual functioning existing concurrently with deficits in adaptive behavior, manifested during the developmental period.

(1) “General intellectual functioning” is defined as the results obtained by assessment with one or more of the individually administered general intelligence tests developed for the purpose of assessing intellectual functioning;

(2) “Significantly subaverage functioning” is defined as approximately 70 IQ or below;

(3) “Adaptive behavior” is defined as the effectiveness or degree with which individuals meet the standards of personal independence and social responsibility expected for age and cultural group;

(4) “Developmental period” is defined as the period of time between conception and the eighteenth birthday.

b. For the specialized license, “persons with developmental disabilities” means persons with a severe, chronic disability which:

- (1) Is attributable to mental or physical impairment, or a combination of physical and mental impairments;
- (2) Is manifested before the person attains the age of 22;
- (3) Is likely to continue indefinitely;
- (4) Results in substantial functional limitations in three or more of the following areas of life activity; self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living and economic self-sufficiency; and
- (5) Reflects the person’s need for a combination and sequence of services which are of lifelong or extended duration.

c. For the specialized license, “persons with chronic mental illness” means adults aged 18 or older, with persistent mental or emotional disorders that seriously impair their functioning relative to such primary aspects of daily living as personal relations, living arrangement or employment. Persons with chronic mental illness typically meet at least one of the following criteria:

- (1) Have undergone psychiatric treatment more intensive than outpatient care more than once in a lifetime (e.g., emergency services, alternative home care, partial hospitalization or in-patient hospitalization);
- (2) Have experienced a single episode of continuous, structured supportive residential care other than hospitalization.

In addition, such persons typically meet at least two of the following criteria, on a continuing or intermittent basis for at least two years:

1. Are unemployed, or employed in a sheltered setting, or have markedly limited skills and a poor work history;
2. Require financial assistance for out-of-hospital maintenance and may be unable to procure this assistance without help;
3. Show severe inability to establish or maintain a personal social support system;
4. Require help in basic living skills;
5. Exhibit inappropriate social behavior which results in demand for intervention by the mental health or judicial system.

In atypical instances chronically mentally ill persons may vary from the above criteria.

**63.47(10)** For the specialized license, there shall be implemented an individual program plan (IPP) of goals and objectives for each resident developed using evaluations, assessments and progress reports. (II)

**63.47(11)** For the specialized license, “age-appropriate” shall mean activities, settings, personal appearance and possessions commensurate with the person’s chronological age.

**63.47(12)** For the specialized license, “least restrictive” shall mean the availability to the person of programs, services and settings that give the greatest opportunity for human development and to associate with and become part of the general society.

**63.47(13)** “Individual program plan” shall be a written plan for the provision of services to the person and, when appropriate, to the person’s family, that is developed and implemented, using an interdisciplinary process, which identifies the person’s and, when appropriate, the person’s family’s functional status, strengths, and needs, and service activities designed to enable a person to maintain or move toward independent functioning. The plan is developed in accordance with the developmental model, which is a service approach that recognizes and assumes the potential for positive change, growth, and sequential development in all people. (II)

a. An individual program plan shall be developed and implemented for each individual accepted for service, regardless of the individual’s chronological age or developmental level. (I, II)

b. The interdisciplinary team shall develop the plan. (II) For the purpose of the specialized license, the team shall include:

(1) The person, the person's legal guardian, and the person's family unless the family's participation is contrary to the wishes of the adult person who has not been legally determined to be incompetent; (II, III)

(2) The service coordinator or case manager; (II, III)

(3) All current service providers; and (II, III)

(4) Other persons whose appropriateness may be identified through the diagnosis and evaluation or current reevaluation. (III)

*c.* The person or the person's legal guardian has the ultimate authority to accept or reject the plan unless otherwise determined by court. (III)

*d.* The resident and the facility retain the rights of appeal and due process from the interdisciplinary team decisions. (II, III)

**63.47(14)** Goals and objectives shall be stated separately and a time frame shall be specified for their achievement. (II, III)

*a.* Each individual enrolled shall have an individual program plan. (II)

*b.* The initial individual program plan shall be developed within 30 calendar days after the individual is enrolled in this service. (II)

*c.* The individual program shall be developed by an appropriately constituted interdisciplinary team. (II)

*d.* The individual program plan shall state specific objectives to reach identified goals and shall identify the individuals responsible for implementation. (II, III)

*e.* Goals and objectives shall be stated separately. (II, III)

*f.* Goals and objectives shall be assigned projected evaluation completion dates and shall be reviewed at least annually. (II, III)

*g.* Goals and objectives shall be expressed in behavioral terms that provide measurable indices of progress. (II)

*h.* Goals and objectives shall be sequenced with a developmental progression appropriate to the individual. (II, III)

*i.* Goals and objectives of the individual program plans shall be assigned priorities by the interdisciplinary team and implemented with documentation of needed resources. (II, III)

*j.* The individual program plan shall be written in terms that are understandable to all concerned. (II, III)

**63.47(15)** Where implementation is a shared responsibility, the individual program plan shall identify the agencies or persons responsible for delivering the services required. (III)

**63.47(16)** A review of the individual program plan shall be made at least quarterly by a member or members of the individual's interdisciplinary team, as determined by the team, in order to ensure the continuing implemented appropriateness of the plan and any necessary action to be initiated. (II)

*a.* Problems or changes that call for review of the individual program plan by the team shall be indicated. (II)

*b.* The team shall be convened at least annually to review the individual program plan where problems or changes that call for review by the team are indicated. (II, III)

*c.* The team review shall assess the individual's response to activities designed to achieve the objective stated in the individual program plan. (II, III)

*d.* The team review shall modify activities or objectives as necessary. (II, III)

*e.* The team review shall determine the services that are needed. (II, III)

*f.* The team review shall include consideration of the advisability of continued enrollment or alternative placements. (II, III)

[ARC 0765C, IAB 5/29/13, effective 7/3/13]

**481—63.48(135C) County care facilities.** Rescinded ARC 0765C, IAB 5/29/13, effective 7/3/13.

**481—63.49(135C) Another business or activity in a facility.** A facility is allowed to have another business or activity in a health care facility or in the same physical structure of the facility, if the other

business or activity is under the control of and is directly related to and incidental to the operation of the health care facility, or the business or activity is approved by the department and the state fire marshal.

To obtain the approval of the department and the state fire marshal, the facility must submit to the department a written request for approval which identifies the service(s) to be offered by the business and addresses the factors outlined in paragraphs “a” through “j” of this rule. (I, II, III)

**63.49(1)** The following factors will be considered by the department in determining whether a business or activity will interfere with the use of the facility by residents, interfere with services provided to residents, or be disturbing to residents:

- a. Health and safety risks for residents;
- b. Compatibility of the proposed business or activity with the facility program;
- c. Noise created by the proposed business or activity;
- d. Odors created by the proposed business or activity;
- e. Use of entrances and exits for the business or activity in regard to safety and disturbance of residents and interference with delivery of services;
- f. Use of the facility’s corridors or rooms as thoroughfares to the business or activity in regard to safety and disturbance of residents and interference with delivery of services;
- g. Proposed staffing for the business or activity;
- h. Sharing of services and staff between the proposed business or activity and the facility;
- i. Facility layout and design; and
- j. Parking area utilized by the business or activity.

**63.49(2)** Approval of the state fire marshal shall be obtained before approval of the department will be considered.

**63.49(3)** A business or activity conducted in a health care facility or in the same physical structure as a health care facility shall not reduce space, services or staff available to residents below minimums required in these rules and 481—Chapter 60. (I, II, III)

**481—63.50(135C) Respite care services.** Respite care services means an organized program of temporary supportive care provided for 24 hours or more to a person in order to relieve the usual caregiver of the person from providing continual care to the person. A facility which chooses to provide respite care services must meet the following requirements related to respite care services and must be licensed as a health care facility.

**63.50(1)** A facility which chooses to provide respite care services is not required to obtain a separate license or pay a license fee.

**63.50(2)** Rules regarding involuntary discharge or transfer rights do not apply to residents who are being cared for under a respite care contract.

**63.50(3)** The facility shall have a contract with each resident in the facility. When the resident is there for respite care services, the contract shall specify the time period during which the resident will be considered to be receiving respite care services. At the end of that period, the contract may be amended to extend that period of time. The contract shall specifically state the resident may be involuntarily discharged while being considered as a respite care resident. The contract shall meet other requirements for contracts between a health care facility and resident, except the requirements concerning the holding and charging for a bed when a resident is hospitalized or leaves the facility temporarily for recreational or therapeutic reasons.

**63.50(4)** Respite care services shall not be provided by a facility to persons requiring a level of care which is higher than the level of care the facility is licensed to provide.

These rules are intended to implement Iowa Code sections 10A.202, 10A.402, 135C.1, 135C.2(5), 135C.2(6), 135C.6(1), 135C.14(3), 135C.14(5), 135C.14(8), 135C.25, 135C.25(3), 135C.36, 227.4, 235B.1(6), and 235B.1(11) and 1988 Iowa Acts, chapter 1239.

[Filed 8/18/77, Notice 2/23/77—published 9/7/77, effective 10/13/77]

[Filed without Notice 10/14/77—published 11/2/77, effective 12/8/77]

[Filed 1/20/78, Notice 12/14/77—published 2/8/78, effective 3/15/78]

[Filed 7/7/78, Notice 5/31/78—published 7/26/78, effective 9/1/78]

[Filed 10/13/78, Notice 9/6/78—published 11/1/78, effective 12/7/78]  
 [Filed 11/9/78, Notice 6/28/78—published 11/29/78, effective 1/3/79]  
 [Filed emergency 11/22/78—published 12/13/78, effective 1/3/79]  
 [Filed 5/20/82, Notice 12/23/81—published 6/9/82, effective 7/14/82]  
 [Filed 1/10/86, Notice 11/6/85—published 1/29/86, effective 3/5/86<sup>1</sup>]  
 [Filed 5/15/86, Notice 2/26/86—published 6/4/86, effective 7/9/86]  
 [Filed 5/16/86, Notice 1/1/86—published 6/4/86, effective 7/9/86]  
 [Filed emergency 7/1/86—published 7/16/86, effective 7/1/86]<sup>2</sup>  
 [Filed emergency 9/19/86—published 10/8/86, effective 9/19/86]  
 [Filed emergency after Notice 3/12/87, Notice 12/31/86—published 4/8/87, effective 3/12/87]  
 [Filed 3/12/87, Notice 1/25/87—published 4/8/87, effective 5/13/87]  
 [Filed emergency 6/25/87—published 7/15/87, effective 7/1/87]  
 [Filed 2/5/88, Notice 10/7/87—published 2/24/88, effective 3/30/88]<sup>0</sup>  
 [Filed 4/28/88, Notice 12/16/87—published 5/18/88, effective 6/22/88]  
 [Filed 5/26/88, Notice 4/20/88—published 6/15/88, effective 7/20/88]  
 [Filed 9/30/88, Notice 8/24/88—published 10/19/88, effective 11/23/88]<sup>3</sup>  
 [Filed 12/9/88, Notices 8/24/88, 10/5/88—published 12/28/88, effective 2/1/89]  
 [Filed 6/23/89, Notice 5/17/89—published 7/12/89, effective 8/16/89]  
 [Filed 7/20/89, Notice 6/14/89—published 8/9/89, effective 9/13/89]  
 [Filed 8/16/89, Notices 4/19/89, 7/12/89—published 9/6/89, effective 10/11/89]  
 [Filed 6/8/90, Notice 1/10/90—published 6/27/90, effective 8/1/90]  
 [Filed 7/17/90, Notice 5/2/90—published 8/8/90, effective 9/12/90]  
 [Filed 3/14/91, Notice 9/19/90—published 4/3/91, effective 5/8/91]  
 [Filed emergency 5/10/91—published 5/29/91, effective 5/10/91]  
 [Filed 1/31/92, Notice 11/13/91—published 2/19/92, effective 3/25/92]<sup>4</sup>  
 [Filed 3/12/92, Notice 12/11/91—published 4/1/92, effective 5/6/92]  
 [Filed 3/11/94, Notice 9/15/93—published 3/30/94, effective 5/4/94]  
 [Filed 5/16/95, Notice 3/15/95—published 6/7/95, effective 7/12/95]  
 [Filed 11/30/95, Notice 9/13/95—published 12/20/95, effective 1/24/96]  
 [Filed 1/21/97, Notice 8/14/96—published 2/12/97, effective 3/19/97]  
 [Filed 7/11/97, Notice 4/23/97—published 7/30/97, effective 9/3/97]  
 [Filed emergency 7/25/97—published 8/13/97, effective 7/25/97]  
 [Filed emergency 11/14/97—published 12/3/97, effective 11/14/97]  
 [Filed 11/14/97, Notice 8/13/97—published 12/3/97, effective 1/7/98]  
 [Filed 3/31/98, Notice 12/3/97—published 4/22/98, effective 5/27/98]  
 [Filed 7/9/98, Notice 4/22/98—published 7/29/98, effective 9/2/98]  
 [Filed 1/15/04, Notice 10/1/03—published 2/4/04, effective 3/10/04]  
 [Filed 1/15/04, Notice 12/10/03—published 2/4/04, effective 3/10/04]  
 [Filed 9/20/06, Notice 8/2/06—published 10/11/06, effective 11/15/06]  
 [Filed 7/9/08, Notice 1/30/08—published 7/30/08, effective 9/3/08]  
 [Filed ARC 0663C (Notice ARC 0513C, IAB 12/12/12), IAB 4/3/13, effective 5/8/13]  
 [Filed ARC 0765C (Notice ARC 0600C, IAB 2/6/13), IAB 5/29/13, effective 7/3/13]  
 [Filed ARC 0903C (Notice ARC 0776C, IAB 5/29/13), IAB 8/7/13, effective 9/11/13]  
 [Filed ARC 1050C (Notice ARC 0907C, IAB 8/7/13), IAB 10/2/13, effective 11/6/13]

<sup>0</sup> Two or more ARCs

<sup>1</sup> Effective date of 63.15(2) “a” and “b” delayed 70 days by the Administrative Rules Review Committee, IAB 2/26/86.  
 Effective date of 63.15(2) “a” and “b” delayed until the expiration of 45 calendar days into the 1987 session of the General Assembly pursuant to Iowa Code section 17A.8(9), IAC 6/4/86.

<sup>2</sup> See IAB, Inspections and Appeals Department.

<sup>3</sup> Two ARCs

<sup>4</sup> Rule 481—63.49(135C), effective 7/1/92.

CHAPTER 65  
INTERMEDIATE CARE FACILITIES  
FOR PERSONS WITH MENTAL ILLNESS (ICF/PMI)

**481—65.1(135C) Definitions.** For the purposes of these rules, the following terms shall have the meaning indicated in this chapter. The definitions set out in Iowa Code section 135C.1 shall be considered incorporated verbatim in the rules. The use of the words “shall” and “must” indicate these standards are mandatory.

“*Abuse*” means any of the following as a result of the willful or negligent acts or omissions of a caretaker:

1. Physical abuse;
2. Physical injury to or unreasonable confinement or cruel punishment of a resident;
3. Sexual abuse;
4. Mental abuse;
5. Verbal abuse;
6. Exploitation of a resident; or
7. The deprivation of the minimum food, shelter, clothing, supervision, physical and mental health care, and other care necessary to maintain a resident’s life or health as a result of the acts or omissions of the caretaker.

“*Academic services*” means those activities provided to assist a person to acquire general information and skills which establish the basis for subsequent acquisition and application of knowledge.

“*Activity coordinator*” means a person who has completed the state-approved activity coordinator’s course.

“*Age appropriate*” means those activities, settings, and personal appearance and possessions commensurate with the person’s chronological age.

“*Chronic mental illness*” (see the definition of “Mental illness”).

“*Commission*” means the mental health and disability services commission.

“*Community living training services*” are those activities provided to assist a person to acquire or sustain the knowledge and skills essential to independent functioning to the person’s maximum potential in the physical and social environment. These services may focus on the following areas:

1. Independent living skills which include those skills necessary to sustain oneself in the physical environment and are essential to the management of one’s personal property and business. This includes self-advocacy skills.
2. Socialization skills which include self-awareness and self-control, social responsiveness, group participation, social amenities and interpersonal skills.
3. Communication skills which include expressive and receptive skills in verbal and nonverbal language, including reading and writing.
4. Leisure time and recreational skills which include the skills necessary for a person to use leisure time in a manner which is satisfying and constructive to the person.
5. Parenting skills which include those skills necessary to meet the needs of the person’s child. This service is designed to assist the person with mental illness to acquire or sustain the skills necessary for parenting.

“*Department*” means the Iowa department of inspections and appeals.

“*Diagnosis*” means the investigation and analysis of the cause or nature of a person’s condition, situation or problem.

“*Direct care staff*” means those staff persons who provide a homelike environment for the residents and assist or supervise the resident in meeting the goals in the resident’s program plan.

“*Evaluation services*” means those activities designed to identify a person’s current functioning level and those factors which are barriers to maintaining the current level or achieving a higher level of functioning.

*“Exploitation”* means the act or process of taking unfair advantage of a resident, or the resident’s physical or financial resources for one’s own personal or pecuniary profit by the use of undue influence, harassment, duress, deception, false representation or false pretenses.

*“Goals”* means general statements of attainable expected accomplishments to be achieved in meeting identified needs.

*“Incident”* means all accidental, purposeful, or other occurrences within the facility or on the premises affecting residents, visitors, or employees whether there is apparent injury or where hidden injury may have occurred.

*“Individual program plan (IPP)”* means a written plan for the provision of services to the resident that is developed and implemented using an interdisciplinary process that is based on the resident’s functional status, strengths, and needs and that identifies service activities designed to enable a person to maintain or move toward independent functioning. The plan identifies a continuum of development and outlines progressive steps and anticipated outcomes of services.

*“Informed consent”* means an agreement by a person, or by the person’s legally authorized representative, based upon an understanding of:

1. A full explanation of the procedures to be followed including an identification of those that are and are not experimental;
2. A description of the attendant discomforts, risks, and benefits to be expected; and
3. A disclosure of appropriate alternative procedures that would be advantageous for the person.

*“Interdisciplinary process”* means an approach to assessment, individual program planning, and service implementation in which planning participants function as a team. Each participant utilizing the skills, competencies, insights and perspectives provided by the participant’s training and experience focuses on identifying the service needs of the resident and the resident’s family. The purpose of the process is for participants to review and discuss, face-to-face, all information and recommendations and to reach decisions as a team. Participants share all information and recommendations, and develop as a team, a single, integrated individual program plan to meet the resident’s needs and, when appropriate, the resident’s family’s needs.

*“Interdisciplinary team”* means the group of persons who develop a single, integrated individual program plan to meet a resident’s needs for services. The interdisciplinary team consists of, at a minimum, the resident, the resident’s legal guardian, if applicable, the resident’s advocate, if desired by the resident, a referral agency representative, other appropriate staff members, the resident’s attending psychiatrist and QMHP, other providers of services, and other persons relevant to the resident’s needs.

*“Least restrictive environment”* means the environment in which the interventions in the lives of people with mental illness can be carried out with a minimum of limitation, intrusion, disruption, and departure from commonly accepted patterns of living.

It is the environment which allows residents to participate, to the maximum extent possible, in everyday life and to have control over the decisions that affect them. It is an environment that provides needed supports which do not interfere with personal liberty and do not unduly interfere with a person’s access to the normal events of life.

*“Legal services”* means those activities designed to assist the person in exercising constitutional and legislatively enacted rights.

*“Level of functioning”* means a person’s current physiological and psychological status and current academic, community living, self-care and vocational skills.

*“Mechanical restraint”* means a device applied to a person’s limbs, head or body which restricts a person’s movement and includes, but is not limited to, leather straps, leather cuffs, camisoles or handcuffs.

*“Mental abuse”* means, but is not limited to, humiliation, harassment, and threats of punishment or deprivation.

*“Mental health counselor”* means a person who is certified or eligible for certification as a mental health counselor by the National Academy of Certified Clinical Mental Health Counselors.

*“Mental health, mental retardation commission”* means the commission described in Iowa Code section 225C.5.

*“Mental illness”* means a substantial disorder of thought or mood which significantly impairs judgment, behavior, or the capacity to recognize reality or the ability to cope with the ordinary demands of life. Mental illnesses include the organic and functional psychoses, neuroses, personality disorders, alcoholism and drug dependence, behavioral disorders and other disorders as defined by the current edition of “American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders.” Mental illness is chronic when it is of long duration or marked by frequent recurrences.

*“Normalization”* means helping persons, in accordance with their needs and preferences, to achieve a lifestyle that is consistent with the norms and patterns of general society in ways which incorporate the age-appropriate and least restrictive principles.

*“Objectives”* means specific, time-limited, and measurable statements showing outcomes or accomplishments necessary to progress toward the goal.

*“Physical abuse”* means, but is not limited to, corporal punishment and the use of restraints as punishment.

*“Physical injury”* means damage to any bodily tissue to the extent the tissue must undergo a healing process in order to be restored to a sound and healthy condition. It may also mean damage to the extent the bodily tissue cannot be restored to a sound and healthy condition, or results in the death of the resident whose bodily tissue sustained the damage.

*“Physical or physiological treatment”* means those activities designed to prevent, halt, control, relieve, or reverse symptoms or conditions which interfere with the physical or physiological functioning of the human body.

*“Physical restraint”* means a technique involving the use of one or more of a staff person’s arms, legs, hands or other body areas to restrict or control the movements of a resident. This does not include the use of mechanical restraint.

*“Physician”* means a person who is currently licensed in Iowa to practice medicine and surgery, osteopathic medicine and surgery, or osteopathy.

*“Program”* means a set of related resources and services directed to the accomplishment of a fixed set of goals and objectives for any of the following:

1. Special target populations;
2. The population of a specified geographic area(s);
3. A specified purpose; and
4. A person.

*“Psychiatric nurse”* means a person who meets the requirements of certified psychiatric-mental health nurse practitioner pursuant to 655—Chapter 7, Iowa Administrative Code, or is eligible for certification.

*“Psychiatrist”* means a doctor of medicine or osteopathic medicine and surgery who is certified by the American Board of Psychiatry and Neurology or who is eligible for certification.

*“Psychologist”* means a person who is licensed to practice psychology in the state of Iowa, or is certified by the Iowa department of education as a school psychologist, or is eligible for certification.

*“Psychotherapeutic treatment”* means those activities designed to assist a person in the identification or modification of beliefs, emotions, attitudes, or behaviors in order to maintain or improve the person’s functioning in response to the physical, emotional and social environment.

*“Qualified mental health professional (QMHP)”* means a person who:

1. Holds at least a master’s degree in a mental health field, including but not limited to: psychology, counseling and guidance, nursing and social work; or is a doctor of medicine (M.D.) or a doctor of osteopathic medicine and surgery (D.O.); and
2. Holds a current Iowa license when required by the Iowa licensure law; and
3. Has at least two years of postdegree experience, supervised by a mental health professional, in assessing mental problems and needs of individuals and in providing appropriate mental health services for those individuals. See rule 481—65.4(135C) for variance procedures.

*“Resident”* means a person who has been admitted to the facility to receive care and services.

*“Seclusion”* means the isolation of the resident in a locked room which cannot be opened by the resident.

“*Self-care training services*” means those activities provided to assist a person to acquire or sustain the knowledge, habits and skills essential to the daily needs of the person. The activities focus on personal hygiene, general health maintenance, mobility skills and other activities of daily living.

“*Service*” means a set of interrelated activities provided to a resident pursuant to the IPP.

“*Sexual abuse*” means, but is not limited to, the exposing of pubes to a resident, the exposure of a resident’s genitals, pubes, breasts or buttocks for sexual satisfaction, fondling or touching the inner thigh, groin, buttocks, anus or breast of a resident or the clothing covering these areas, sexually suggestive comments or remarks made to a resident, a genital to genital or rectal, or oral to genital or rectal contact, or the commission of a sexual offense under Iowa Code chapter 709 or Iowa Code section 726.2.

“*Social worker*” means a person who is licensed to practice social work in the state of Iowa, or who is eligible for licensure.

“*Support services*” means those activities provided to or on behalf of a person in the areas of personal care and assistance and property maintenance in order to allow a person to live in the least restrictive environment.

“*Transportation services*” means those activities designed to assist a person to travel from one place to another to obtain services or carry out life’s activities.

“*Verbal abuse*” means, but is not limited to, the use of derogatory terms or names, undue voice volume and rude comments, orders or responses to residents.

“*Vocational training services*” means those activities designed to familiarize a person with production or employment requirements and to maintain or develop the person’s ability to function in a work setting. This service includes programming which allows or promotes the development of skills, attitudes and personal attributes appropriate to the work setting.

“*Work*” means any activity during which a resident provides goods or services for wages.

“*Written, in writing or recorded*” means that an account or entry is made in a permanent form.

[ARC 0766C, IAB 5/29/13, effective 7/3/13]

**481—65.2(135C) Application for license.** In order to obtain an initial license for an ICF/PMI, the applicant must comply with the rules and standards contained in Iowa Code chapter 135C and the standards in 481—Chapter 61. Variances from Chapter 61 regulations are allowed under rule 481—61.2(135C). An application must be submitted to the department which states the type and category of license for which the facility is applying.

**65.2(1)** Each application shall include:

- a. A floor plan of each floor of the facility drawn on 8½- × 11-inch paper showing room areas in proportion, room dimensions, room numbers for all rooms, including bathroom, and designation of the use to which room will be put and window and door location;
- b. A photograph of the front and side elevation of the facility;
- c. The statutory fee for an intermediate care facility license;
- d. Evidence of a certificate signed by the state fire marshal or deputy state fire marshal as to compliance with fire safety rules.

**65.2(2)** A résumé of care with a narrative which includes the following information shall be submitted:

- a. The purpose of the facility;
- b. A description of the target population and limitations on resident eligibility;
- c. An identification and description of the services the facility will provide. This shall include at least specific and measurable goals and objectives for each service available in the facility and a description of the resources needed to provide each service including staff, physical facilities and funds;
- d. A description of the human service system available in the area, including, but not limited to, social, public health, visiting nurse, vocational training, employment services, sheltered living arrangements, and services of private agencies;
- e. A description of working relationships with the human service agencies when applicable which shall include at least how the facility will coordinate with:

(1) The department of human services to facilitate continuity of care and coordination of services to residents; and

(2) Other agencies to identify unnecessary duplication of services and plan for development and coordination of needed services;

*f.* A list of members of the care review committee; and

*g.* A description of a program of training for the care review committee concerning their role in the ongoing care and treatment of residents.

**65.2(3)** In order to obtain a renewal or change of ownership license of the ICF/PMI the applicant must:

*a.* Submit to the department the completed application form 30 days prior to annual license renewal or change of ownership date of the ICF/PMI license;

*b.* Submit the statutory license fee for an ICF/PMI with the application for renewal or change of ownership;

*c.* Have an approved current certificate signed by the state fire marshal or deputy state fire marshal as to compliance with fire safety rules; and

*d.* Submit documentation of review of résumé of care pursuant to subrule 65.2(1), paragraph “a,” and a copy of any revisions to the plan.

This rule is intended to implement Iowa Code sections 135C.7 and 135C.9.

**481—65.3(135C) Licenses for distinct parts.** Separate licenses may be issued for distinct parts which are clearly identifiable parts of a health care facility, containing contiguous rooms in a separate wing or building or on a separate floor of the facility, which provide care and services of separate categories.

The following requirements shall be met for a separate licensing of a distinct part:

1. The distinct part shall serve only residents who require the category of care and services immediately available to them within that part. (III)

2. The distinct part shall meet all the standards, rules and regulations pertaining to the category for which a license is being sought.

3. The distinct part must be operationally and financially feasible.

4. A separate personal care staff with qualifications appropriate to the care and services being rendered must be regularly assigned and working in the distinct part under responsible management. (III)

5. Separately licensed distinct parts may have certain services such as management, building maintenance, laundry and dietary in common with each other.

This rule is intended to implement Iowa Code section 135C.6(2).

**481—65.4(135C) Variances.** Variances from these rules may be granted by the director of the department when:

1. The need for a variance has been established consistent with the résumé of care or the resident’s individual program plan.

2. There is no danger to the health, safety, welfare or rights of any resident.

3. The variance will apply only to a specific intermediate care facility for the mentally ill.

Variances shall be reviewed at least at the time of each licensure survey and any other time by the department to see if the need for the variance is still acceptable.

**65.4(1)** To request a variance, the licensee must:

*a.* Apply in writing on a form provided by the department;

*b.* Cite the rule or rules from which a variance is desired;

*c.* State why compliance with the rule or rules cannot be accomplished;

*d.* Explain how the variance is consistent with the résumé of care or the individual program plan; and

*e.* Demonstrate that the requested variance will not endanger the health, safety, welfare or rights of any resident.

**65.4(2)** Upon receipt of a request for variance, the director will:

- a. Examine the rule from which the variance is requested;
- b. Evaluate the requested variance against the requirement of the rule to determine whether the request is necessary to meet the needs of the residents;
- c. Examine the effect of the requested variance on the health, safety or welfare of the residents;
- d. Consult with the applicant to obtain additional written information if required; and
- e. Obtain approval of the Iowa mental health and disability services commission, when the request is for a variance from the requirement for qualification of a mental health professional.

**65.4(3)** Based upon this information, approval of the variance will be either granted or denied within 120 days of receipt.

[ARC 0766C, IAB 5/29/13, effective 7/3/13]

**481—65.5(135C) General requirements.**

**65.5(1)** A valid license shall be posted in each facility so the public can easily see it. (III)

**65.5(2)** Each license is valid only for the premises and person named on the license and is not transferable.

**65.5(3)** The posted license shall accurately reflect the current status of the facility. (III)

**65.5(4)** Each citation or a copy of each citation issued by the department for a Class I or Class II violation shall be prominently posted by the facility in plain view of the residents, visitors, and persons inquiring about placement in the facility. The citation or copy of the citation shall remain posted until the violation is corrected to the satisfaction of the department. (III)

**65.5(5)** Licenses expire one year after the date of issuance or as indicated on the license.

**65.5(6)** There shall be no more beds erected than are stipulated on the license. (II, III)

This rule is intended to implement Iowa Code section 135C.8.

**481—65.6(135C) Notification required by the department.** The department shall be notified within 48 hours, by letter, of any reduction or loss of personal care or dietary staff lasting more than seven days which places the staff ratio below that required for licensing. No additional residents shall be admitted until the minimum staff requirements are achieved. (II, III)

**65.6(1)** Other required notification and time periods are:

- a. Within 30 days of any proposed change in the résumé of care for the ICF/PMI; (II, III)
- b. Thirty days before addition, alteration, or new construction is begun in the ICF/PMI or on the premises; (III)
- c. Thirty days before the ICF/PMI closes; (III)
- d. Within two weeks of any change of administrator; (II, III) and
- e. Within 30 days when any change in the category of license is sought. (III)

**65.6(2)** Prior to the purchase, transfer, assignment, or lease of an ICF/PMI the licensee shall:

- a. Inform the department in writing of the pending sale, transfer, assignment, or lease of the facility; (III)
- b. Inform the department in writing of the name and address of the prospective purchaser, transferee, assignee or lessee at least 30 days before the sale, transfer, assignment or lease is completed; (III) and
- c. Submit a written authorization to the department permitting the department to release information of whatever kind from the department's files concerning the licensee's ICF/PMI to the named prospective purchaser, transferee, assignee or lessee. (III)

**65.6(3)** After the authorization has been submitted to the department, the department shall upon request send or give copies of all recent licensure surveys and any other pertinent information relating to the facility's licensure status to the prospective purchaser, transferee, assignee or lessee. Costs for copies requested shall be paid by the prospective purchaser, transferee, assignee or lessee. No information personally identifying any resident shall be provided to the prospective purchaser, transferee, assignee or lessee. (II, III)

This rule is intended to implement Iowa Code sections 135C.6(3) and 135C.16(2).

**481—65.7(135C) Administrator.** Each ICF/PMI shall have one person in charge, duly approved by the department or acting in a provisional capacity in accordance with these regulations. (II, III)

**65.7(1)** The administrator shall be at least 21 years of age and shall meet at least one of the following conditions:

*a.* Be licensed in Iowa as a nursing home administrator, or certified as a residential care administrator. No residential care facility administrator certified under a waiver from the department shall administrate an intermediate care facility for persons with mental illness. The administrator must have at least two years' experience in direct care or supervision of people with mental illness and at least one year of experience in an administrative capacity; (II, III) or

*b.* Be a qualified mental health professional (QMHP) with at least one year of experience in an administrative capacity. (II, III)

If an ICF/PMI is a distinct part of a licensed health care facility, the administrator of the facility as a whole may serve as the administrator of the ICF/PMI without meeting the requirements of subrule 65.7(1), paragraph "a" or "b." When this occurs, the person in charge of the ICF/PMI distinct part shall meet the requirements of subrule 65.7(1), paragraph "a" or "b." (II, III)

**65.7(2)** The administrator of more than one facility shall be responsible for no more than 150 beds in total. (II, III)

*a.* The distance between the two farthest facilities shall be no greater than 50 miles. (II, III)

*b.* An administrator of more than one facility must designate an administrative staff person in each facility who shall be responsible for directing programs in the facility during the administrator's absence. (II, III)

**65.7(3)** The administrative staff person shall be designated in writing and immediately available to the facility on a 24-hour basis when the administrator is absent and residents are in the facility. (II, III)

The person(s) designated shall:

*a.* Have at least two years' experience or training in a supervisory or direct care position in a mental health setting; (II, III)

*b.* Be knowledgeable of the operation of the facility; (II, III)

*c.* Have access to records concerned with the operation of the facility; (II, III)

*d.* Be capable of carrying out administrative duties and of assuming administrative responsibilities; (II, III)

*e.* Be at least 21 years of age; (III)

*f.* Be empowered to act on behalf of the licensee during the administrator's absence concerning the health, safety and welfare of the residents; (II, III) and

*g.* Have training to carry out assignments and take care of emergencies and sudden illnesses of residents. (II, III)

**65.7(4)** If an administrator serves more than one facility, a written plan shall be developed, implemented and available for review by the department designating regular and specific times the administrator will be available to meet with the staff and residents to provide direction and supervision of resident care and services. (II, III)

**65.7(5)** When a facility has been unable to replace the administrator, through no fault of its own, a provisional administrator meeting the qualifications of the administrative staff person may be appointed on a temporary basis by the licensee to assume the administrative responsibilities for the facility. This person shall not serve more than three months without approval from the department. The department must be notified before the appointment of the provisional administrator. (III)

**65.7(6)** A facility applying for initial licensing shall not have a provisional administrator. (III)

This rule is intended to implement Iowa Code section 135C.14(2).

**481—65.8(135C) Administration.**

**65.8(1)** The licensee shall:

*a.* Be responsible for the overall operation of the ICF/PMI; (III)

*b.* Be responsible for compliance with all applicable laws and with the rules of the department; (II, III)

*c.* Establish written policies, which shall be available for review by the department or other agencies designated by Iowa Code section 135C.16(3), for the operation of the ICF/PMI including, but not limited to: (III)

- (1) Personnel; (III)
- (2) Admission; (III)
- (3) Evaluation services; (II, III)
- (4) Programming and individual program plan; (II, III)
- (5) Crisis intervention; (II, III)
- (6) Discharge or transfer; (III)
- (7) Medication management; (II)
- (8) Resident property; (II, III)
- (9) Financial affairs; (II, III)
- (10) Records; (III)
- (11) Health and safety; (II, III)
- (12) Nutrition; (III)
- (13) Physical facilities and maintenance; (III)
- (14) Care review committee; (III)
- (15) Resident rights; (II, III) and

*d.* Furnish statistical information concerning the operation of the facility to the department within 30 days of request. (III)

**65.8(2)** The administrator shall be responsible for the implementation of procedures to support the policies established by the licensee. (III)

This rule is intended to implement Iowa Code section 135C.14.

#### **481—65.9(135C) Personnel.**

**65.9(1)** The personnel policies and procedures shall include the following requirements:

*a.* Written job descriptions for all employees or agreements for all consultants, which include duties and responsibilities, education, experience, or other requirements, and supervisory relationships; (III)

*b.* Annual performance evaluations of all employees and consultants which are dated and signed by the employee or consultant and the supervisor; (III)

*c.* Personnel records which are current, accurate, complete and confidential to the extent allowed by law. The record shall contain documentation of how the employee's or consultant's education and experience are relevant to the position for which they were hired; (III)

*d.* Roles, responsibilities, and limitation of student interns and volunteers; (III)

*e.* An orientation program for all newly hired employees and consultants which includes introduction to facility personnel policies and procedures and a discussion of the safety plan. Subparagraphs 65.9(1) "f"(3), (5) and (9) shall be included; (II, III)

*f.* A plan for a continuing education program with a minimum of 12 in-service programs per year. There shall be a written, individualized staff development plan implemented for each employee. The plan shall take into consideration the duties of the employee and the needs of the facility identified in the résumé of care. The plan shall ensure that each employee has the opportunity to develop and enhance skills and to broaden and increase knowledge needed to provide effective resident care including, but not limited to:

- (1) First aid; (II, III)
- (2) Human needs and behavior; (II, III)
- (3) Problems and needs of persons with mental illness; for example, diagnosis and treatment, suicide assessment and prevention; (II, III)
- (4) Medication; (II, III)
- (5) Crisis intervention; for example, use of restraints and seclusion; (II)
- (6) Delivery of services in accordance with the principles of normalization; (III)
- (7) Infection control and wellness; (III)

- (8) Fire safety, disaster, and tornado preparation; (II, III) and
- (9) Resident rights. (II, III)
- g. Equal opportunity and affirmative action employment practices; (III)
- h. Procedures to be used when disciplining an employee; (III) and
- i. Appropriate dress and personal hygiene for staff and residents. (III)

**65.9(2)** There shall be written personnel policies for each facility. Personnel policies shall include the following requirements:

- a. Employees shall have a physical examination before employment and at least every four years after beginning employment. (III)
- b. Screening and testing for tuberculosis shall be conducted pursuant to 481—Chapter 59. (I, II, III)
- c. No one shall provide services in a facility if the person has a disease:
  - (1) Which is transmissible through required workplace contact; (I, II, III)
  - (2) Which presents a significant risk of infecting others; (I, II, III)
  - (3) Which presents a substantial possibility of harming others; (I, II, III)
  - (4) For which no reasonable accommodation can eliminate the risk. (I, II, III)

Refer to Guideline for Infection Control in Hospital Personnel, 1998, Centers for Disease Control, U.S. Department of Health and Human Services, to determine (1), (2), (3) and (4).

d. There shall be written policies for emergency medical care for employees in case of sudden illness or accident. These policies shall include the administrative individuals to be contacted. (III)

e. Health certificates for all employees shall be available for review by the department. (III)

**65.9(3)** Staffing. The facility shall establish, subject to approval of the department, the numbers and qualifications of the staff required in an ICF/PMI using as its criteria the services being offered as indicated on the résumé of care and as required for implementation of individual program plans. (II, III)

a. Direct care staff. Direct care staff shall be present in the facility unless all residents are involved in activities away from the facility. The policies and procedures shall provide for an on-call staff person to be available when residents and staff are absent from the facility. (II, III)

(1) The on-call staff person shall be designated in writing. (II, III)

(2) Residents or another responsible person shall be informed of how to contact the on-call person.

(II, III)

The staffing plan shall ensure that at least one qualified direct care staff person is on duty to carry out and implement the individual program plans. (II, III)

b. Qualified mental health professional. The ICF/PMI shall, by direct employment or contract, provide for sufficient services of a qualified mental health professional to attain or maintain the highest practicable mental and psychosocial well-being of each resident. Attainment shall be determined by resident assessment and individual plans of care. (I, II, III) Responsibilities of the QMHP shall include, but not be limited to:

(1) Approval of each resident's individual program plan; (II, III)

(2) Monitoring the implementation of each resident's individual program plan, including periodic personal contact; (II, III) and

(3) Participation on each resident's interdisciplinary team. (II, III)

c. Nursing staff. Each facility shall have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practical physical, mental and psychosocial well-being of each resident. Attainment shall be determined by resident assessments and individual plans of care.

(1) The director of nursing (DON) shall be a registered nurse who is employed by the facility at least 40 hours per week. This person shall have two years' experience in direct care or supervision of people with mental illness. (II, III)

(2) The facility shall provide 24-hour service by licensed nurses, including at least one registered nurse on the day tour of duty, seven days a week. (II, III)

(3) If the DON has other institutional responsibilities, a qualified registered nurse shall serve as the DON's assistant so there is the equivalent of a full-time nursing supervisor on duty. (II, III)

(4) The department shall establish, on an individual facility basis, the numbers and qualifications of the staff required in the facility using as its criteria the services being offered as indicated on the résumé of care and as required for implementation of individual program plans. (II, III)

(5) The DON shall not serve as charge nurse in a facility with an average daily total occupancy of 60 or more residents. (II, III)

(6) A waived licensed practical nurse shall not be allowed as a charge nurse on any shift. (II, III)

(7) There shall be at least two people capable of rendering nursing service awake, dressed, and on duty at all times. (II, III)

*d.* Activity staff. Each ICF/PMI shall employ a recreational therapist, occupational therapist or activity coordinator to direct the activity program both inside and outside the facility in accordance with each resident's individual program plan. (III)

Staff for the activity program shall be based on the needs of the residents being served as identified on the IPP. (III)

(1) The activity program director shall attend workshops or educational programs which relate to activity programming. These shall total a minimum of ten contact hours per year. (III)

(2) Personnel coverage shall be provided when the activity program director is absent during scheduled activities. (III)

(3) The activity program director shall have access to all information about residents necessary to carry out the program. (III)

*e.* Responsibilities of the activity program director shall include:

(1) Coordinating all activities, including volunteer or auxiliary activities and religious services; (III)

(2) Ensuring that all records required are kept; (III)

(3) Coordinating the activity program with all other services in the facility; (III) and

(4) Participating in the in-service training program in the facility. This shall include attending as well as presenting sessions. (III)

**65.9(4)** Personnel record. A personnel record shall be kept for each employee. (III)

*a.* The record shall include the employee's:

(1) Name and address, (III)

(2) Social security number, (III)

(3) Date of birth, (III)

(4) Date of employment, (III)

(5) References, (III)

(6) Position in the facility, (III)

(7) Job description, (III)

(8) Documentation of experience and education, (III)

(9) Staff development plan, (III)

(10) Annual performance evaluation, (II, III)

(11) Documentation of disciplinary action, (II, III)

(12) Date and reason for discharge or resignation, (III) and

(13) Current physical examination. (III)

*b.* The personnel records shall be made available to the long-term care resident's advocate/ombudsman of the department on aging in response to a complaint being investigated. (III)

**65.9(5)** Employee criminal record checks, child abuse checks and dependent adult abuse checks and employment of individuals who have committed a crime or have a founded abuse. The facility shall comply with the requirements found in Iowa Code section 135C.33 as amended by 2013 Iowa Acts, Senate File 347, and rule 481—50.9(135C) related to completion of criminal record checks, child abuse checks, and dependent adult abuse checks and to employment of individuals who have committed a crime or have a founded abuse. (I, II, III)

This rule is intended to implement Iowa Code sections 135C.14(2) and 135C.14(6).

[ARC 0663C, IAB 4/3/13, effective 5/8/13; ARC 0903C, IAB 8/7/13, effective 9/11/13]

**481—65.10(135C) General admission policies.** There shall be admission policies which address the following:

1. No resident shall be admitted or retained who is in need of greater services than the facility can provide. (II, III)

2. Residents shall be admitted only on a written order signed by a physician. (II, III)

3. A preplacement visit shall be completed prior to admission, except in case of an emergency admission or readmission, to familiarize the applicant with the facility and services offered. The policies and procedures may allow for waiving the requirement at the request of a person seeking admission when the completion of the visit would create a hardship for the person seeking admission. If the distance to be traveled makes it impossible to complete the visit in an eight-hour day, this may be considered to create a hardship. (III)

4. Prior to admission of an applicant, the facility shall obtain sufficient information to determine if its program is appropriate and adequate to meet the person's needs. (III)

5. Admission criteria shall include, but not be limited to, age, sex, current diagnosis from an American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders, substance abuse, dual diagnosis and criteria that are consistent with the résumé of care. (III)

6. Each facility shall maintain a waiting list with selection priorities identified. (III)

7. No ICF/PMI may admit more residents than the number of beds for which it is licensed. (II, III)

8. There shall be a written, organized orientation program for all residents which shall be planned and implemented to resolve or reduce personal, family, business, and emotional problems that may interfere with the health care, recovery, and rehabilitation of the individual and which shall be available for review by the department. (III)

9. Infants and children under the age of 18 shall not be admitted as residents to an ICF/PMI for adults unless given prior written approval by the department. A distinct part of an ICF/PMI, segregated from the adult section, may be established based on a résumé of care submitted by the licensee or applicant which is commensurate with the needs of the residents of the health care facility and has received the department's review and approval. (III)

10. Within 30 days of a resident's admission to a health care facility receiving reimbursement through the medical assistance program under Iowa Code chapter 249A, the facility shall ask the resident or the resident's personal representative whether the resident is a veteran and shall document the response. If the facility determines that the resident is a potential veteran, the facility shall report the resident's name along with the names of the resident's spouse and any dependent children, as well as the name of the contact person for this information, to the Iowa department of veterans affairs. Where appropriate, the facility may also report such information to the Iowa department of human services.

If a resident is eligible for benefits through the United States Department of Veterans Affairs or other third-party payor, the facility first shall seek reimbursement from the identified payor source before seeking reimbursement from the medical assistance program established under Iowa Code chapter 249A.

The provisions of this paragraph shall not apply to the admission of an individual as a resident to a state mental health institute for acute psychiatric care. (II, III)

This rule is intended to implement Iowa Code sections 135C.3 and 135C.23.

**481—65.11(135C) Evaluation services.** Each resident admitted shall have a physical examination and tuberculin test no more than 30 days before admission and a physical examination annually after that. Each annual examination shall be sufficient to ensure the resident has no physical condition which precludes living in the facility. If the resident is admitted directly from a hospital, a copy of the hospital admission physical and discharge summary may meet this requirement. (II, III)

**65.11(1)** In addition to the required initial physical examination, each resident shall be evaluated to identify physical health, current level of functioning and the need for services. This evaluation shall be completed within 30 days of admission and annually after that. Information from other sources may be used in the evaluation if the information meets the requirements of subrules 65.11(2) and 65.11(3). (II, III)

**65.11(2)** The portion of the evaluation which describes the resident's physical health shall:

*a.* Identify current illnesses and disabilities and include recommendations for physical and physiological treatment and services; (II, III)

*b.* Include a description of the resident's ability for health maintenance; (II)

*c.* Include a mental status examination and history of mental health and treatments; (II, III) and

*d.* Be performed by a physician with a valid license to practice medicine and surgery, osteopathic medicine and surgery or osteopathy in Iowa. If the evaluation is not conducted in Iowa, it must be by a physician who holds a current license in the state in which the examination is performed. If the doctor is not a psychiatrist, a psychiatrist or health service provider in psychology licensed under Iowa Code section 154B.7 shall be consulted regarding the results of the mental status examination. (II, III)

**65.11(3)** The portion of the evaluation which describes the resident's current functioning level and need for services shall:

*a.* Identify the functioning level and need for services in self-care, community living skills, psychotherapeutic treatment, vocational skills, and academic skills as appropriate; (II, III)

*b.* Contain sufficient detail about skills and needs to determine appropriate placement; (II, III)

*c.* Be made without regard to the availability of services; (III) and

*d.* Be performed by a QMHP, consulting with an interdisciplinary team. (III)

**65.11(4)** Results of all evaluations shall be in writing and maintained in resident records. After the initial evaluation, all subsequent evaluations shall contain sufficient detail to determine changes in the resident's physical and mental health, skills, and need for services. (II, III)

**65.11(5)** A narrative social history shall be completed for each resident within 30 days of admission. The social history shall be completed and approved by the qualified mental health professional before the IPP is developed. (III)

*a.* When a social history is secured from another provider, the information shall be reviewed within 30 days of admission. The date of the review and a summary of significant changes in the information shall be entered in the resident's record. The social worker who reviews the history shall sign it. (III)

*b.* An annual review of the social history information shall be incorporated in the individual program plan progress notes. (III)

*c.* The social history shall address at least the following areas:

(1) Referral source and reason for admission; (II, III)

(2) Legal status; (II, III)

(3) Previous living arrangements; (III)

(4) Services received previously and current service involvements; (II, III)

(5) Significant medical and mental health conditions including at least illnesses, hospitalizations, past and current drug therapy, and special diets; (II, III)

(6) Substance abuse history; (II, III)

(7) Work history; (III)

(8) Education history; (II)

(9) Relationship with family, significant others, and other support systems; (III)

(10) Cultural, ethnic and religious background; (II, III)

(11) Hobbies and leisure time activities; (III)

(12) Likes, dislikes, habits, and patterns of behavior; (II, III)

(13) History of aggressive or suicidal behavior; (I, II, III) and

(14) Impressions and recommendations. (II, III)

This rule is intended to implement Iowa Code section 135C.14(7).

**481—65.12(135C) Individual program plan (IPP).** An initial program plan shall be developed within 24 hours of admission. This plan shall be based on information gained from the resident, family, physician or referring facility. Services to be provided shall be addressed. Intervention to be provided, if and when the need arises, shall also be addressed in the IPP. The plan shall be followed until the IPP required in subrule 65.12(1) is complete. The initial plan shall be completed by a registered nurse, a qualified social worker or a QMHP. (II, III)

**65.12(1)** An individual program plan for each resident shall be developed by an interdisciplinary team. The resident or the resident's legal guardian has the ultimate authority to accept or reject the plan unless otherwise determined by the court. The IPP shall be approved and have implementation monitored by the QMHP. (II, III)

*a.* The IPP shall be based on the individual service plan of the referring agency, if available, the information contained in the social history, the need for services identified in the evaluation, and any other pertinent information. (III)

*b.* The facility shall assist the resident in obtaining access to academic services, community living skills training, legal services, self-care training, support services, transportation, treatment, and vocational education as needed. These services may be provided by the facility or obtained from other providers. (III)

*c.* Services to the resident shall be provided in the least restrictive environment and shall incorporate the principle of normalization. (III)

*d.* If needed services are not available and accessible, the facility shall document the actions taken to locate and obtain those services. The documentation shall identify needs which will not be met because of the lack of available services. (III)

*e.* The IPP shall be developed within 30 days following admission to the facility and renewed at least annually. (II, III)

*f.* The IPP shall be written, dated, signed by the interdisciplinary team members, and maintained in the resident's record. (III)

*g.* Written notice of the meeting to develop an IPP shall be mailed or delivered to everyone included in the interdisciplinary team conference at least two weeks before the scheduled meeting. (III)

**65.12(2)** The IPP shall include the following:

*a.* Goals, (III)

*b.* Objectives, (III)

*c.* Specific services to be provided, (III)

*d.* People or agency responsible for providing services, (III)

*e.* Beginning date, (III) and

*f.* Anticipated duration of services. (III)

**65.12(3)** The IPP shall set out the procedure to be used to evaluate whether objectives are achieved. This procedure shall incorporate a process for ongoing review and revision. (III)

**65.12(4)** The interdisciplinary team shall review the IPP at a team meeting at least quarterly and when the resident's condition changes. (II, III)

*a.* The interdisciplinary team shall develop a written report which addresses:

(1) The resident's progress toward objectives; (II, III)

(2) The need for continued services; (II, III)

(3) Recommendations concerning alternative services or living arrangements; (II, III) and

(4) Any recommended change in guardianship, conservatorship or commitment status. (II, III)

*b.* The report shall reflect those involved in the review, the date of the review, and be maintained in the resident's record. (III)

**65.12(5)** There shall be procedures for recording the activities of each service provider and a mechanism to coordinate the activities of all service providers. Resident response to all activities shall be recorded. (III)

*a.* Staff shall create a record at the time of a service required by the IPP. If this is not possible, the record shall be written no more than seven days later. (III)

*b.* When the services are provided more than once a week, staff may make a monthly summarized entry in the resident's record. (III)

*c.* Entries shall be dated and signed by the person who provides the service. (III)

*d.* Entries shall be made when incidents occur. (III)

*e.* Entries shall be written in terms of behavioral observations and specific activities. Entries that involve subjective interpretations of a resident's behavior or progress shall be clearly identified and shall be supplemented with descriptions of behavior upon which the interpretation was based. (III)

This rule is intended to implement Iowa Code section 135C.14.

**481—65.13(135C) Activity program.** Each ICF/PMI shall have an organized activity program which is directed by a person qualified as required by 65.9(3)“d.”

**65.13(1)** An activity program plan for the facility shall be based on needs identified in IPPs and on other interests expressed by residents. The activity program shall include leisure time management. (III)

**65.13(2)** Activities shall be offered at least daily during the daytime hours if residents are present, twice weekly in the evening and twice on the weekend. (III)

**65.13(3)** Activities offered shall be varied and shall be planned for individuals, small groups or large groups. (III)

**65.13(4)** Monthly calendars shall be prepared in advance and shall be kept for review by the department. Substitutions and cancellations shall be noted. (III)

**65.13(5)** Activities department personnel shall coordinate programs with other facility personnel. (III)

**481—65.14(135C) Crisis intervention.** There shall be written policies and procedures concerning crisis intervention. (II) These policies and procedures shall be:

1. Directed to maximizing the growth and development of the individual by incorporating a hierarchy of available alternative methods that emphasize positive approaches; (II, III)

2. Available in each program area and living unit; (II, III)

3. Available to individuals and their families; (II, III) and

4. Developed with the participation, as appropriate, of individuals served. (II, III)

**65.14(1)** Corporal punishment, physical abuse, and verbal abuse, for example, shouting, screaming, swearing, name calling, or any other activity which might damage an individual's self-respect shall be prohibited. All residents shall be treated with fairness and respect as required by rule 481—65.25(135C). (II)

**65.14(2)** Medication shall not be used as punishment, for the convenience of staff, or as a substitute for a program. Direct care staff shall monitor residents on medication and notify the physician if a resident is too sedated to participate in the IPP. (I, II)

**481—65.15(135C) Restraint or seclusion.** Physician's orders are required to use any kind of mechanical restraints or seclusion. (I, II, III) Restraints are defined as the following:

1. Type I is physical restraint which uses equipment to promote the safety of the individual. It is not applied directly to a person. Examples: divided doors and side rails.

2. Type II is mechanical restraint applied to someone's body. A device is applied to the body to promote safety of the individual. Examples: vests or soft tie devices, hand socks, geriatric chairs.

3. Type III is mechanical restraint applied to any part of the body which inhibits only the movement of that part of the body. Examples: wrist, ankle or leg restraints and waist straps.

**65.15(1)** Temporary restraint of residents shall be used only to prevent injury to the resident or to others. (I, II)

**65.15(2)** Temporary seclusion may be used:

*a.* To prevent injury to the resident or to others; (I, II)

*b.* To prevent serious disruption to the treatment program of other residents; (I, II)

*c.* To decrease stimulation which contributes to psychotic behavior; (I, II) and

*d.* When other interventions have failed. (I, II)

Restraint and seclusion shall not be used for punishment, for the convenience of staff, or as a substitution for supervision of program. Seclusion shall be used only in a department approved seclusion room. (I, II)

**65.15(3)** Restraints shall be stored in an area easily accessible to staff. (I, II, III) Type II and Type III restraints shall be specifically designed, manufactured, and customarily used to restrain individuals hospitalized in licensed psychiatric hospitals. Metal and plastic handcuffs, rope and makeshift devices are prohibited. (I, II)

**65.15(4)** Under no circumstances shall a resident be allowed to participate in the restraint of another resident. (I, II)

**65.15(5)** There shall be written policies that address the basic assumption and philosophy that govern the use of seclusion and physical and mechanical restraint. These shall:

- a. Define the uses of seclusion and mechanical restraints; (III)
- b. Designate staff who may authorize its use; (III)
- c. Identify procedures to follow when implementing the policy which shall include provisions to ensure privacy and safety for restrained residents; (III) and
- d. A written plan for treatment following the use of restraint or seclusion.

**65.15(6)** The physician and QMHP shall be notified immediately of the resident's need for placement in restraint or seclusion. An order for restraint or seclusion identifying the type, purpose and duration of use shall be obtained from the physician. If the resident is in seclusion longer than four hours, the physician and qualified mental health professional shall visit and evaluate the resident before the seclusion order is continued. If the resident is in restraint for two hours, the physician shall be called before the restraint order can be continued. If the resident is in restraint longer than four hours, the physician and QMHP shall visit and evaluate the resident before a restraint order is continued. Standing or PRN orders for seclusion or restraint are prohibited. (I, II)

**65.15(7)** If a resident is restrained with Type II or Type III restraints for 6 hours or secluded for 12 hours in a 24-hour period; or if the resident is secluded or restrained with Type II or Type III restraints for any amount of time in three consecutive 24-hour periods, the physician and QMHP shall visit the resident and assess the resident's need for a higher level of care. If the need for restraint or seclusion continues, the resident shall be transferred to an acute level of care. (I, II)

**65.15(8)** During any period of mechanical restraint or seclusion, the facility shall provide for the emotional and physical needs of the resident. (I, II)

**65.15(9)** The resident shall be informed of the reason for seclusion and restraint and conditions for release. The resident's guardian shall be notified when Type II or Type III restraints or seclusion is used. The facility shall also notify the resident's family or other significant person if the resident has previously signed a form granting consent to do so. (I, II, III)

**65.15(10)** Each resident's record shall contain all information about restraints or seclusion. The administrator shall maintain a daily record of seclusion use. This record shall be available for review by the department. (II, III)

Documentation of each incident of restraint or seclusion shall include at least:

- a. Clinical assessment before the resident is secluded or restrained; (I, II)
- b. Circumstances that led to seclusion or restraint; (I, II)
- c. Explanation of less restrictive measures used before restraint or seclusion; (I, II)
- d. Physician's order; (I, II)
- e. Visual observation of the resident every 15 minutes, or more frequently if needed, to monitor general well-being including respirations, circulation, positioning and alertness as indicated; (I, II)
- f. Description of the resident's activity at the time of observation to include verbal exchange and behavior; (I, II)
- g. Description of safety procedures taken (removal of dangerous objects, etc.); (I, II)
- h. Vital signs, including blood pressure, pulse and respiration unless contraindicated by resident behavior and reasons documented; (I, II)
- i. Release of each mechanical restraint and exercise and massage every two hours; (I, II, III)
- j. Record of intake of food and fluid; (I, II, III)
- k. Use of toilet; (II, III) and
- l. Number of hours and minutes in seclusion. (II, III)

**65.15(11)** The facility shall educate staff on restraint and seclusion theory and techniques. The training shall be conducted by people with experience and documented education in the appropriate use of restraint and seclusion. (II, III)

*a.* The facility shall keep a record of the training for review by the department and shall include attendance. (II, III)

*b.* Only staff who have documented training in restraint and seclusion theory and techniques shall be authorized to assist with seclusion or restraint of a resident. (I, II, III)

**65.15(12)** The facility shall maintain a record of the hours and minutes of each type of restraint and seclusion used on a monthly basis.

**481—65.16(135C) Discharge or transfer.** Procedures for the discharge or transfer of the resident shall be established and followed. (II, III)

**65.16(1) Discharge plan.** The decision to discharge a person and the plan for doing so shall be established through the participation of the resident, members of the interdisciplinary team and other resource personnel as appropriate for the welfare of the individual. (II, III)

*a.* Discharge planning shall begin within 30 days of admission and be carried out in accordance with the IPP. (II, III)

*b.* As changes occur in a resident's physical or mental condition necessitating services or care which cannot be adequately provided by the facility, the resident shall be transferred promptly to another appropriate facility pursuant to subrule 65.10(1). (II, III)

*c.* Notification shall be made to the next of kin, legal representative, attending physician, and sponsoring agency, if any, prior to transfer or discharge of any resident. (III)

*d.* Proper arrangements shall be made for the welfare of the resident prior to the transfer or discharge in the event of an emergency or inability to reach the next of kin or legal representative. (III)

*e.* The licensee shall not refuse to discharge or transfer a resident when directed by the physician, resident, legal representative, or court. (II, III)

*f.* Advanced notification by telephone shall be made to the receiving facility prior to the transfer of any resident. (III)

*g.* When a resident is transferred or discharged, the current evaluation and treatment plan and progress notes for the last 30 days, as set forth in these rules, shall accompany the resident. (II, III)

*h.* Prior to the transfer or discharge of a resident to another health care facility, arrangements to provide for continuity of care shall be made with the facility to which the resident is being sent. (II, III)

*i.* A discharge or transfer authorization and summary shall be prepared for each resident who has been discharged or transferred from the facility. It shall be disseminated to appropriate persons to ensure continuity of care and in accordance with the requirements to ensure confidentiality. (II, III)

*j.* A transfer to a part of a facility that has a different license must be handled the same way as a transfer to another facility, and not as an intrafacility transfer. (II, III)

**65.16(2) Intrafacility transfer.** Residents shall not be arbitrarily moved from room to room within a health care facility. (II, III)

*a.* Involuntary relocation may occur only to implement goals and objectives in the IPP and in the following situations:

(1) Incompatibility with or behavior disturbing to roommates, as documented in the residents' records; (I, II)

(2) To allow a new admission to the facility which would otherwise not be possible due to separation of roommates by sex; (II, III)

(3) Reasonable and necessary administrative decisions regarding the use and functioning of the building. (II, III)

*b.* Unreasonable and unjustified reasons for changing a resident's room without the concurrence of the resident or legal guardian include:

(1) Punishment or behavior modification; (II) and

(2) Discrimination on the basis of race or religion. (II, III)

c. If intrafacility relocation is necessary for reasons outlined in paragraph “a,” the resident shall be notified at least 48 hours prior to the transfer and the reason shall be explained. The legal guardian shall be notified as soon as possible. The notification shall be documented in the resident’s record and signed by the resident or legal guardian within seven days unless documentation indicates that it was not possible to contact the legal guardian or obtain their signature. (II, III)

d. If emergency relocation is required to protect the safety or health of the resident or other residents, the notification requirements may be waived. The conditions of the emergency shall be documented. The family and legal guardian shall be notified immediately, or as soon as possible, of the condition requiring emergency relocation, and the notification shall be documented. (II, III)

**65.16(3) *Involuntary discharge or transfer—reasons.*** Residents shall be transferred or discharged from the facility in accordance with contract arrangements and requirements of Iowa Code chapter 135C which states that a resident shall be transferred or discharged only for the following:

a. Medical reasons which include:

(1) Acute stage of alcoholism, mental illness, or an active state of a communicable disease; (I, II)

or

(2) Need for medical procedures as determined by a physician, or services which cannot be or are not being carried out in the facility; (I, II)

b. Resident’s welfare or welfare of other residents which includes residents who are dangerous to themselves or other residents; (I) or

c. Nonpayment except as prohibited by Medicaid. (II)

**65.16(4) *Involuntary transfer or discharge—written notice.*** Involuntary transfer or discharge of a resident from a facility shall be preceded by a written notice to the resident or responsible party at least 30 days in advance of the proposed transfer or discharge. (II) The 30-day requirement shall not apply in any of the following instances:

a. If an emergency transfer or discharge is mandated by the resident’s health care needs and is in accord with the written orders and written medical justification of the attending physician. Emergency transfers or discharges may also be mandated to protect the health, safety, or well-being of other residents and staff. (I, II)

b. If the transfer or discharge is subsequently agreed to by the resident or by the resident’s legal guardian, and notification is given to the legal guardian, physician, and the person or agency responsible for the resident’s placement, maintenance and care in the facility. (II)

**65.16(5) *Contents of notice.*** The notice required by 65.16(4) shall contain all of the following information:

a. The stated reason for the proposed transfer or discharge. (II)

b. The effective date of the proposed transfer or discharge. (II)

c. The following statement must be included:

“You have a right to appeal the facility’s decision to transfer or discharge you. If you think you should not have to leave this facility, you may request a hearing in writing or verbally with the Iowa department of inspections and appeals (hereinafter referred to as “department”) within 7 days after receiving this notice. You have a right to be represented at the hearing by an attorney or any other individual of your choice. If you request a hearing, it will be held no later than 14 days after receipt of your request by the department and you will not be transferred prior to a final decision. Provision may be made for extension of the 14-day requirement upon request to the department designee in emergency circumstances. If you lose the hearing, you will not be transferred before the expiration date of 30 days following receipt of the original notice of the discharge or transfer, or no sooner than 5 days following final decision of such hearing. To request a hearing or receive further information, call the department at (515)281-4115 or you may write to the department to the attention of: Administrator, Division of Health Facilities, Iowa Department of Inspections and Appeals, Lucas State Office Building, Des Moines, Iowa 50319-0083.” (II)

**65.16(6) *Stay of transfer or discharge.*** A request for a hearing made under 65.16(5) “c” shall stay a transfer or discharge pending a hearing or appeal decision. (II)

*a.* The type of hearing determined by a representative of the department. Notice of the date, time, and place of the hearing shall be sent by United States mail or delivered in person to the licensee, resident, legal guardian, and Iowa department on aging's long-term care resident's advocate/ombudsman of record not later than five full business days after receipt of the request. This notice shall also inform the licensee, resident, and legal guardian that they have a right to appear at the hearing in person or be represented by their attorneys or other individuals. The hearing shall be dismissed if neither party is present or represented at the hearing. If only one party appears or is represented, the hearing shall proceed with one party present. The Iowa department on aging's long-term care resident's advocate/ombudsman shall have the right to appear at the hearing. (II)

*b.* The hearing shall be heard by a department of inspections and appeals administrative law judge pursuant to department rules. The licensee or designee shall have the opportunity to present oral testimony or written materials to show by a preponderance of the evidence just cause why a transfer or discharge may be made. The resident and legal guardian shall also have an opportunity to present oral testimony or written material to show just cause why a transfer or discharge should not be made; the burden of proof rests on the party requesting the transfer or discharge. (II)

*c.* Based upon all testimony and materials submitted to the representative of the department, the representative shall issue, in accordance with Iowa Code chapter 17A, written findings of fact, conclusions of law, and issue a decision and order. This decision shall be mailed by regular mail to the licensee, resident, legal guardian, and department on aging's long-term care resident's advocate/ombudsman within ten working days after the hearing has been concluded. (II)

*d.* Based upon all testimony and material submitted to the representative of the department, the representative shall issue, in accordance with Iowa Code chapter 17A, written findings of fact and conclusions of law and issue a decision and order in respect to the adverse action. This decision shall be mailed by certified mail to the licensee, resident, responsible party, and department on aging's long-term care resident's advocate/ombudsman within 10 working days after the hearing has been concluded. The representative shall have the power to issue fines and citations against the facility in appropriate circumstances.

A request for review of a proposed decision in which the department is the final decision maker shall be made within 15 days of issuance of the proposed decision, unless otherwise provided by statute. Requests shall be mailed or delivered by either party to the Director, Department of Inspections and Appeals, Lucas State Office Building, Des Moines, Iowa 50319-0083. Failure to request review will preclude judicial review unless the department reviews a proposed decision upon its own motion within 15 days of the issuance of the decision. (II)

*e.* A copy of the notice required by 65.16(4) shall be personally delivered to the resident by the licensed facility and a copy placed in the resident's record. A copy shall also be transmitted to the department, the resident's legal guardian, physician, the person or agency responsible for the resident's placement, maintenance, and care in the facility, and the department on aging's long-term care resident's advocate/ombudsman. (II)

*f.* If nonpayment is the basis for involuntary transfer or discharge, the resident shall have the right to make full payment up to the date that the discharge or transfer is to be made and then shall have the right to remain in the facility. (II)

*g.* The involuntary transfer or discharge shall be discussed with the resident, legal guardian, and the person or agency responsible for the resident's placement, maintenance, and care in the facility within 48 hours after notice of discharge has been received. The explanation and discussion of the reasons for involuntary transfer or discharge shall be given by the facility administrator or other appropriate facility representative as the administrator's designee. The content of the discussion and explanation shall be summarized in writing and shall include the names of the individuals involved in the discussions and shall be made a part of the resident's record. (II)

*h.* The resident shall receive counseling services before (by the sending facility) and after (by the receiving facility) the involuntary transfer to minimize the possible adverse effects of the involuntary transfer. Counseling shall be documented in the resident's record. Counseling shall be provided by a qualified individual who meets one of the following criteria:

- (1) Has a bachelor's or master's degree in social work from an accredited college; (II)
- (2) Is a graduate of an accredited four-year college and has had at least one year of full-time paid employment in a social work capacity with a public or private agency; (II)
- (3) Has been employed in a social work capacity for a minimum of four years in a public or private agency; (II) or

(4) Is a licensed psychologist or psychiatrist. (II)

*i.* The facility shall develop a plan to provide for the orderly and safe transfer or discharge of each resident to be discharged or transferred. (II)

*j.* The receiving health care facility of a resident involuntarily discharged or transferred shall immediately formulate and implement a plan of care which takes into account possible adverse effects the transfer may cause. (II)

*k.* In the case of an emergency transfer or discharge as outlined in 65.16(4) "b," the resident must still be given a written notice prior to or within 48 hours following transfer or discharge. A copy of this notice must be placed in the resident's file and it must contain all the information required by 65.16(5). In addition, the notice must contain a statement in not less than 12-point type, which reads:

"You have a right to appeal the facility's decision to transfer or discharge you on an emergency basis. If you think you should not have to leave this facility, you may request a hearing in writing or verbally with the Iowa department of inspections and appeals (hereinafter referred to as "department") within seven days after receiving this notice. You have the right to be represented at the hearing by an attorney or any other individual of your choice. If you request a hearing, it will be held no later than 14 days after receipt of your request by the department. You may be transferred or discharged before the hearing is held or before a final decision is rendered. If you win the hearing, you have the right to be transferred back into the facility. To request a hearing or receive further information, call the department at (515)281-4115 or you may write to the department to the attention of: Administrator, Division of Health Facilities, Department of Inspections and Appeals, Lucas State Office Building, Des Moines, Iowa 50319-0083."

A hearing requested pursuant to this subrule shall be held in accordance with 65.16(6) "a," "b" and "c." (II)

*l.* Residents shall not have the right to a hearing to contest an involuntary discharge or transfer resulting from the revocation of the facility's license by the department. In the case of a facility voluntarily closing, a period of 30 days must be allowed for an orderly transfer of residents to other facilities. (II)

This rule is intended to implement Iowa Code sections 135C.14(8), 135C.31, 135C.43, and 135C.46.

**481—65.17(135C) Medication management.** Medications shall be prescribed on an individual basis by a person who is authorized by Iowa law to prescribe. (I, II)

- 1. Medication orders shall be correctly implemented by qualified personnel. (II)
- 2. Qualified staff shall ensure that residents are able to take their own medication. (I, II)
- 3. Each physician order allowing a resident to self-administer medications shall specify whether this self-medication shall be without supervision or under the supervision of qualified staff as defined in 65.17(2). (I, II)

**65.17(1)** A properly trained person shall be charged with the responsibility of administering nonparenteral medications.

*a.* The individual shall have knowledge of the purpose of the drugs, their dangers, and contraindications.

*b.* This person shall be a licensed nurse or physician or shall have successfully completed a department-approved medication aide course or passed a department-approved medication aide challenge examination administered by an area community college.

*c.* Prior to taking a department-approved medication aide course, the individual shall:

- (1) Successfully complete an approved nurse aide course, nurse aide training and testing program or nurse aide competency examination.

(2) Be employed in the same facility for at least six consecutive months prior to the start of the medication aide course. This requirement is not subject to waiver.

(3) Have a letter of recommendation for admission to the medication aide course from the employing facility.

*d.* A person who is a nursing student or a graduate nurse may take the challenge examination in place of taking a medication aide course. This individual shall do all of the following before taking the medication aide challenge examination:

(1) Complete a clinical or nursing theory course within six months before taking the challenge examination;

(2) Successfully complete a nursing program pharmacology course within one year before taking the challenge examination;

(3) Provide to the community college a written statement from the nursing program's pharmacology or clinical instructor indicating the individual is competent in medication administration;

(4) Successfully complete a department-approved nurse aide competency evaluation.

*e.* A person who has written documentation of certification as a medication aide in another state may become a medication aide in Iowa by successfully completing a department-approved nurse aide competency examination and a medication aide challenge examination.

The requirements of paragraph "c" of this subrule do not apply to this individual.

*f.* Unit dose medication shall remain in the identifiable unit dose package until given to the resident. (II)

*g.* Medications that are not contained in unit dose packaging shall be set up, identified by resident name and medication name, and administered by the same person. The medications shall be administered within one hour of preparation. (II)

*h.* The person administering medications must observe and check to make sure the resident swallows oral medications and must record the date, time, amount and name of each medication given. (II)

*i.* Injectable medications shall be administered as permitted by Iowa law by a qualified nurse, physician, pharmacist, or physician assistant (PA). In the case of a resident who has been certified by the resident's physician or physician assistant (PA) as capable of taking the resident's own insulin, the resident may prepare and inject the resident's own insulin. (II)

*j.* Current and accurate records must be kept on the receipt and disposition of all Schedule II drugs. (II, III)

**65.17(2)** For each resident who is taking medication with or without supervision, there shall be documentation on the individual's record to include:

*a.* Name of resident; (II, III)

*b.* Name of drug, dose, and schedule; (II, III)

*c.* Method of administration; (II, III)

*d.* Identified drug allergies and observed adverse reactions; (I, II)

*e.* Special precautions for that resident; (I, II) and

*f.* Documentation of resident's continuing ability to administer own medication. (I, II)

**65.17(3)** Medication counseling shall be provided for all residents in accordance with the IPP on an ongoing basis and as part of discharge planning unless contraindicated in writing by the physician with reasons and pursuant to 65.12(2)"c." (II, III)

Each resident and when appropriate, a family member or other identified caregiver, shall be given verbal and written information about all medications the resident is currently using, including over-the-counter medications. A suggested reference is "USPDI, Advice for the Patient." (II, III)

The information shall include:

*a.* Name, reason for, and amount of medication to be taken; (II)

*b.* Time medication is to be taken and reason that the schedule was established; (II)

*c.* Possible benefits, risks and side effects of each medication, including over-the-counter medications; (II)

*d.* A list of resources in the community qualified to answer questions about medications; (II, III) and

*e.* A list of available resources or agencies which may assist the resident to obtain medication after discharge. (III)

**65.17(4)** Residents who have been certified in writing by the physician as capable of taking their own medications may retain these medications in a secure centralized location. Individual locked storage shall be utilized. (II, III)

*a.* Drug storage for residents who are unable to take their own medications and require supervision shall meet the following requirements:

(1) Adequate size cabinet with lock which can be used for storage of drugs, solutions, and prescriptions. A locked drug cart may be used. (II, III)

(2) A bathroom shall not be used for drug storage. (II, III)

(3) The drug storage cabinet shall be kept locked when not in use. (II, III)

(4) The drug storage cabinet key shall be in the possession of the employee charged with the responsibility of administering medication. (II, III)

(5) Medications requiring refrigeration which are stored in a common refrigerator shall be kept in a locked box properly labeled, and separated from food and other items. (II, III)

(6) Drugs for external use shall be stored separately from drugs for internal use. External medications are those to be applied to the outside of the body and include, but are not limited to, salves, ointments, gels, paste, soaps, baths, and lotions. Internal medications are those to be applied inside the body or ingested and include, but are not limited to, oral and injectable medications, eye drops and ointments, ear drops and ointments, and suppositories. Also, eye drops and ear drops shall be separated from each other as well as from other internal and external medications. (II, III)

(7) All potent, poisonous, or caustic materials shall be stored in a separate room from the medications. (II, III)

(8) Inspection of the condition of stored drugs shall be made by the administrator and a licensed pharmacist not less than once every three months. The inspection shall be verified by a report signed by the administrator and the pharmacist and filed with the administrator. The report shall include, but need not be limited to, certifying absence of the following: expired drugs, deteriorated drugs, improper labeling, drugs for which there is no current order, and drugs improperly stored. (III)

(9) Double-locked storage of Schedule II drugs shall not be required under single unit package drug distribution systems in which the quantity stored does not exceed a seven-day supply and a missing dose can be readily detected but must be kept in a locked medication cabinet. Quantities in excess of a seven-day supply must be double-locked. (II)

*b.* Bulk supplies of prescription drugs shall not be kept. (III)

**65.17(5)** All labels on medications must be legible. If labels are not legible, the medication shall be sent back to the dispenser as defined in Iowa Code section 147.107 for relabeling. (II, III)

*a.* The medication for each resident shall be kept or stored in the original dispensed containers. (II, III)

*b.* The facility shall adopt policies and procedures to destroy unused prescription drugs for residents who die. The policies and procedures shall include, but not be limited to, the following:

(1) Drugs shall be destroyed by the person in charge in the presence of the administrator or the administrator's designee or, if a unit dose system is used, the drugs shall be returned to the supplying pharmacist; (III)

(2) Notation of the destruction shall be made in the resident's chart, with signatures of the persons involved in the destruction; (III)

(3) The manner in which the drugs are disposed of shall be identified (i.e., incinerator, sewer, landfill). (II, III)

*c.* Reserved.

*d.* The facility shall also adopt policies and procedures for the disposal of controlled substances as defined by the Iowa board of pharmacy dispensed to residents whose administration has been

discontinued by the prescriber. These policies and procedures shall include, but not be limited to, the following:

- (1) Procedures for obtaining a release from the resident; (II, III)
- (2) The manner in which the drugs were destroyed and by whom, including witnesses to the destruction; (II, III)
- (3) Mechanisms for recording the destruction; (II, III)
- (4) Procedures to be used when the resident or the conservator or guardian refuses to grant permission for destruction. (II, III)
  - e.* The facility shall adopt policies and procedures for the disposal of unused, discontinued medication. The procedures shall include, but not be limited to:
    - (1) A specified time after which medication must be destroyed, sent back to the dispenser or placed in long-term storage; (II, III)
    - (2) Procedures for obtaining permission of the resident, or the conservator or guardian; (II, III)
    - (3) Procedures to be used when the resident, conservator or guardian refuses to grant permission for disposal; (II, III)
    - (4) Unused, discontinued medication shall be locked and shall be separate from current medication. (II, III)
  - f.* Reserved.
  - g.* Residents shall not keep any prescription or over-the-counter medication in their possession unless the resident has been determined to be capable of self-administration of medications. (I, II, III)
  - h.* No prescription drugs shall be administered to a resident without a written order signed by a person qualified to prescribe the medication and renewed quarterly. (II)
  - i.* Prescription drugs shall be reordered only with the permission of the attending prescriber. (II, III)
  - j.* No medications prescribed for one resident may be administered to or allowed in the possession of another resident. (II)

**65.17(6)** Each facility shall establish policies and procedures to govern the administration of prescribed medications to residents on leave from the facility. (III)

- a.* Medication may be issued to residents who will be on leave from a facility for less than 24 hours. Non-child-resistant containers may be used. Each container may hold only one medication. A label on each container shall indicate the date, the resident's name, the facility, the medication, its strength, dose, and time of administration. (II, III)
- b.* Medication for residents on leave from a facility longer than 24 hours shall be obtained in accordance with requirements established by the Iowa board of pharmacy examiners. (II, III)
- c.* Medication distributed as described in this subrule may be issued only by facility personnel responsible for administering medication. (II, III)

**65.17(7)** Each ICF/PMI that administers controlled substances shall annually obtain a registration from the Iowa board of pharmacy examiners pursuant to Iowa Code section 204.302(1). (III)

This rule is intended to implement Iowa Code section 135C.14.

[ARC 1050C, IAB 10/2/13, effective 11/6/13]

**481—65.18(135C) Resident property and personal affairs.** The admission of a resident does not give the facility or any employee of the facility the right to manage, use, or dispose of any property of the resident except with the written authorization of the resident or the resident's legal guardian. (II, III)

**65.18(1)** The admission of a resident shall not grant the ICF/PMI the authority or responsibility to manage the personal affairs of the resident except as may be necessary for the resident's safety and for safe and orderly management of the facility as required by these rules and in accordance with the IPP. (III)

**65.18(2)** An ICF/PMI shall provide for the safekeeping of personal effects, funds, and other property of its residents. The facility may require that items of exceptional value or which would convey unreasonable responsibilities to the licensee be removed from the premises of the facility for safekeeping. (III)

**65.18(3)** Residents' funds held by the ICF/PMI shall be in a trust account and kept separate from funds of the facility. (III)

**65.18(4)** No administrator, employee or their representative shall act as guardian, trustee, or conservator for any resident or the resident's property, unless the resident is related to the person acting as guardian within the third degree of consanguinity. (III)

**65.18(5)** If a facility is a county care facility, upon the verified petition of the county board of supervisors, the district court may appoint, without fee, the administrator of a county care facility as conservator or guardian, or both, of a resident of such a county care facility. The administrator may establish either separate or common bank accounts for cash funds of these residents. (III)

This rule is intended to implement Iowa Code section 135C.24.

**481—65.19(135C) Financial affairs.** Residents who have not been assigned a guardian or conservator by the court may manage their personal financial affairs, and to the extent, under written authorization by the residents that the facility assists in management, the management shall be carried out in accordance with Iowa Code section 135C.24. (II)

**65.19(1)** *Written account of resident funds.* The facility shall maintain a written account of all residents' funds received by or deposited with the facility. (II)

*a.* An employee shall be designated in writing to be responsible for resident accounts. (II)

*b.* The facility shall keep on deposit personal funds over which the resident has control when requested by the resident. (II)

*c.* If the resident requests these funds, they shall be given to the resident with a receipt maintained by the facility and a copy to the resident. If a conservator or guardian has been appointed for the resident, the conservator or guardian shall designate the method of disbursing the resident's funds. (II)

*d.* If the facility makes a financial transaction on a resident's behalf, the resident or the resident's legal guardian or conservator must receive or acknowledge having seen an itemized accounting of disbursements and current balances at least quarterly. A copy of this statement shall be maintained in the resident's financial or business record. (II)

**65.19(2)** *Contracts.* There shall be a written contract between the facility and each resident which meets the following requirements:

*a.* States the base rate or scale per day or per month, the services included, and the method of payment; (III)

*b.* Contains a complete schedule of all offered services for which a fee may be charged in addition to the base rate; (III)

*c.* Stipulates that no further additional fees shall be charged for items not contained in complete schedule of services listed in this subrule; (III)

*d.* States the method of payment of additional charges; (III)

*e.* Contains an explanation of the method of assessment of additional charges and an explanation of the method of periodic reassessment, if any, resulting in changing such additional charges; (III)

*f.* States that additional fees may be charged to the resident for nonprescription drugs, other personal supplies, and services by a barber, beautician, etc.; (III)

*g.* Contains an itemized list of those services, with the specific fee the resident will be charged and method of payment, as related to the resident's current condition, based on the program assessment at the time of admission, which is determined in consultation with the administrator; (III)

*h.* Includes the total fee to be charged initially to the specific resident; (III)

*i.* States the conditions whereby the facility may make adjustments to its overall fees for residential care as a result of changing costs. (III) Furthermore, the contract shall provide that the facility shall give:

(1) Written notification to the resident and responsible party, when appropriate, of changes in the overall rates of both base and additional charges at least 30 days prior to the effective date of changes; (III)

(2) Notification to the resident and payer, when appropriate, of changes in additional charges based on a change in the resident's condition. Notification must occur prior to the date the revised additional

charges begin. If notification is given orally, subsequent written notification must also be given within a reasonable time, not to exceed one week, listing specifically the adjustments made; (III) and

(3) The terms of agreement in regard to refund of all advance payments, in the event of transfer, death, or voluntary or involuntary discharge; (III)

*j.* States the terms of agreement concerning holding and charging for a bed in the event of temporary absence of the resident, which terms shall include, at a minimum, the following provisions:

(1) If a resident has a temporary absence from a facility for medical treatment, the facility shall hold the bed open and shall receive payment for the absent period in accordance with provisions of the contract between the resident or the legal guardian and the facility. (II)

(2) If a resident has a temporary absence from a facility in accordance with the IPP, the facility shall ask the resident and payer if they wish the bed held open. This shall be documented in the resident's record including the response. The bed shall be held open and the facility shall receive payment for the absent periods in accordance with the provisions of the contract between the resident or the legal guardian and the facility. (II)

*k.* States the conditions under which the involuntary discharge or transfer of a resident would be affected; (III)

*l.* States the conditions of voluntary discharge or transfer; (III) and

*m.* Sets forth any other matters deemed appropriate by the parties to the contract. No contract or any provision shall be drawn or construed so as to relieve any health care facility of any requirement or obligation imposed upon it by this chapter or any standards or rules in force pursuant to this chapter. (III)

**65.19(3)** *Contract—copy to party.* Each party shall receive a copy of the signed contract. (III)

**65.19(4)** The contract shall state the terms of agreement concerning the holding and charging for a bed when a resident is hospitalized or leaves the facility temporarily for recreational or therapeutic reasons. The terms shall contain a provision that the bed will be held at the request of the resident or the resident's legal representative.

*a.* The facility shall ask the resident or legal representative if they want the bed held. This request shall be made before the resident leaves or within 48 hours after the resident leaves. The inquiry and the response shall be documented. (II)

*b.* The facility shall reserve the bed when requested for as long as payments are made in accordance with the contract. (II)

This rule is intended to implement Iowa Code sections 135C.23(1) and 135C.24.

#### **481—65.20(135C) Records.**

**65.20(1)** *Resident record.* The licensee shall keep a permanent record about each resident with all entries current, dated, and signed. (II) The record shall include:

*a.* Name and previous address of resident; (III)

*b.* Birth date, sex, and marital status of resident; (III)

*c.* Church affiliation; (III)

*d.* Physician's name, telephone number, and address; (III)

*e.* Dentist's name, telephone number, and address; (III)

*f.* Name, address and telephone number of next of kin or legal representative; (III)

*g.* Name, address and telephone number of the person to be notified in case of emergency; (III)

*h.* Funeral director, telephone number, and address; (III)

*i.* Pharmacy name, telephone number, and address; (III)

*j.* Results of evaluation pursuant to rule 481—65.11(135C); (III)

*k.* Certification by the physician that the resident requires no higher level of care than the facility is licensed to provide; (III)

*l.* Physician's orders for medication and treatments in writing, signed by the physician quarterly and diet orders renewed yearly; (III)

*m.* A notation of yearly or other visits to physician or other professionals, all consultation reports and progress notes; (III)

*n.* Any change in the resident's condition; (II, III)

- o.* A notation describing the resident's condition on admission, transfer, and discharge; (III)
- p.* In the event of a resident's death, notations in the resident's record shall include the date and time of the resident's death, the circumstances of the resident's death, the disposition of the resident's body, and the date and time that the resident's family and physician were notified of the resident's death; (III)
- q.* A copy of instructions given to the resident, legal representative, or facility in the event of discharge or transfer; (III)
- r.* Disposition of personal property; (III)
- s.* Copy of IPP pursuant to subrule 65.12(1); (III) and
- t.* Progress notes pursuant to subrules 65.12(4) and 65.12(5). (III)

**65.20(2) Confidentiality of resident records.** The facility shall have policies and procedures providing that each resident shall be ensured confidential treatment of all information, including information contained in an automatic data bank. The resident's or the resident's legal guardian's written informed consent shall be required for the release of information to persons not otherwise authorized under law to receive it. (II)

A release of information form shall be used which includes to whom the information shall be released, the reason for the information being released, how the information is to be used, and the period of time for which the release is in effect. A third party, not requesting the release, shall witness the signing of the release of information form. (II)

*a.* The facility shall limit access to any resident records to staff and consultants providing professional service to the resident. Information shall be made available to staff only to the extent that the information is relevant to the staff person's responsibilities and duties. (II)

Only those personnel concerned with financial affairs of the residents may have access to the financial information. This is not meant to preclude access by representatives of state or federal regulatory agencies. (II)

*b.* The resident, or the resident's legal guardian, shall be entitled to examine all information and shall have the right to secure full copies of the record at reasonable cost upon request, unless the physician or QMHP determines the disclosure of the record or section is contraindicated in which case this information will be deleted prior to making the record available to the resident. This determination and the reasons for it must be documented in the resident's record by the physician or qualified mental health professional in collaboration with the resident's interdisciplinary team. (II)

**65.20(3) Incident records.** Each ICF/PMI shall maintain an incident record report and shall have available incident report forms. (II, III)

*a.* The report of every incident shall be in detail on a printed incident report form. (II, III)

*b.* The person in charge at the time of the incident shall oversee the preparation and sign the report. (III)

*c.* A copy of the incident report shall be kept on file in the facility available for review and a part of administrative records. (III)

**65.20(4) Retention of records.** Records shall be retained in the facility for five years following termination of services to the resident even when there is a change of ownership. (III)

When the facility ceases to operate, the resident's record shall be released to the facility to which the resident is transferred. If no transfer occurs, the record shall be released to the individual's physician. (III)

This rule is intended to implement Iowa Code section 135C.24.

#### **481—65.21(135C) Health and safety.**

**65.21(1) Physician.** Each resident shall have a designated licensed physician who may be called when needed. (III)

**65.21(2) Emergency care.** Each facility shall have written policies and procedures for emergency medical or psychiatric care to include:

a. A written agreement with a hospital or psychiatric facility or documentation of attempt to obtain a written agreement for the timely admission of a resident who, in the opinion of the attending physician, requires inpatient services; (II, III)

b. Provisions consistent with Iowa Code chapter 229; (II, III) and

c. Immediate notification by the person in charge to the physician or QMHP, as appropriate, of any accident, injury or adverse change in the resident's condition. (I, II)

**65.21(3) First-aid kit.** A first-aid emergency kit shall be available on each floor in every facility. (II, III)

**65.21(4) Infection control.** Each facility shall have a written and implemented infection control program addressing the following:

a. Techniques for hand washing consistent with Guidelines for Handwashing and Hospital Control, 1985, Centers for Disease Control, U.S. Department of Health and Human Services, PB85-923404; (I, II, III)

b. Techniques for handling of blood, body fluids, and body wastes consistent with Guideline for Isolation Precautions in Hospitals, Centers for Disease Control, U.S. Department of Health and Human Services, PB96-138102; (I, II, III)

c. Decubitus care; (I, II, III)

d. Infection identification; (I, II, III)

e. Resident care procedures to be used when there is an infection present consistent with Guideline for Isolation Precautions in Hospitals, Centers for Disease Control, U.S. Department of Health and Human Services, PB96-138102; (I, II, III)

f. Sanitation techniques for resident care equipment; (I, II, III)

g. Techniques for sanitary use and reuse of enteral feeding bags, feeding syringes and urine collection bags; (I, II, III)

h. Techniques for use and disposal of needles, syringes, and other sharp instruments consistent with Guideline for Isolation Precautions in Hospitals, Centers for Disease Control, U.S. Department of Health and Human Services, PB96-138102; (I, II, III) and

i. Aseptic techniques when using:

(1) Intravenous or central line catheter consistent with Guideline for Prevention of Intravascular Device Related Infections, Centers for Disease Control, U.S. Department of Health and Human Services, PB97-130074, (I, II, III)

(2) Urinary catheter, (I, II, III)

(3) Respiratory suction, oxygen or humidification, (I, II, III)

(4) Dressings, soaks, or packs, (I, II, III)

(5) Tracheostomy, (I, II, III)

(6) Nasogastric or gastrostomy tubes, (I, II, III)

(7) Sanitary use and reuse of feeding syringes and single-resident uses and reuse of urine collection bags. (I, II, III)

CDC Guidelines may be obtained from the U.S. Department of Commerce, Technology Administration, National Technical Information Service, 5285 Port Royal Rd., Springfield, Virginia 22161 (1-800-553-6847).

**65.21(5) Disposable items.** There shall be disposable or one-time use items available with provisions for proper disposal to prevent reuse except as allowed by 65.21(4) "g."

**65.21(6) Infection control committee.** Each facility shall establish an infection control committee of representative professional staff responsible for overall infection control in the facility. (III)

a. The committee shall annually review and revise the infection control policies and procedures to monitor effectiveness and suggest improvement. (III)

b. The committee shall meet at least quarterly, submit reports to the administrator, and maintain minutes in sufficient detail to document its proceedings and actions. (III)

c. The committee shall monitor the health aspect and the environment of the facility. (III)

These rules are intended to implement Iowa Code sections 135C.14(3), 135C.14(5) and 135C.14(8).

**65.21(7) Dental services.** The facility shall assist residents to obtain regular and emergency dental services and provide necessary transportation. Dental services shall be performed only on the request of the resident or legal guardian. The resident's physician shall be advised of the resident's dental problems. (III)

**65.21(8) Safe environment.** The licensee of an ICF/PMI is responsible for the provision and maintenance of a safe environment for residents and personnel. (I, II) The ICF/PMI may have locked exit doors and shall meet the fire and safety rules and regulations as promulgated by the state fire marshal. (I, II)

**65.21(9) Disaster.** The licensee shall have a written emergency plan to be followed in the event of fire, tornado, explosion, or other emergency. (II, III)

*a.* The plan shall be posted. (II, III)

*b.* Training shall be provided to ensure that all employees and residents are knowledgeable of the emergency plan. The training shall be documented. (II, III)

*c.* Residents shall be permitted to smoke only in posted areas where proper facilities are provided. Smoking by residents considered to be careless shall be prohibited except under direct supervision and in accordance with the IPP. (II, III)

**65.21(10) Safety precautions.** The facility shall take reasonable measures to ensure the safety of residents and shall involve the residents in learning the safe handling of household supplies and equipment in accordance with the policies and procedures established by the facility. (II)

All potent, poisonous, or caustic materials shall be plainly labeled and stored in a specific locked, well-illuminated cabinet, closet, or storeroom and made accessible only to authorized persons. (I, II)

**65.21(11) Hazards.** Entrances, exits, steps, and outside steps and walkways shall be cleared of ice and snow as soon as possible, and kept free of other hazards. (II, III)

**65.21(12) Laundry.** All soiled linens shall be collected in and transported to the laundry room in closed, leakproof laundry bags or covered, impermeable containers. (III)

*a.* Except for related activities, the laundry room shall not be used for other purposes. (III)

*b.* Personal laundry shall be marked with an identification unless the residents are responsible for doing their own laundry as indicated in the individual program plan. (III)

*c.* There shall be an adequate supply of clean, stain-free linens so that each resident shall have at least three washcloths, hand towels, and bath towels per week. (III)

*d.* Each bed shall be provided with clean, stain-free washable bedspreads and sufficient lightweight serviceable blankets. A complete change of bed linens shall be available for each bed. Linens on beds shall be clean, stain-free and in good repair at all times. (III)

**65.21(13) Supplies, equipment, and storage.** Each facility shall provide a variety of supplies and equipment of a nature calculated to fit the needs and interests of the residents. These may include: books (standard and large print), magazines, newspapers, radio, television, bulletin boards, board games, game equipment, songbooks, cards, craft supplies, record player, movie projector, piano, and outdoor equipment. Supplies and equipment shall be appropriate to the chronological age of the residents. (III)

Storage shall be provided for recreational equipment and supplies. (III)

This rule is intended to implement Iowa Code section 135C.14(1).

**481—65.22(135C) Nutrition.** There shall be policies and procedures written and implemented for dietary staffing.

1. The person responsible for planning menus and monitoring the kitchens in each facility shall have completed training, approved by the department, in sanitation and food preparation. (III)

2. In facilities licensed for over 15 beds, food service personnel shall be on duty during a 12-hour span extending from the preparation of breakfast through supper. (III)

3. There shall be written work schedules and time schedules covering each type of job in the food service department for facilities over 15 beds. These work and time schedules shall be posted or kept in a notebook which is available for use in the food service area. (III)

**65.22(1) Nutrition and menu planning.** Residents shall be encouraged to the maximum extent possible to participate in meal planning, shopping, and in preparing and serving the meal and cleaning

up. The facility shall be responsible for helping residents become knowledgeable of what constitutes a nutritionally adequate diet. (III)

*a.* Menus shall be planned and served to meet nutritional needs of residents in accordance with the physician's diet orders which shall be renewed yearly. Menus shall be planned and served to include foods and amounts necessary to meet the recommended daily dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences. Other foods shall be included to meet energy requirements (calories) to add to the total nutrients and variety of meals. (II, III)

*b.* At least three meals or their equivalent shall be made available to each resident daily, consistent with those times normally existing in the community. (II, III)

(1) There shall be no more than a 14-hour span between the substantial evening meal and breakfast. (III)

(2) To the extent medically possible, bedtime nourishments, containing a protein source, shall be offered routinely to all residents. Special nourishments shall be available when ordered by the physician. (II, III)

*c.* Menus shall include a variety of foods prepared in various ways. The same menus shall not be repeated on the same day of the following week. (III)

*d.* If modified diets are ordered by the physician, the person responsible for writing the menus shall have completed department-approved training in simple therapeutic diets. A copy of a modified diet manual approved by the department and written within the past five years shall be available in the facility. (II, III)

*e.* Therapeutic diets shall be served accurately. (II, III)

*f.* Menus shall be written at least one week in advance. The current menu shall be located in an accessible place in the dietetic service department for easy use by persons purchasing, preparing, and serving food. (III)

*g.* Records of menus as served shall be filed and maintained for 30 days and shall be available for review by departmental personnel. When substitutions are necessary, they shall be of similar nutritive value and recorded on the menu or in a notebook. (III)

*h.* A file of tested recipes adjusted to the number of people to be fed in the facility shall be maintained. (III)

**65.22(2)** *Dietary storage, food preparation, service.* In each stage, food shall be handled with maximum care for safety and good health.

*a.* The use of foods from salvaged, damaged, or unlabeled containers is prohibited. (II, III)

*b.* No perishable food shall be allowed to stand at room temperature any longer than is required to prepare and serve. (II, III)

*c.* Canning food is prohibited. The facility may freeze fruits, vegetables, and meats provided strict sanitary procedures are followed and in accordance with recommendations in the "Food Service Sanitation Manual," revised 1976, U.S. Department of Health, Education, and Welfare, Public Health Service, U.S. Government Printing Office, Washington, D.C. (II)

*d.* Supplies of staple foods for a minimum of a one-week period and of perishable foods for a minimum of a three-day period shall be maintained on the premises. (III)

*e.* If family-style service is used, all leftover prepared food that has been on the table shall be safely handled. (III)

*f.* Poisonous compounds shall not be kept in food storage or preparation areas except for a sanitizing agent which shall be kept in a locked cabinet. (II, III)

**65.22(3)** *Sanitation in food preparation area.* The facility shall develop and implement policies and procedures to address sanitation, meal preparation and service in accordance with recommendations in the "Food Service Sanitation Manual" reference in 65.22(2) "c," which shall be used as the established, nationally recognized reference for establishing and determining satisfactory compliance with the department's food service and sanitation rules. (III)

*a.* In facilities of 15 beds or fewer, residents may be allowed in the food preparation area in accordance with their IPP. (III)

- b.* In facilities licensed for over 15 beds, the kitchen shall not be used for serving meals to residents, food service personnel, or other staff. (III)
- c.* All appliances and work areas shall be kept clean and sanitary. (III)
- d.* There shall be written procedures established for cleaning all work and serving areas in facilities over 15 beds and a schedule of duties to be performed daily shall be posted in each food area. (III)
- e.* The food service area shall be located so it will not be used as a passageway by residents, guests, or nonfood service staff in facilities over 15 beds. (III)
- f.* Dirty linen shall not be carried through the food service area unless it is in sealed, leakproof containers. (III)
- g.* Mops, scrub pails, and other cleaning equipment used in the resident areas shall not be stored or used in the dietary area. (III)

**65.22(4) *Hygiene of food service personnel.*** If food service employees are assigned duties outside the dietetic service, these duties shall not interfere with sanitation, safety, or time required for dietetic work assignments. (II, III)

- a.* Employees shall wear clean, washable uniforms that are not used for duties outside the food service area in facilities over 15 beds. (III)
- b.* Hair nets shall be worn by all food service personnel and residents who do work in the kitchen in facilities over 15 beds and effective hair restraints in facilities with fewer than 15 beds. (III)
- c.* People who handle food shall use correct hand-washing and food-handling techniques as identified in the “Food Service Sanitation Manual.” People who handle dirty dishes shall not handle clean dishes without washing their hands. (III)

This rule is intended to implement Iowa Code section 135C.14.

#### **481—65.23(135C) Physical facilities and maintenance.**

**65.23(1) *Housekeeping.*** The facility shall have written procedures for daily and weekly cleaning (III) which include, but need not be limited to:

- a.* All rooms including furnishings, all corridors, storage areas, linen closets, attics, and basements shall be kept in a clean, orderly condition, free of unserviceable furniture and equipment or accumulations of refuse. (III)
- b.* All resident bedrooms, including furnishings, shall be cleaned and sanitized before use by another resident. (III)
- c.* Polishes used on floors shall provide a slip-resistant finish. (III)

**65.23(2) *Equipment.*** Housekeeping and maintenance personnel shall be provided with well-constructed and properly maintained equipment appropriate to the function for which it is to be used. (III)

- a.* All facilities shall be provided with clean and sanitary storage for cleaning equipment, supplies, and utensils. In facilities over 15 beds, a janitor’s closet shall be provided. It shall be equipped with water for filling scrub pails and a janitor’s sink for emptying scrub pails. A hallway or corridor shall not be used for storage of equipment. (III)
- b.* Sufficient numbers of noncombustible trash containers, which have covers, shall be available. (III)
- c.* All containers for trash shall be watertight, rodent-proof, and have tight-fitting covers and shall be thoroughly cleaned each time a container is emptied. (III)
- d.* All wastes shall be properly disposed of in compliance with the local ordinances and state codes. (III)

**65.23(3) *Bedrooms.*** Each resident shall be provided with a bed, substantially constructed and in good repair. (III)

- a.* Rollaway beds, metal cots, or folding beds are not acceptable. (III)
- b.* Each bed shall be equipped with the following: casters or glides; clean springs in good repair; a clean, comfortable, well-constructed mattress approximately 5 inches thick and standard in size for the bed; and clean, comfortable pillows of average bed size. (III)

c. There shall be a comfortable chair, either a rocking chair or arm chair, per resident bed. The resident's personal wishes shall be considered and documented. (III)

d. There shall be drawer space for each resident's clothing. In a multiple bedroom, drawer space shall be assigned each resident. (III)

e. There shall be a bedside table with a drawer and a reading lamp for each resident. (III)

f. All furnishings and equipment shall be durable, cleanable, and appropriate to its function. (III)

g. All resident areas shall be decorated, painted, and furnished to provide a homelike atmosphere and in a manner which is age and culture appropriate. (III)

h. Upholstery materials shall be moisture- and soil-resistant, except on furniture which is provided and owned by the resident. (III)

i. Beds and other furnishings shall not obstruct free passage to and through doorways. (III)

j. Beds shall not be placed with the side of the bed against a radiator or in close proximity to it unless the radiator is covered to protect the resident from contact with it or from excessive heat. (III)

**65.23(4) Bath and toilet facilities.** All lavatories shall have nonreusable towels or an air dryer and an available supply of soap. (III)

**65.23(5) Dining and living rooms.** Dining rooms and living rooms shall be available for use by residents at appropriate times to allow social, diversional, individual, and group activities. (III)

a. Every facility shall have a dining room and a living room easily accessible to all residents which are never used as bedrooms. (III)

b. A combination dining room and living room may be permitted if the space requirements of a multipurpose room as provided in 481—subrule 61.6(2) are met. (III)

c. Living rooms shall be suitably furnished and maintained for the use of residents and their visitors and may be used for recreational activities. (III)

d. Dining rooms shall be furnished with dining tables and chairs appropriate to the size and function of the facility. These rooms and furnishings shall be kept clean and sanitary. (III)

**65.23(6) Family and employee accommodations.** Resident bedrooms shall not be occupied by employees, family members of employees, or family members of the licensee. (III)

a. In facilities where the total occupancy of family, employees, and residents is five or fewer, one toilet and one tub or shower is the minimum requirement. (III)

b. In all health care facilities, if the family or employees live within the facility, living quarters shall be required for the family or employees separate from areas provided for residents. (III)

**65.23(7) Pets—policies.** Any facility in which a pet is living shall implement written policies and procedures addressing the following:

a. Vaccination schedule; (III)

b. Veterinary visit schedule; (III)

c. Housing or sleeping quarters; (III) and

d. Assignment of responsibility for feeding, bathing and cleanup. (III)

**65.23(8) Maintenance.** Each facility shall establish a program to ensure continued maintenance of the facility, to promote good housekeeping procedures, and to ensure sanitary practices throughout. In facilities over 15 beds, this program shall be in writing and be available for review by the department. (III)

a. The buildings, furnishings and grounds shall be maintained in a clean, orderly condition and be in good repair. (III)

b. The buildings and grounds shall be kept free of flies, other insects, rodents, and their breeding areas. (III)

**65.23(9) Buildings, furnishings, and equipment.**

a. Battery-operated, portable emergency lights in good working condition shall be available at all times, at a ratio of one light per employee on duty from 6 p.m. to 6 a.m. (III)

b. All windows shall be supplied with curtains and shades or drapes which are kept in good repair. (III)

c. Wherever glass sliding doors or transparent panels are used, they shall be marked conspicuously and decoratively. (III)

**65.23(10) *Water supply.*** Every facility shall have an adequate water supply from an approved source. A municipal source of water shall be considered as meeting this requirement. Private sources of water to a facility shall be tested annually and the report submitted with the annual application for license. (III)

*a.* A bacterially unsafe source of water shall be grounds for denial, suspension, or revocation of license. (III)

*b.* The department may require testing of private sources of water to a facility at its discretion in addition to the annual test. The facility shall supply reports of tests as directed by the department. (III)

This rule is intended to implement Iowa Code section 135C.14.

**481—65.24(135C) *Care review committee.*** Each facility shall have a care review committee in accordance with Iowa Code section 135C.25, which shall operate within the scope of the rules for care review committees promulgated by the department on aging. (III)

**65.24(1) *Role of committee in complaint investigations.***

*a.* The department shall notify the facility's care review committee of a complaint from the public. The department shall not disclose the name of a complainant.

*b.* The department may refer complaints to the care review committee for initial evaluation or investigation by the committee pursuant to rules promulgated by the department on aging. Within ten days of completion of the investigation, the committee shall report to the department in writing the results of the evaluation of the investigation.

*c.* When the department investigates a complaint, upon conclusion of its investigation, it shall notify the care review committee and the department on aging of its findings, including any citations and fines issued.

*d.* Results of all complaint investigations addressed by the care review committee shall be forwarded to the department within ten days of completion of the investigation.

**65.24(2) *Complaints monitored.*** The care review committee shall, upon department request, be responsible for monitoring correction of substantiated complaints.

**65.24(3) *Family member information.*** When requested, names, addresses and telephone numbers of family members shall be given to the care review committee, unless the family refuses. The facility shall provide a form on which a family member may refuse to have the member's name, address or telephone number given to the care review committee.

This rule is intended to implement Iowa Code section 135C.25.

**481—65.25(135C) *Residents' rights in general.*** Each facility shall ensure that policies and procedures are written and implemented which include at least provisions in subrules 65.25(1) to 65.25(21). These shall govern all services provided to staff, residents, their families or legal representatives. The policies and procedures shall be available to the public and shall be reviewed annually. (II)

**65.25(1) *Grievances.*** Written policies and procedures shall include a method for submitting grievances and recommendations by residents or their legal representatives and for ensuring a response and disposition by the facility. The written procedure shall ensure protection of the resident from any form of reprisal or intimidation and shall include:

*a.* An employee or an alternate designated to be responsible for handling grievances and recommendations; (II)

*b.* Methods to investigate and assess the validity of a grievance or recommendation; (II) and

*c.* Methods to resolve grievances and take action. (II)

**65.25(2) *Informed of rights.*** Policies and procedures shall include a provision that residents be fully informed of their rights and responsibilities as residents and of all rules governing resident conduct and responsibilities. This information must be provided upon admission, or when the facility adopts or amends residents' rights policies. It shall be posted in locations accessible to all residents. (II)

*a.* The facility shall make known to residents what they may expect from the facility and its staff, and what is expected from residents. The facility shall communicate these expectations during a period not more than two weeks before or later than five days after admission. The communication shall be in writing in a separate handout or brochure describing the facility. It shall be interpreted verbally, as

part of a preadmission interview, resident counseling, or in individual or group orientation sessions after admission. (II)

*b.* Residents' rights and responsibilities shall be presented in language understandable to residents. If the facility serves residents who do not speak English or are deaf, steps shall be taken to translate the information into a foreign or sign language. Blind residents shall be provided either Braille or a recording. Residents shall be encouraged to ask questions about their rights and responsibilities. Their questions shall be answered. (II)

*c.* A statement shall be signed by the resident and legal guardian, if applicable, to indicate the resident understands these rights and responsibilities. The statement shall be maintained in the record. The statement shall be signed no later than five days after admission. A copy of the signed statement shall be given to the resident or legal guardian. (II)

*d.* All residents, next of kin, or legal guardian shall be advised within 30 days of changes made in the statement of residents' rights and responsibilities. Appropriate means shall be used to inform non-English-speaking, deaf or blind residents of changes. (II)

**65.25(3) Resident abuse prohibited.** Each resident shall receive kind and considerate care at all times and shall be free from physical, sexual, mental and verbal abuse, exploitation, and physical injury. (I, II)

**65.25(4) Claim of abuse.** Upon a claim of dependent adult abuse of a resident being reported, the administrator of the facility shall separate the victim and accused abuser immediately and maintain the separation until the abuse investigation is completed. (I, II)

**65.25(5) Report of abuse.** Pursuant to Iowa Code chapter 235B, a mandatory reporter of dependent adult abuse is any person who, in the course of employment, examines, attends, counsels, or treats a dependent adult and reasonably believes the dependent adult has suffered abuse. This includes a member of the staff or employee of a health care facility. (II, III)

If a staff member or employee is required to report pursuant to this subrule, the staff member or employee shall immediately notify the person in charge of the facility or the person's designated agent, and the person in charge or the designated agent shall make the report to the department of human services. (II, III)

**65.25(6) Informed of health condition.** Each resident or legal guardian shall be fully informed by a physician of the health and medical condition of the resident unless a physician documents reasons not to in the resident's record. (II)

**65.25(7) Research.** The resident or legal guardian shall decide whether a resident participates in experimental research. Participation shall occur only when the resident or guardian is fully informed and signs a consent form. (II, III)

Any clinical investigation involving residents must be sponsored by an institution with a human subjects review board functioning in accordance with the requirement of Public Law 93-348, as implemented by Part 46 of Title 45 of the Code of Federal Regulations, as amended December 1, 1981 (45 CFR 46). (III)

**65.25(8) Resident work.** Services performed by the resident for the facility shall be in accordance with the IPP. (II)

*a.* Residents shall not be used to provide a source of labor for the facility against the resident's will. Physician's approval is required for all work programs and must be renewed yearly. (II, III)

*b.* If the individual program plan requires activities for therapeutic or training reasons, the plan for these activities must be professionally developed and implemented. Therapeutic or training goals must be clearly stated and measurable and the plan shall be time limited and reviewed at least quarterly. (II, III)

*c.* A resident engaged in work programs in the ICF/PMI shall be paid wages commensurate with wage and hour regulations for comparable work and productivity. (II)

*d.* The resident shall have the right to employment options commensurate with training and skills. (II)

*e.* Residents performing work shall not be used to replace paid employees to fulfill staff requirements. (II)

**65.25(9) *Encouragement to exercise rights.*** Residents shall be encouraged and assisted throughout their period of stay to exercise resident and citizen rights. Residents may voice grievances and recommend changes in policies and services to administrative staff or to an outside representative of their choice free from interference, coercion, discrimination, or reprisal. (II)

**65.25(10) *Posting names.*** The facility shall post the name, telephone number, and address of the:

- a. Long-term care resident's advocate/ombudsman; (II)
- b. Survey agency; (II)
- c. Local law enforcement agency; (II)
- d. Care review committee members; (II)
- e. Administrator; (II)
- f. Members of the board of directors; (II)
- g. Corporate headquarters; (II) and the
- h. Iowa Protection and Advocacy Services, Inc. (II)

The text of Iowa Code section 135C.46 shall also be available to provide residents another course of redress. These items shall be posted in an area where residents and visitors can read them. (II)

**65.25(11) *Dignity preserved.*** Residents shall be treated with consideration, respect, and full recognition of their dignity and individuality, including privacy in treatment and in care of personal needs. (II)

a. Staff shall display respect for residents when speaking with, caring for, or talking about them as constant affirmation of the individuality and dignity of human beings. (II)

b. Schedules of daily activities shall allow maximum flexibility for residents to exercise choice about what they will do and when they will do it. Residents' individual preferences regarding such things as menus, clothing, religious activities, friendships, activity programs, entertainment, sleeping, eating, and times to retire at night and arise in the morning shall be elicited and considered by the facility. The facility shall make every effort to match nonsmokers with other nonsmokers. (II)

c. Residents shall not have their personal lives regulated beyond reasonable adherence to meal schedules, bedtime hours, and other written policies which may be necessary for the orderly management of the facility and as required by these rules; however, residents shall be encouraged to participate in recreational programs. (II)

d. Residents shall be examined and treated in a manner that maintains the privacy of their bodies. A closed door shall shield the resident from passersby. People not involved in the care of a resident shall not be present without the resident's consent during examination or treatment. (II)

e. Privacy for each person shall be maintained when residents are being taken to the toilet or being bathed and while they are being helped with other types of personal hygiene, except as needed for resident safety or assistance. (II)

f. Staff shall knock and be acknowledged before entering a resident's room unless the resident is not capable of response. This does not apply under emergency conditions. (II)

**65.25(12) *Communications.*** Each resident may communicate, associate, and meet privately with persons of the resident's choice, unless to do so would infringe upon the rights of other residents. Each resident may send and receive personal mail unopened unless prohibited in the IPP which has explicit approval of the resident or legal guardian. Telephones consistent with ANSI standards 42 CFR 405.1134(c) (10-1-86) shall be available and accessible for residents to make and receive calls with privacy. Residents who need help shall be assisted in using the telephone. (II)

Arrangements shall be made to provide assistance to residents who require help in reading or sending mail. (II)

**65.25(13) *Visiting policies and procedures.*** Subject to reasonable scheduling restrictions, visiting policies and procedures shall permit residents to receive visits from anyone they wish. Visiting hours shall be posted. (II)

a. Reasonable, regular visiting hours shall not be less than 12 hours per day and shall take into consideration the special circumstances of each visitor. A particular visitor(s) may be restricted by the facility for one of the following reasons:

- (1) The resident refuses to see the visitor(s). (II)

- (2) The visit would not be in accordance with the IPP. (II)
- (3) The visitor's behavior is unreasonably disruptive to the functioning of the facility. (II)

Reasons for denial of visitation shall be documented in resident records. (II)

*b.* Decisions to restrict a visitor shall be reevaluated at least quarterly by the QMHP or at the resident's request. (II)

*c.* Space shall be provided for residents to receive visitors in comfort and privacy. (II)

**65.25(14) Resident activities.** Each resident may participate in activities of social, religious, and community groups as desired unless contraindicated for reasons documented by the attending physician or qualified mental health professional, as appropriate, in the resident's record. (II)

Residents who wish to meet with or participate in activities of social, religious or community groups in or outside the facility shall be informed, encouraged, and assisted to do so. (II)

Residents shall be permitted to leave the facility and environs at reasonable times unless there are justifiable reasons established in writing by the attending physician, QMHP, or facility administrator for refusing permission. (II)

**65.25(15) Resident property.** Each resident may retain and use personal clothing and possessions as space permits and provided use is not otherwise prohibited in these rules. (II)

*a.* Residents shall be permitted to keep reasonable amounts of personal clothing and possessions for their use while in the facility. The personal property shall be kept in a secure location which is convenient to the resident. (II)

*b.* Residents shall be advised, prior to or at the time of admission, of the kinds and amounts of clothing and possessions permitted for personal use, and whether the facility will accept responsibility for maintaining these items, e.g., cleaning and laundry. (II)

*c.* Any personal clothing or possession retained by the facility for the resident shall be identified and recorded on admission and the record placed on the resident's chart. The facility shall be responsible for secure storage of items. They shall be returned to the resident promptly upon request or upon discharge from the facility. (II)

**65.25(16) Sharing rooms.** Residents, including spouses staying in the same facility, shall be permitted to share a room, if available, if requested by both parties, unless reasons to the contrary are in the IPP. Reasons for denial shall be documented in the resident's record. (II)

**65.25(17) Choice of physician and pharmacy.** Each resident shall be permitted free choice of a physician and a pharmacy. The facility may require the pharmacy selected to use a drug distribution system compatible with the system currently used by the facility. (II)

**481—65.26(135C) Incompetent residents.** Each facility shall provide that all rights and responsibilities of incompetent residents devolve to the legal guardian when a hearing has been held and the resident is judged incompetent in accordance with state law. (II)

A facility is not absolved from advising incompetent residents of their rights to the extent the resident is able to understand them. The facility shall also advise the legal guardian, if any, and acquire a statement indicating an understanding of resident's rights. (II)

This rule is intended to implement Iowa Code sections 135C.14(8) and 135C.24.

**481—65.27(135C) County care facilities.** In addition to these rules, county care facilities licensed as intermediate care facilities for persons with mental illness must also comply with department of human services rules 441—Chapter 37. Violation of any standard established by the department of human services is a Class II violation pursuant to 481—56.2(135C).

This rule is intended to implement Iowa Code section 227.4.

**481—65.28(135C) Violations.** Classification of violations is I, II and III, determined by the division using the provisions in 481—Chapter 56, "Fining and Citations," to enforce a fine to cite a facility.

**481—65.29(135C) Another business or activity in a facility.** A facility is allowed to have another business or activity in a health care facility or in the same physical structure of the facility, if the other

business or activity is under the control of and is directly related to and incidental to the operation of the health care facility, or the business or activity is approved by the department and the state fire marshal.

To obtain the approval of the department and the state fire marshal, the facility must submit to the department a written request for approval which identifies the service(s) to be offered by the business and addresses the factors outlined in paragraphs “a” through “j” of this rule. (I, II, III)

**65.29(1)** The following factors will be considered by the department in determining whether a business or activity will interfere with the use of the facility by residents, interfere with services provided to residents, or be disturbing to residents:

- a. Health and safety risks for residents;
- b. Compatibility of the proposed business or activity with the facility program;
- c. Noise created by the proposed business or activity;
- d. Odors created by the proposed business or activity;
- e. Use of entrances and exits for the business or activity in regard to safety and disturbance of residents and interference with delivery of services;
- f. Use of the facility’s corridors or rooms as thoroughfares to the business or activity in regard to safety and disturbance of residents and interference with delivery of services;
- g. Proposed staffing for the business or activity;
- h. Sharing of services and staff between the proposed business or activity and the facility;
- i. Facility layout and design; and
- j. Parking area utilized by the business or activity.

**65.29(2)** Approval of the state fire marshal shall be obtained before approval of the department will be considered.

**65.29(3)** A business or activity conducted in a health care facility or in the same physical structure as a health care facility shall not reduce space, services or staff available to residents below minimums required in these rules and 481—Chapter 61. (I, II, III)

**481—65.30(135C) Respite care services.** Respite care services means an organized program of temporary supportive care provided for 24 hours or more to a person in order to relieve the usual caregiver of the person from providing continual care to the person. A facility which chooses to provide respite care services must meet the following requirements related to respite care services and must be licensed as a health care facility.

**65.30(1)** A facility which chooses to provide respite care services is not required to obtain a separate license or pay a license fee.

**65.30(2)** Rules regarding involuntary discharge or transfer rights do not apply to residents who are being cared for under a respite care contract.

**65.30(3)** The facility shall have a contract with each resident in the facility. When the resident is there for respite care services, the contract shall specify the time period during which the resident will be considered to be receiving respite care services. At the end of that period, the contract may be amended to extend that period of time. The contract shall specifically state the resident may be involuntarily discharged while being considered as a respite care resident. The contract shall meet other requirements for contracts between a health care facility and resident, except the requirements concerning the holding and charging for a bed when a resident is hospitalized or leaves the facility temporarily for recreational or therapeutic reasons.

**65.30(4)** Respite care services shall not be provided by a facility to persons requiring a level of care which is higher than the level of care the facility is licensed to provide.

These rules are intended to implement Iowa Code sections 135C.2(6), 135C.4, 135C.6(2), 135C.6(3), 135C.7, 135C.8, 135C.14, 135C.16(2), 135C.23, 135C.24, 135C.25, 135C.31, and 227.4.

[Filed 11/20/91, Notice 8/7/91—published 12/11/91, effective 1/15/92]

[Filed 3/12/92, Notice 12/11/91—published 4/1/92, effective 5/6/92]

[Filed 5/16/95, Notice 3/15/95—published 6/7/95, effective 7/12/95]

[Filed 11/30/95, Notice 9/13/95—published 12/20/95, effective 1/24/96]

[Filed 1/21/97, Notice 8/14/96—published 2/12/97, effective 3/19/97]

[Filed 7/11/97, Notice 4/23/97—published 7/30/97, effective 9/3/97]

[Filed emergency 7/25/97—published 8/13/97, effective 7/25/97]

[Filed emergency 11/14/97—published 12/3/97, effective 11/14/97]

[Filed 11/14/97, Notice 8/13/97—published 12/3/97, effective 1/7/98]

[Filed 3/31/98, Notice 12/3/97—published 4/22/98, effective 5/27/98]

[Filed 7/9/98, Notice 4/22/98—published 7/29/98, effective 9/2/98]

[Filed 1/15/04, Notice 12/10/03—published 2/4/04, effective 3/10/04]

[Filed 3/12/04, Notice 1/7/04—published 3/31/04, effective 5/5/04]

[Filed 9/20/06, Notice 8/2/06—published 10/11/06, effective 11/15/06]

[Filed 11/15/06, Notice 10/11/06—published 12/6/06, effective 1/10/07]

[Filed ARC 0663C (Notice ARC 0513C, IAB 12/12/12), IAB 4/3/13, effective 5/8/13]

[Filed ARC 0766C (Notice ARC 0601C, IAB 2/6/13), IAB 5/29/13, effective 7/3/13]

[Filed ARC 0903C (Notice ARC 0776C, IAB 5/29/13), IAB 8/7/13, effective 9/11/13]

[Filed ARC 1050C (Notice ARC 0907C, IAB 8/7/13), IAB 10/2/13, effective 11/6/13]

CHAPTER 67  
GENERAL PROVISIONS FOR ELDER GROUP HOMES, ASSISTED LIVING PROGRAMS,  
AND ADULT DAY SERVICES

**481—67.1(231B,231C,231D) Definitions.** The following definitions apply to this chapter and to 481—Chapters 68, 69, and 70.

“*Activities of daily living*” means the following self-care tasks: bathing, dressing, grooming, eating, transferring, toileting, and ambulation.

“*Ambulatory*” or “*ambulation*” means physically and cognitively able to walk without aid of another person.

“*Applicable requirements*” means Iowa Code chapters 135C, 231B, 231C, 231D, 235B, 235E, and 562A, this chapter, and 481—Chapters 68, 69, and 70, as applicable, and includes any other applicable administrative rules and provisions of the Iowa Code.

“*Applicant or certificate holder*” means the owner and operator of a program. If a program is operated under an operating agreement, both the owner and the operator are the applicant or certificate holder. If a program is leased, the lessee is the applicant or certificate holder.

“*Assignment*” means the distribution of work for which each staff member, regardless of certification or licensure status, is responsible during a given work period and includes a nurse directing an individual to do something the individual is already authorized to do.

“*Assistance*” means aid to a tenant who self-directs or participates in a task or activity or who retains the mental or physical ability, or both, to participate in a task or activity. Cueing of the tenant regarding a particular task or activity shall be construed to mean the tenant has participated in the task or activity.

“*Blueprint*” means copies of all completed drawings, schedules, and specifications that have been certified, sealed, and signed by an Iowa-licensed architect or Iowa-licensed engineer of record. The department may allow electronic transfer of blueprints pursuant to policy.

“*Certified staff*” means certified nursing assistants (CNAs) and certified medication assistants (CMAs) employed by the program.

“*Dementia*” means an illness characterized by multiple cognitive deficits which represent a decline from previous levels of functioning and includes memory impairment and one or more of the following cognitive disturbances: aphasia, apraxia, agnosia, and disturbance in executive functioning.

“*Department*” means the department of inspections and appeals.

“*Director*” means the director of the department of inspections and appeals.

“*Direct supervision*” means the provision of guidance and oversight of a delegated nursing task through the physical presence of the licensed nurse to observe and direct certified and noncertified staff.

“*Elope*” means that a tenant who has impaired decision-making ability leaves the program without the knowledge or authorization of staff.

“*Global Deterioration Scale*” or “*GDS*” means the seven-stage scale for assessment of primary degenerative dementia developed by Dr. Barry Reisberg.

“*Health care professional*” means a physician, physician assistant, registered nurse or advanced registered nurse practitioner licensed in Iowa by the respective licensing board.

“*Health-related care*” means services provided by a registered nurse or a licensed practical nurse, on a part-time or intermittent basis, and services provided by other licensed health care professionals, on a part-time or intermittent basis. “Health-related care” includes nurse-delegated assistance.

“*Human service professional*” means an individual with a bachelor’s degree in a human service field including, but not limited to: human services, gerontology, social work, sociology, psychology, or family science. Two years of experience in a human service field may be substituted for up to two years of the required education. For example, an individual with an associate’s degree in a human service field and two years of experience in a human service field is a human service professional.

“*Impaired decision-making ability*” means a lack of capacity to make safe and prudent decisions regarding one’s own routine safety as determined by the program manager or nurse or means having a GDS score of four or above.

*“Independent reviewer”* means an attorney licensed in the state of Iowa who is not currently and has not been employed by the department in the past eight years, or has not appeared in front of the department on behalf of a health care facility in the past eight years. Preference shall be given to an attorney with background knowledge, experience or training in long-term care.

*“Indirect supervision”* means the provision of guidance and oversight of a delegated nursing task through means other than direct supervision, including written and verbal communication.

*“Instrumental activities of daily living”* means those activities that reflect the tenant’s ability to perform household and other tasks necessary to meet the tenant’s needs within the community, which may include but are not limited to shopping, housekeeping, chores, and traveling within the community.

*“Medication setup”* means assistance with various steps of medication administration to support a tenant’s autonomy, which may include but is not limited to routine prompting, cueing and reminding, opening containers or packaging at the direction of the tenant, reading instructions or other label information, or transferring medications from the original containers into suitable medication dispensing containers, reminder containers, or medication cups.

*“Modification”* means any addition to or change in physical dimensions or structure, except as incidental to the customary maintenance of the physical structure of the program’s facility.

*“Monitoring”* means an on-site evaluation of a program, a complaint investigation, or a program-reported incident investigation performed by the department to determine compliance with applicable requirements. A monitor who performs a monitoring for the department shall be a registered nurse, human service professional, or another person with program-related expertise.

*“Noncertified staff”* means unlicensed and uncertified personnel employed by the program.

*“Nurse delegation”* means the action of a registered nurse, advanced registered nurse practitioner, or licensed practical nurse to direct competent certified and noncertified staff to perform selected nursing tasks in selected situations. The decision of a nurse to delegate is based on the delegation process, including assessment, planning, implementation, supervision, and evaluation of the tenant, nursing tasks, personnel, and the situation. The nurse, as a licensed professional, retains accountability for the delegation process and the decision to delegate. Licensed practical nurses may delegate within the scope of their license with the supervision of a registered nurse.

*“Occupancy agreement”* or *“contractual agreement”* means a written contract entered into between a program and a tenant that clearly describes the rights and responsibilities of the program and the tenant and other information required by applicable requirements. An occupancy agreement may include a separate signed lease and signed service agreement.

*“Part-time or intermittent care”* means licensed nursing services and professional therapies that are provided no more than 5 days per week; or licensed nursing services and professional therapies that are provided 6 or 7 days per week for a temporary period of time with a predictable end within 21 days; or licensed nursing services and professional therapies that do not exceed 28 hours per week or, for adult day services, 4 hours per day and are provided in combination with nurse-delegated assistance with medications or activities of daily living.

*“Personal care”* means assistance with the essential activities of daily living which may include but are not limited to transferring, bathing, personal hygiene, dressing, and grooming that are essential to the health and welfare of a tenant.

*“Physician extender”* means nurse practitioners, clinical nurse specialists, and physician assistants.

*“Preponderance of the evidence”* means that the evidence, considered and compared with the evidence opposed to it, produces the belief in a reasonable mind that the allegations are more likely true than not true.

*“Program”* means one or more of the following, as applicable: an elder group home as defined in Iowa Code section 231B.1 and 481—Chapter 68, an assisted living program as defined in Iowa Code section 231C.1 and 481—Chapter 69, or adult day services as defined in Iowa Code section 231D.1 and 481—Chapter 70.

*“Program staff”* means all employees of the program, regardless of certification or licensure status.

“*Qualified professional*” means a facility plant engineer familiar with the type of program being provided, or a licensed plumbing, heating, cooling, or electrical contractor who furnishes regular service to such equipment.

“*Recognized accrediting entity*” means a nationally recognized accrediting entity that the department recognizes as having specific program standards equivalent to the program standards established by the department.

“*Regulatory insufficiency*” means a violation of an applicable requirement.

“*Remodeling*” means a modification of any part of an existing building, an addition of a new wing or floor to an existing building, or a conversion of an existing building.

“*Routine*” means more often than not or on a regular customary basis.

“*Self-administration*” means a tenant’s taking personal responsibility for all phases of medication except for any component assigned to the program under medication setup, and may include the tenant’s use of an automatic pill dispenser.

“*Service plan*” means the document that defines all services necessary to meet the needs and preferences of a tenant, whether or not the services are provided by the program or other service providers.

“*Significant change*” means a major decline or improvement in the tenant’s status which does not normally resolve itself without further interventions by staff or by implementing standard disease-related clinical interventions that have an impact on the tenant’s mental, physical, or functional health status.

“*Substantial compliance*” means a level of compliance with applicable requirements such that any identified regulatory insufficiency poses no greater risk to tenant health or safety than the potential for causing minimal harm.

“*Tenant*” means an individual who receives services through a program. In the context of adult day services, “tenant” means a participant as defined in 481—Chapter 70.

“*Tenant advocate*” means the office of long-term care resident’s advocate established in Iowa Code section 231.42.

“*Tenant’s legal representative*” means a person appointed by the court to act on behalf of a tenant or a person acting pursuant to a power of attorney. In the context of adult day services, “tenant’s legal representative” means a participant’s legal representative as defined in 481—Chapter 70.

“*Waiver*” means action taken by the department that suspends in whole or in part the requirements or provisions of a rule.

[ARC 8174B, IAB 9/23/09, effective 1/1/10; ARC 0961C, IAB 8/21/13, effective 9/25/13; ARC 1055C, IAB 10/2/13, effective 1/1/14]

**481—67.2(231B,231C,231D) Program policies and procedures, including those for incident reports.** A program’s policies and procedures must meet the minimum standards set by applicable requirements. The program shall follow the policies and procedures established by a program. All programs shall have policies and procedures related to the reporting of incidents including allegations of dependent adult abuse.

**67.2(1)** The program’s policies and procedures on incident reports, at a minimum, shall include the following:

- a. The program shall have available incident report forms for use by program staff.
- b. An incident report shall be in detail and shall be provided on an incident report form.
- c. The person in charge at the time of the incident shall prepare and sign the report.
- d. The incident report shall include statements from individuals, if any, who witnessed the incident.
- e. All accidents or unusual occurrences within the program’s building or on the premises that affect tenants shall be reported as incidents.
- f. A copy of the completed incident report shall be kept on file on the program’s premises for a minimum of three years.

**67.2(2)** The program’s policies and procedures on allegations of dependent adult abuse shall be consistent with Iowa Code chapter 235E and rules adopted pursuant to that chapter and, at a minimum, shall include:

- a. Reporting requirements for staff and employees, and
- b. Requirements that the victim and alleged abuser be separated.

[ARC 8174B, IAB 9/23/09, effective 1/1/10]

**481—67.3(231B,231C,231D) Tenant rights.** All tenants have the following rights:

**67.3(1)** To be treated with consideration, respect, and full recognition of personal dignity and autonomy.

**67.3(2)** To receive care, treatment and services which are adequate and appropriate.

**67.3(3)** To receive respect and privacy in the tenant's medical care program. Personal and medical records shall be confidential, and the written consent of the tenant shall be obtained for the records' release to any individual, including family members, except as needed in case of the tenant's transfer to a health care facility or as required by law or a third-party payment contract.

**67.3(4)** To be free from mental and physical abuse.

**67.3(5)** To receive from the manager and staff of the program a reasonable response to all requests.

**67.3(6)** To associate and communicate privately and without restriction with persons and groups of the tenant's choice, including the tenant advocate, on the tenant's initiative or on the initiative of the persons or groups at any reasonable hour.

**67.3(7)** To manage the tenant's own financial affairs unless a tenant's legal representative has been appointed for the purpose of managing the tenant's financial affairs.

**67.3(8)** To present grievances and recommend changes in program policies and services, personally or through other persons or in combination with others, to the program's staff or person in charge without fear of reprisal, restraint, interference, coercion, or discrimination.

[ARC 8174B, IAB 9/23/09, effective 1/1/10]

**481—67.4(231B,231C,231D) Program notification to the department.** The director or the director's designee shall be notified within 24 hours, or the next business day, by the most expeditious means available:

**67.4(1)** Of any accident causing major injury. For the purposes of this rule, "major injury" shall also mean a substantial injury.

a. "Major injury" shall be defined as any injury which:

(1) Results in death; or

(2) Requires admission to a higher level of care for treatment, other than for observation; or

(3) Requires consultation with the attending physician, designee of the physician, or physician extender who determines, in writing on a form designated by the department, that an injury is a "major injury" based upon the circumstances of the accident, the previous functional ability of the tenant, and the tenant's prognosis.

b. The following are not reportable accidents:

(1) An ambulatory tenant who falls when neither the program nor its employees have culpability related to the fall, even if the tenant sustains a major injury; or

(2) Spontaneous fractures; or

(3) Hairline fractures.

**67.4(2)** When damage to the program is caused by a natural or other disaster.

**67.4(3)** When there is an act that causes major injury to a tenant or when a program has knowledge of a pattern of acts committed by the same tenant on another tenant that results in any physical injury. For the purposes of this subrule, "pattern" means two or more times within a 30-day period.

**67.4(4)** When a tenant elopes from a program.

**67.4(5)** When a tenant attempts suicide, regardless of injury.

**67.4(6)** When a fire occurs in a program and the fire requires the notification of emergency services, requires full or partial evacuation of the program, or causes physical injury to a tenant.

**67.4(7)** When a defect or failure occurs in the fire sprinkler or fire alarm system for more than 4 hours in a 24-hour period. (This reporting requirement is in addition to the requirement to notify the state fire marshal.)

NOTE: Additional reporting requirements are created by other rules and statutes, including but not limited to Iowa Code chapters 235B and 235E, which require reporting of dependent adult abuse. [ARC 8174B, IAB 9/23/09, effective 1/1/10]

**481—67.5(231B,231C,231D) Medications.** Each program shall follow its own written medication policy, which shall include the following:

**67.5(1)** The program shall not prohibit a tenant from self-administering medications.

**67.5(2)** A tenant shall self-administer medications unless:

*a.* The tenant or the tenant's legal representative delegates in the occupancy agreement or signed service plan any portion of medication setup to the program.

*b.* The tenant delegates medication setup to someone other than the program.

*c.* The program assumes partial control of medication setup at the direction of the tenant. The medication plan shall not be implemented by the program unless the program's registered nurse deems it appropriate under applicable requirements, including those in Iowa Code section 231C.16A and subrule 67.9(4). The program's registered nurse must agree to the medication plan.

**67.5(3)** A tenant shall keep medications in the tenant's possession unless the tenant or the tenant's legal representative, if applicable, delegates in the occupancy agreement or signed service plan partial or complete control of medications to the program. The service plan shall include the tenant's choice related to storage.

**67.5(4)** When a tenant has delegated medication administration to the program, the program shall maintain a list of the tenant's medications. If the tenant self-administers medications, the tenant may choose to maintain a list of medications in the tenant's apartment or to disclose a current list of medications to the program for the purpose of emergency response. If the tenant discloses a medication list to the program in case of an emergency, the tenant remains responsible for the accuracy of the list.

**67.5(5)** When medication setup is delegated to the program by the tenant, staff via nurse delegation may transfer medications from the original prescription containers or unit dosing into medication reminder boxes or medication cups.

**67.5(6)** When medications are administered traditionally by the program:

*a.* The administration of medications shall be provided by a registered nurse, licensed practical nurse or advanced registered nurse practitioner registered in Iowa or by certified and noncertified staff in accordance with subrule 67.9(4) or a physician assistant (PA) in accordance with 645—Chapter 327. Injectable medications shall be administered as permitted by Iowa law by a registered nurse, licensed practical nurse, advanced registered nurse practitioner, physician, pharmacist, or physician assistant (PA).

*b.* Medications shall be kept in a locked place or container that is not accessible to persons other than employees responsible for the administration or storage of such medications.

*c.* The program shall maintain a list of each tenant's medications and document the medications administered.

**67.5(7)** Narcotics protocol shall be determined by the program's registered nurse.

[ARC 8174B, IAB 9/23/09, effective 1/1/10; ARC 0961C, IAB 8/21/13, effective 9/25/13; ARC 1050C, IAB 10/2/13, effective 11/6/13]

**481—67.6(231B,231C,231D) Another business or activity located in a program.**

**67.6(1)** A business or activity serving persons other than tenants of a program is allowed in a designated part of the physical structure in which the program is located if the other business or activity meets the requirements of applicable state and federal codes, administrative rules, and federal regulations.

**67.6(2)** A business or activity conducted in the designated part of the physical structure in which the program is located shall not interfere with the use of the program by tenants or with services provided to tenants or disturb tenants.

**67.6(3)** A business or activity conducted in the designated part of the physical structure in which the program is located shall not reduce access, space, services, or staff available to tenants or necessary to meet the needs of tenants.

[ARC 8174B, IAB 9/23/09, effective 1/1/10]

**481—67.7(231B,231C,231D) Waiver of criteria for retention of a tenant in the program.**

**67.7(1) *Time-limited waiver.*** Upon receipt of a program's request for waiver of the criteria for retention of a tenant, the department may grant a waiver of the criteria under applicable requirements for a time-limited basis. Absent extenuating circumstances, a waiver of the criteria for retention of a tenant is limited to a period of six months or less.

**67.7(2) *Waiver petition procedures.*** The following procedures shall be used to request and to receive approval of a waiver from criteria for the retention of a tenant:

*a.* A program shall submit the waiver request on a form and in a manner designated by the department as soon as it becomes apparent that a tenant exceeds retention criteria pursuant to an evaluation by a health care or human service professional.

*b.* The department shall respond in writing to a waiver request within 15 working days of receipt of all required documentation. In consultation with the program, the department may take an additional 15 working days to report its determination regarding the waiver request.

*c.* The program shall provide to the department within 5 working days written notification of any changes in the condition of the tenant as described in the approved waiver request.

**67.7(3) *Factors for consideration for waiver of criteria for retention of a tenant.*** In addition to the criteria established in Iowa Code subsection 17A.9A(2), the following factors may be demonstrative in determining whether the criteria for issuance of a waiver have been met.

*a.* It is the informed choice of the tenant or the tenant's legal representative, if applicable, to remain in the program;

*b.* The program is able to provide the staff necessary to meet the tenant's service needs in addition to the service needs of the other tenants;

*c.* The department shall only issue a waiver if the waiver will not jeopardize the health, safety, security or welfare of the tenant, program staff, or other tenants; and

*d.* The tenant has been diagnosed with a terminal illness and has been admitted to hospice, and the tenant exceeds the criteria for retention and admission for a temporary period of less than six months. A terminal diagnosis means the tenant is within six months of the end of life.

**67.7(4) *Conditional waiver.*** A conditional waiver may be granted contingent upon the department's receipt of additional information or performance of monitoring.

*a.* If a waiver has been in effect for six months, a monitoring shall be conducted to determine whether the tenant meets the criteria to continue on a waiver.

*b.* The department may seek additional information during the period to determine if a waiver should be granted.

[ARC 8174B, IAB 9/23/09, effective 1/1/10]

**481—67.8(231B,231C,231D) All other waiver requests.** Waiver requests relating to topics other than retention of a tenant in a program shall be filed in accordance with 481—Chapter 6.

[ARC 8174B, IAB 9/23/09, effective 1/1/10]

**481—67.9(231B,231C,231D) Staffing.**

**67.9(1) *Number of staff.*** A sufficient number of trained staff shall be available at all times to fully meet tenants' identified needs.

**67.9(2) *Emergency procedures.*** All program staff shall be able to implement the accident, fire safety, and emergency procedures.

**67.9(3) *Training documentation.*** The program shall have training records and staffing schedules on file and shall maintain documentation of training received by program staff, including training of certified and noncertified staff on nurse-delegated procedures.

**67.9(4) Nurse delegation procedures.** The program's registered nurse shall ensure certified and noncertified staff are competent to meet the individual needs of tenants. Nurse delegation shall, at a minimum, include the following:

*a.* The program's newly hired registered nurse shall within 60 days of beginning employment as the program's registered nurse document a review to ensure that staff are sufficiently trained and competent in all tasks that are assigned or delegated.

*b.* Within 30 days of beginning employment, all program staff shall receive training by the program's registered nurse(s).

*c.* Training for noncertified staff shall include, at a minimum, the provision of activities of daily living and instrumental activities of daily living.

*d.* Certified and noncertified staff shall receive training regarding service plan tasks (e.g., wound care, pain management, rehabilitation needs and hospice care) in accordance with medical or nursing directives and the acuity of the tenants' health, cognitive or functional status.

*e.* The program's registered nurse(s) shall provide direct or indirect supervision of all certified and noncertified staff as necessary in the professional judgment of the program's registered nurse and in accordance with the needs of the tenants and certified and noncertified staff.

*f.* Services shall be provided to tenants in accordance with the training provided.

*g.* The program shall have in place a system by which certified or noncertified staff communicate in writing occurrences that differ from the tenant's normal health, functional and cognitive status. The program's registered nurse or designee shall train certified and noncertified staff on reporting to the program's registered nurse or designee and documenting occurrences that differ from the tenant's normal health, functional and cognitive status. The written communication required by this paragraph shall be retained by the program for a period of not less than three years, and shall be accessible to the department upon request.

*h.* In the absence of the program's registered nurse due to vacation or other temporary circumstances, the nurse assuming the duties of the program's registered nurse shall have access to staff training in relation to tenant needs.

**67.9(5) Prohibited services.** A program staff member shall not be designated as attorney-in-fact, guardian, conservator, or representative payee for a tenant unless the program staff member is related to the tenant by blood, marriage, or adoption.

[ARC 8174B, IAB 9/23/09, effective 1/1/10; ARC 0961C, IAB 8/21/13, effective 9/25/13; ARC 0963C, IAB 8/21/13, effective 9/25/13]

#### **481—67.10(17A,231B,231C,231D) Monitoring.**

**67.10(1) Frequency of monitoring.** The department shall monitor a certified program at least once during the program's certification period.

**67.10(2) Accessibility of records and program areas.** All records and areas of the program deemed necessary to determine compliance with the applicable requirements shall be accessible to the department for purposes of monitoring.

**67.10(3) Standard for determining whether a regulatory insufficiency exists.** The department shall use a preponderance-of-the-evidence standard when determining whether a regulatory insufficiency exists. A preponderance-of-the-evidence standard does not require that the monitor shall have personally witnessed the alleged violation.

[ARC 8174B, IAB 9/23/09, effective 1/1/10; ARC 1055C, IAB 10/2/13, effective 1/1/14]

#### **481—67.11(231B,231C,231D) Complaint and program-reported incident report investigation procedure.**

**67.11(1) Complaints.** The process for filing a complaint is as follows:

*a.* Any person with concerns regarding the operation or service delivery of a program may file a complaint with the Department of Inspections and Appeals, Complaints Unit, Lucas State Office Building, Third Floor, 321 E. 12th Street, Des Moines, Iowa 50319-0083; by use of the complaint hotline, 1-877-686-0027; by facsimile sent to (515)281-7106; or through the Web site address: [https://dia-hfd.iowa.gov/DIA\\_HFD/Home.do](https://dia-hfd.iowa.gov/DIA_HFD/Home.do).

*b.* When the nature of the complaint is outside the department's authority, the department shall forward the complaint or refer the complainant, if known, to the appropriate investigatory entity.

*c.* The complainant shall include as much of the following information as possible in the complaint: the complainant's name, address and telephone number; the complainant's relationship to the program or tenant; and the reason for the complaint. The complainant's name shall be confidential information and shall not be released by the department. The department shall act on anonymous complaints unless the department determines that the complaint is intended to harass the program. If the department, upon preliminary review, determines that the complaint is intended as harassment or is without reasonable basis, the department may dismiss the complaint.

**67.11(2) Program-reported incident reports.** When the program is required pursuant to applicable requirements to report an incident, the program shall make the report to the department via:

*a.* The Web-based reporting tool accessible from the following Internet site, [https://dia-hfd.iowa.gov/DIA\\_HFD/Home.do](https://dia-hfd.iowa.gov/DIA_HFD/Home.do), under the "Complaints" tab;

*b.* Mail by sending the complaint to the Department of Inspections and Appeals, Complaints Unit, Lucas State Office Building, Third Floor, 321 E. 12th Street, Des Moines, Iowa 50319-0083;

*c.* The complaint hotline, 1-877-686-0027; or

*d.* Facsimile sent to (515)281-7106.

**67.11(3) Time frames for investigation of complaints or program-reported incident reports.** Upon receipt of a complaint or program-reported incident report made in accordance with this rule, the department shall conduct a preliminary review of the complaint or report to determine if a potential regulatory insufficiency has occurred. If a potential regulatory insufficiency exists, the department shall institute a monitoring of the program within 20 working days unless there is the possibility of immediate danger, in which case the department shall institute a monitoring of the program within 2 working days of receipt of the complaint or incident report.

**67.11(4) Standard for determining whether a complaint is substantiated.** The department shall apply a preponderance-of-the-evidence standard in determining whether or not a complaint or program-reported incident report is substantiated.

**67.11(5) Notification of program and complainant.** The department shall notify the program and, if known, the complainant of the final report regarding the complaint investigation.

**67.11(6) Notification of accrediting entity.** In addition, for any credible report of alleged improper or inappropriate conduct or conditions within an accredited program, the department shall notify the accrediting entity by the most expeditious means possible of any actions taken by the department with respect to certification enforcement.

**67.11(7) Notification of complainant when complaint not investigated.** The department shall notify the complainant, if known, if the department does not investigate a complaint. The reasons for not investigating the complaint shall be included in the notification.

[ARC 8174B, IAB 9/23/09, effective 1/1/10; ARC 1055C, IAB 10/2/13, effective 1/1/14]

**481—67.12(17A,231B,231D) Adult day services and elder group homes—preliminary report, plan of correction and request for reconsideration.**

**67.12(1) Preliminary report.** When a regulatory insufficiency is found, a preliminary report detailing the insufficiency shall be sent by the department to the adult day services program or elder group home within 10 working days. The department may send the report electronically or by certified mail.

**67.12(2) Plan of correction.** Within 10 working days following receipt of the preliminary report, the adult day services program or elder group home shall submit a plan of correction to the department.

*a. Contents of plan.* The plan of correction shall include:

- (1) Elements detailing how the program will correct each regulatory insufficiency;
- (2) The date by which the regulatory insufficiency will be corrected;
- (3) What measures will be taken to ensure the problem does not recur;
- (4) How the program plans to monitor performance to ensure compliance; and
- (5) Any other required information.

The date by which the regulatory insufficiency will be corrected shall not exceed 30 days following the date of the exit interview without approval of the department.

*b. Review of plan.* The department shall review the plan of correction within 10 working days of receipt. The department may request additional information or suggest revisions to the plan. Once an acceptable plan of correction has been received, the department shall issue a final report within 10 working days and shall determine whether any enforcement action related to the program's continued certification is necessary.

**67.12(3) Request for reconsideration.** Within 10 working days of receiving the preliminary report, the adult day services program or elder group home may submit a request for reconsideration in response to a regulatory insufficiency. Regardless of whether a request for reconsideration is submitted, a plan of correction must be submitted.

*a.* The request may include additional information to support the request for reconsideration.

*b.* The department shall review the request for reconsideration and additional information and determine whether to withdraw or modify the regulatory insufficiency.

*c.* The department shall accept a request for reconsideration if the additional information submitted by the program shows by a preponderance of the evidence that the regulatory insufficiency did not exist at the time of the monitoring.

*d.* The department's decision regarding a request for reconsideration shall be reflected in the final report.

**67.12(4) Final report.** The final report shall be issued after the plan of correction and request for reconsideration have been considered. The department shall issue a final report regarding a monitoring whether or not any regulatory insufficiency is found. The final report may be delivered to the applicant or certificate holder by electronic or certified mail, or by personal service.

**67.12(5) Appeal of final report.** The final report and the civil penalty, if assessed, may be appealed. A written notice of appeal and request for hearing shall be delivered to the department within 30 days after the mailing or service of notice.

**67.12(6) Hearings.** Hearings shall be conducted by the administrative hearings division of the department pursuant to Iowa Code chapter 17A and 481—Chapter 10.

**67.12(7) Monitoring revisit.** The department may conduct a monitoring revisit to ensure that the plan of correction has been implemented and the regulatory insufficiency has been corrected. The department may issue a regulatory insufficiency for failure to implement the plan of correction. A monitoring revisit by the department shall review the program prospectively from the date of the plan of correction to determine compliance.

[ARC 8174B, IAB 9/23/09, effective 1/1/10; ARC 1055C, IAB 10/2/13, effective 1/1/14]

#### **481—67.13(17A,231C,85GA,SF394) Assisted living programs—exit interview, final report, plan of correction.**

**67.13(1) Exit interview.** The department shall provide an exit interview in person or by telephone at the conclusion of a monitoring, during which the department shall inform the assisted living program's representative of all issues and areas of concern related to insufficient practices. A second exit interview shall be provided if the department identifies additional issues or areas of concern. The program shall have 2 working days from the date of the exit interview to submit additional or rebuttal information to the department.

**67.13(2) Final report.** The department shall issue the final report of a monitoring within 10 working days after completion of the on-site monitoring or the receipt by the department of additional or rebuttal information, by personal service, electronically or by certified mail. The department shall issue a final report regarding a monitoring whether or not any regulatory insufficiency is found.

**67.13(3) Plan of correction.** Within 10 working days following receipt of the final report, the program shall submit a plan of correction to the department.

*a. Contents of plan.* The plan of correction shall include:

- (1) Elements detailing how the program will correct each regulatory insufficiency;
- (2) The date by which the regulatory insufficiency will be corrected;

- (3) What measures will be taken to ensure the problem does not recur;
- (4) How the program plans to monitor performance to ensure compliance; and
- (5) Any other required information.

The date by which the regulatory insufficiency will be corrected shall not exceed 30 days from receipt of the final report pursuant to subrule 67.13(2) without approval of the department.

*b. Review of plan.* The department shall review the plan of correction within 10 working days. The department may request additional information or suggest revisions to the plan.

**67.13(4) Monitoring revisit.** The department may conduct a monitoring revisit to ensure that the plan of correction has been implemented and the regulatory insufficiency has been corrected. The department may issue a regulatory insufficiency for failure to implement the plan of correction. A monitoring revisit by the department shall review the program prospectively from the date of the plan of correction to determine compliance.

[ARC 8174B, IAB 9/23/09, effective 1/1/10; ARC 1055C, IAB 10/2/13, effective 1/1/14]

**481—67.14(17A,231C,85GA,SF394) Assisted living programs—response to final report.** Within 20 working days after the issuance of the final report and assessment of civil penalty, if any, the assisted living program shall respond in the following manner.

**67.14(1) If not contesting final report.** If the program does not desire to seek an informal conference or contest the final report and civil penalty, if assessed, the program shall remit to the department of inspections and appeals the amount of the civil penalty, if assessed. If an assisted living program has been assessed a civil penalty, the civil penalty shall be reduced by 35 percent if the requirements of subrule 67.17(5) are met.

**67.14(2) Informal conference.** If the assisted living program desires to contest the final report and civil penalty, if assessed, and request an informal conference, the assisted living program shall notify the department of inspections and appeals in writing that it desires to contest the final report and civil penalty and request in writing an informal conference with an independent reviewer.

*a. Request for informal conference.* The request for an informal conference must be in writing and include the following:

- (1) Identification of the regulatory insufficiency(ies) being disputed;
- (2) The type of informal conference requested: face-to-face or telephone conference; and
- (3) A request for monitor's notes for the regulatory insufficiencies being disputed, if desired.

*b. Submission of documentation.* The program shall submit the following within 10 working days from the date of the program's written request for an informal conference:

- (1) The names of those who will be attending the informal conference, including legal counsel; and
- (2) Documentation supporting the assisted living program's position. The assisted living program must highlight or use some other means to identify written information pertinent to the disputed regulatory insufficiency(ies). Supporting documentation that is not submitted with the request for an informal conference will not be considered, except as otherwise permitted by the independent reviewer upon good cause shown. "Good cause" means substantial or adequate grounds for failing to submit documentation in a timely manner. In determining whether the program has shown good cause, the independent reviewer shall consider what circumstances kept the program from submitting the supporting documentation within the required time frame.

*c. Face-to-face or telephone conference.* A face-to-face or telephone conference, if requested, will be scheduled to occur within 10 working days of the receipt of the written request, all supporting documentation and the plan of correction required by subrule 67.13(3).

- (1) Failure to submit supporting documentation will not delay scheduling.
- (2) The conference will be scheduled for one hour. The assisted living program will informally present information and explanation concerning the contested regulatory insufficiency(ies). The department will have time to respond to the assisted living program's presentation. Due to the confidential nature of the conference, attendance may be limited.

(3) If additional information is requested by the independent reviewer during the informal conference, the assisted living program will have 2 working days to deliver the additional materials to the independent reviewer.

(4) When extenuating circumstances preclude a face-to-face conference, a telephone conference will be held or the assisted living program may be given one opportunity to reschedule the face-to-face conference.

*d. Results.* The results of the informal conference will generally be sent within 10 working days after the date of the informal conference, or within 10 working days after the receipt of additional information, if requested.

(1) The independent reviewer may affirm or may modify or dismiss the regulatory insufficiency and civil penalty. The independent reviewer shall state in writing the specific reasons for the affirmation, modification or dismissal of the regulatory insufficiency.

(2) The department will issue an amended (changes in factual content) or corrected (changes in typographical/data errors) final report if changes result from the informal conference.

(3) The assisted living program must submit to the department a new plan of correction for the amended or corrected report within 10 calendar days from the date of the letter conveying the results of the conference.

(4) If the informal conference results in dismissal of a regulatory insufficiency for which a civil penalty was assessed, the corresponding civil penalty will be rescinded.

**67.14(3) Procedure after informal conference.** After the conclusion of an informal conference:

*a.* If the assisted living program does not desire to further contest an affirmed or modified final report, the assisted living program shall, within 5 working days after receipt of the written decision of the independent reviewer, remit to the department of inspections and appeals the civil penalty, if assessed.

*b.* If the assisted living program does desire to further contest an affirmed or modified final report, the assisted living program shall, within 5 working days after receipt of the written decision of the independent reviewer, notify the department of inspections and appeals in writing that it desires to formally contest the final report.

**67.14(4) Appeals.** Formal hearings shall be conducted by the administrative hearings division pursuant to Iowa Code chapter 17A and 481—Chapter 10.

[ARC 8174B, IAB 9/23/09, effective 1/1/10; ARC 1055C, IAB 10/2/13, effective 1/1/14]

#### **481—67.15(17A,231B,231C,231D) Denial, suspension or revocation of a certificate.**

**67.15(1) Notice and request for hearing.** The denial, suspension or revocation of a certificate shall be effected by delivering to the applicant or certificate holder by restricted certified mail or by personal service a notice setting forth the particular reasons for such actions. A denial, suspension or revocation shall be effective 30 days after certified mailing or personal service of the notice, unless the applicant or certificate holder gives the department written notice requesting a hearing within the 30-day period. If a timely request for hearing is made, the notice shall be deemed suspended pending the outcome of the hearing, unless subrule 67.15(3) or 67.15(4) applies. If an enforcement action has been implemented immediately in accordance with subrule 67.15(3) or 67.15(4), the enforcement action remains in effect regardless of a request for hearing.

**67.15(2) Hearings.** Hearings shall be conducted by the administrative hearings division of the department of inspections and appeals pursuant to Iowa Code chapter 17A and 481—Chapter 10.

**67.15(3) Immediate suspension of a certificate.** When the department finds that an imminent danger to the health or safety of tenants of a program exists which requires action on an emergency basis, the department may direct removal of all tenants from the program and suspend the certificate or require additional remedies to ensure the ongoing safety of the program's tenants prior to a hearing.

**67.15(4) Immediate imposition of enforcement action.** When the department finds that an imminent danger to the health or safety of tenants exists which requires action on an emergency basis, the department may immediately impose a conditional certificate and accompanying conditions upon the program in lieu of immediate suspension of the certificate and removal of the tenants from the program

if the department finds that tenants' health and safety would still be protected. The program may request a hearing, but the immediate enforcement action remains in effect regardless of the request for hearing. [ARC 1055C, IAB 10/2/13, effective 1/1/14]

**481—67.16(17A,231B,231C,231D) Conditional certification.**

**67.16(1) Conditional certification.** In lieu of denial, suspension or revocation of a certificate, the department may issue a conditional certificate for a period of up to one year. Notwithstanding subrule 67.15(4), a conditional certificate shall be issued only when regulatory insufficiencies pose no greater risk to tenant health or safety than the potential for causing minimal harm.

*a.* The department shall specify the reasons for the conditional certificate in the notice issuing the conditional certificate.

*b.* The department may place conditions upon a certificate, such as requiring additional training; restriction of the program from accepting additional tenants for a period of time; or any other action or combination of actions deemed appropriate by the department.

*c.* Failure by the program to adhere to the plan of correction or conditions placed on the certificate may result in suspension or revocation of the conditional certification and may result in further enforcement action as available under applicable requirements.

*d.* A program must be in substantial compliance with applicable requirements before the removal of a conditional certificate by the department. Prior to lifting a conditional certificate, the department may conduct a monitoring to verify substantial compliance. Once the program is in substantial compliance with applicable requirements, the department shall lift the conditional certificate.

**67.16(2) Appeal of conditional certificate.** A written request for hearing must be received by the department within 30 days after the mailing or service of notice. The conditional certificate shall not be suspended pending the hearing. Hearings shall be conducted by the administrative hearings division of the department of inspections and appeals pursuant to Iowa Code chapter 17A and 481—Chapter 10. [ARC 1055C, IAB 10/2/13, effective 1/1/14]

**481—67.17(17A,231B,231C,231D) Civil penalties.**

**67.17(1) When civil penalties may be issued.** Civil penalties may be issued when the director finds that any of the following has occurred:

*a.* A program that does not comply with applicable requirements and the noncompliance results in imminent danger or a substantial probability of resultant death or physical harm to a tenant may be assessed a civil penalty of not more than \$10,000.

*b.* A program that continues to fail or refuses to comply with applicable requirements within prescribed time frames established by the department or approved by the department in the program's plan of correction and the noncompliance has a direct relationship to the health, safety, or security of tenants may be assessed a civil penalty of not more than \$5,000.

*c.* A program that prevents, interferes with or attempts to impede in any way any duly authorized representative of the department in the lawful enforcement of applicable requirements may be assessed a civil penalty of not more than \$1,000.

*d.* A program that discriminates or retaliates in any way against a tenant, tenant's family, or an employee of the program who has initiated or participated in any proceeding authorized by Iowa Code chapter 231B, 231C or 231D and the corresponding administrative rules may be assessed a civil penalty of not more than \$5,000.

**67.17(2) Duplicate civil penalties prohibited.** The department shall not impose duplicate civil penalties on a program for the same set of facts and circumstances.

**67.17(3) Factors in determining the amount of a civil penalty.** The department shall consider the following factors when determining the amount of a civil penalty:

*a.* The frequency and length of time the regulatory insufficiency occurred (i.e., whether the regulatory insufficiency was an isolated or a widespread occurrence, practice, or condition);

*b.* The past history of the program as it relates to the nature of the regulatory insufficiency (the department shall not consider more than the current certification period and the immediately previous certification period);

- c. The culpability of the program as it relates to the reasons the regulatory insufficiency occurred;
- d. The extent of any harm to the tenants or the effect on the health, safety, or security of the tenants which resulted from the regulatory insufficiency;
- e. The relationship of the regulatory insufficiency to any other types of regulatory insufficiencies which have occurred in the program;
- f. The actions of the program after the occurrence of the regulatory insufficiency, including when corrective measures, if any, were implemented and whether the program notified the director as required;
- g. The accuracy and extent of records kept by the program which relate to the regulatory insufficiency, and the availability of such records to the department;
- h. The rights of tenants to make informed decisions;
- i. Whether the program made a good-faith effort to address a high-risk tenant's specific needs and whether the evidence substantiates this effort.

**67.17(4) Civil penalties due.** The civil penalty shall be paid to the department within 30 days following the program's receipt of the final report and demand letter. The program may appeal in accordance with rule 481—67.12(17A,231B,231D) or 481—67.14(17A,231C,85GA,SF394). If the program appeals, the civil penalty shall be deemed suspended until the appeal is resolved.

**67.17(5) Reduction of civil penalty amount by 35 percent.** If an assisted living program has been assessed a civil penalty, the civil penalty shall be reduced by 35 percent if both of the following requirements are met:

- a. The program does not request a formal hearing pursuant to rule 481—67.12(17A,231B,231D) or 481—67.14(17A,231C,85GA,SF394), or withdraws its request for formal hearing within 30 calendar days of the date that the civil penalty was assessed; and
- b. The civil penalty is paid and payment is received by the department within 30 calendar days of receipt of the final report.

[ARC 1055C, IAB 10/2/13, effective 1/1/14]

**481—67.18(17A,231B,231C,231D) Judicial review.** Judicial review shall be conducted pursuant to Iowa Code chapter 17A and 481—Chapter 10.

[ARC 1055C, IAB 10/2/13, effective 1/1/14]

**481—67.19(135C,231B,231C,231D) Criminal, dependent adult abuse, and child abuse record checks.**

**67.19(1) Definitions.** The following definitions apply for the purposes of this rule.

“*Background check*” or “*record check*” means criminal history, child abuse and dependent adult abuse record checks.

“*Direct services*” means services provided through person-to-person contact. “Direct services” excludes services provided by individuals such as building contractors, repair workers, or others who are in a program for a very limited purpose, who are not in the program on a regular basis, and who do not provide any treatment or services for residents, patients, tenants, or participants of the provider.

“*Employed in a program*” or “*employment within a program*” means all of the following, if the provider is regulated by the state or receives any federal or state funding:

1. An employee of an assisted living program certified under Iowa Code chapter 231C, if the employee provides direct services to consumers;
2. An employee of an elder group home certified under Iowa Code chapter 231B, if the employee provides direct services to consumers;
3. An employee of an adult day services program certified under Iowa Code chapter 231D, if the employee provides direct services to consumers.

“*Employee*” means any individual who is paid, either by the program or any other entity (i.e., temporary agency, private duty, Medicare/Medicaid or independent contractors).

“*Evaluation*” means review by the department of human services to determine whether a founded child abuse, dependent adult abuse or criminal conviction warrants the person's being prohibited from employment in a program.

*“Indirect services”* means services provided without person-to-person contact such as those provided by administration, dietary, laundry, and maintenance.

*“Program,”* for purposes of this rule, means all of the following, if the provider is regulated by the state or receives any federal or state funding:

1. An assisted living program certified under Iowa Code chapter 231C;
2. An elder group home certified under Iowa Code chapter 231B; and
3. An adult day services program certified under Iowa Code chapter 231D.

**67.19(2)** *Explanation of “crime.”* For purposes of this rule, the term “crime” does not include offenses under Iowa Code chapter 321 classified as simple misdemeanor or equivalent simple misdemeanor offenses from another jurisdiction.

**67.19(3)** *Requirements for employer prior to employing an individual.* Prior to employment of a person in a program, the program shall request that the department of public safety perform a criminal history check and the department of human services perform child and dependent adult abuse record checks of the person in this state.

*a. Informing the prospective employee.* A program shall ask each person seeking employment by the program, “Do you have a record of founded child or dependent adult abuse or have you ever been convicted of a crime other than a simple misdemeanor offense relating to motor vehicles and laws of the road under Iowa Code chapter 321 or equivalent provisions in this state or any other state?” The person shall also be informed that a background check will be conducted. The person shall indicate, by signature, that the person has been informed that the background check will be conducted.

*b. Conducting a background check.* The program may access the single contact repository (SING) to perform the required background check. If the SING is used, the program shall submit the person’s maiden name, if applicable, with the background check request. If SING is not used, the program must obtain a criminal history check from the department of public safety and a check of the child and dependent adult abuse registries from the department of human services.

*c. If a person considered for employment has been convicted of a crime.* If a person being considered for employment in a program has been convicted of a crime under a law of any state, the department of public safety shall notify the program that upon the request of the program the department of human services will perform an evaluation to determine whether the crime warrants prohibition of the person’s employment in the program.

*d. If a person considered for employment has a record of founded child abuse or dependent adult abuse.* If a department of human services child or dependent adult abuse record check shows that a person being considered for employment in a program has a record of founded child or dependent adult abuse, the department of human services shall notify the program that upon the request of the program the department of human services will perform an evaluation to determine whether the founded child or dependent adult abuse warrants prohibition of employment in the program.

*e. Employment pending evaluation.* The program may employ a person for not more than 60 calendar days pending the completion of the evaluation by the department of human services if all of the following apply. The 60-day period begins on the first day of the person’s employment.

(1) The person is being considered for employment other than employment involving the operation of a motor vehicle;

(2) The person does not have a record of founded child or dependent adult abuse;

(3) The person has been convicted of a crime that is a simple misdemeanor offense under Iowa Code section 123.47 or a first offense of operating a motor vehicle while intoxicated under Iowa Code section 321J.2, subsection 1; and

(4) The program has requested an evaluation to determine whether the crime warrants prohibition of the person’s employment.

**67.19(4)** *Validity of background check results.* The results of a background check conducted pursuant to this rule shall be valid for a period of 30 calendar days from the date the results of the background check are received by the program.

**67.19(5) *Employment prohibition.*** A person who has committed a crime or has a record of founded child or dependent adult abuse shall not be employed in a program unless an evaluation has been performed by the department of human services.

**67.19(6) *Transfer of an employee to another program owned or operated by the same person.*** If an employee transfers from one program to another program owned or operated by the same person, without a lapse in employment, the program is not required to request additional criminal and child and dependent adult abuse record checks of that employee.

**67.19(7) *Transfer of ownership of a program.*** If the ownership of a program is transferred, at the time of transfer the background check required by this rule shall be performed for each employee for whom there is no documentation that such background check has been performed. The program may continue to employ such employee pending the performance of the background check and any related evaluation.

**67.19(8) *Change of employment—person with criminal or abuse record—exception to record check evaluation requirements.*** A person with a criminal or abuse record who is or was employed by a certified program and is hired by another certified program shall be subject to the background check.

*a.* A reevaluation of the latest record check is not required, and the person may commence employment with the other certified program if the following requirements are met:

(1) The department of human services previously performed an evaluation concerning the person's criminal or abuse record and concluded the record did not warrant prohibition of the person's employment;

(2) The latest background check does not indicate a crime was committed or founded abuse record was entered subsequent to the prior evaluation;

(3) The position with the subsequent employer is substantially the same or has the same job responsibilities as the position for which the previous evaluation was performed;

(4) Any restrictions placed on the person's employment in the previous evaluation by the department of human services and still applicable shall remain applicable in the person's subsequent employment; and

(5) The person subject to the background check has maintained a copy of the previous evaluation and provided it to the subsequent employer, or the previous employer provides the previous evaluation from the person's personnel file pursuant to the person's authorization. If a physical copy of the previous evaluation is not provided to the subsequent employer, a current record check evaluation shall be performed.

*b.* For purposes of this subrule, a position is "substantially the same or has the same job responsibilities" if the position requires the same certification, licensure, or advanced training. For example, a licensed nurse has substantially the same or the same job responsibilities as a director of nursing; a certified nurse aide does not have substantially the same or the same job responsibilities as a licensed nurse.

*c.* The subsequent employer must maintain the previous evaluation in the employee's personnel file for verification of the exception to the requirement for a record check evaluation.

*d.* The subsequent employer may request a reevaluation of the background check and may employ the person while the reevaluation is being performed, even though an exemption under paragraph 67.19(8) "a" may be authorized.

**67.19(9) *Employee notification of criminal convictions or founded abuse after employment.*** If a person employed by an employer that is subject to this rule is convicted of a crime or has a record of founded child or dependent adult abuse entered in the abuse registry after the person's employment application date, the person shall inform the employer of such information within 48 hours of the criminal conviction or entry of the record of founded child or dependent adult abuse.

*a.* The employer shall act to verify the information within 48 hours of notification. "Verify," for purposes of this subrule, means to access the single contact repository (SING) to perform a background check, to request a criminal background check from the department of public safety, to request an abuse record check from the department of human services, to conduct an online search through the Iowa

Courts Online Web site, or to contact the county clerk of court office and obtain a copy of relevant court documents.

*b.* If the information is verified, the program shall follow the requirements of paragraphs 67.19(3) “*c*” and “*d*.”

*c.* The employer may continue to employ the person pending the performance of an evaluation by the department of human services.

*d.* A person who is required by this subrule to inform the person’s employer of a conviction or entry of an abuse record and fails to do so within the required period commits a serious misdemeanor under Iowa Code section 135C.33.

*e.* The employer may notify the county attorney for the county where the employer is located of any violation or failure by an employee to notify the employer of a criminal conviction or entry of an abuse record within the period required under this subrule.

**67.19(10)** *Program receipt of credible information that an employee has been convicted of a crime or founded for abuse.* If the program receives credible information, as determined by the program, from someone other than the employee, that the employee has been convicted of a crime or a record of founded child or dependent adult abuse has been entered in the abuse registry after employment, and the employee has not informed the employer of the information within the time required by subrule 67.19(9), the program shall take the following actions:

*a.* The program shall act to verify credible information within 48 hours of receipt. “Verify,” for purposes of this subrule, means to access the single contact repository (SING) to perform a background check, to request a criminal background check from the department of public safety, to request an abuse record check from the department of human services, to conduct an online search through the Iowa Courts Online Web site, or to contact the county clerk of court office and obtain a copy of relevant court documents.

*b.* If the information is verified, the program shall follow the requirements of paragraphs 67.19(3) “*c*” and “*d*.”

**67.19(11)** *Proof of background checks for temporary employment agencies and contractors.* Proof of background checks may be kept in the files maintained by temporary employment agencies and contractors. Facilities may require temporary employment agencies and contractors to provide a copy of the result of the background checks. Copies of such results shall be made available to the department upon request.

This rule is intended to implement Iowa Code sections 231B.2(1), 231C.3(1), 231D.2(2), and 135C.33 and 2013 Iowa Acts, Senate File 347.  
[ARC 0963C, IAB 8/21/13, effective 9/25/13]

**481—67.20(17A,231C,231D) Emergency removal of tenants.** If the department determines that the health or safety of tenants is in jeopardy and the tenants need to be removed from the program, the department shall use the following procedures to ensure a safe and orderly transfer.

**67.20(1)** The department shall notify the department of human services, the tenant advocate, the appropriate area agency on aging, and other agencies as necessary and appropriate:

- a.* To alert them to the need to transfer tenants from a program;
- b.* To request assistance in identifying alternative programs or other appropriate settings; and
- c.* To contact the tenants and their legal representatives or family members, if applicable, and others as appropriate, including health care professionals.

**67.20(2)** The department shall notify the program of the immediate need to transfer tenants and of any assistance available, in coordination with the appropriate parties under subrule 67.20(1).

**67.20(3)** The department, in conjunction with other agencies as necessary and appropriate, shall proceed with the transfer of tenants.

[ARC 8174B, IAB 9/23/09, effective 1/1/10; ARC 1055C, IAB 10/2/13, effective 1/1/14]

**481—67.21(231C) Nursing assistant work credit.**

**67.21(1)** A person who is certified as a nursing assistant, including a medication aide, and who is supervised by a registered nurse may submit information to the department to obtain credit toward

maintaining certification for working in a program. A program may add an employee to the direct care worker registry by calling (515)281-4077 or by registering through the health facilities division Web site at [https://dia-hfd.iowa.gov/DIA\\_HFD/Home.do](https://dia-hfd.iowa.gov/DIA_HFD/Home.do), under the “Documents” tab.

**67.21(2)** A program shall complete and submit to the department a direct care worker registry application for each certified nursing assistant who works in the program. A registered nurse employed by the program shall supervise the nursing assistant. The application may be obtained by telephone at (515)281-4077 or via the health facilities division Web site at [https://dia-hfd.iowa.gov/DIA\\_HFD/Home.do](https://dia-hfd.iowa.gov/DIA_HFD/Home.do), under the “Documents” tab.

**67.21(3)** A program shall complete and submit to the department a direct care worker registry quarterly employment report whenever a change in the employment of a certified nursing assistant occurs. The report form may be obtained by telephone at (515)281-4077 or via the health facilities division Web site at [https://dia-hfd.iowa.gov/DIA\\_HFD/Home.do](https://dia-hfd.iowa.gov/DIA_HFD/Home.do), under the “Documents” tab.

[ARC 8174B, IAB 9/23/09, effective 1/1/10; ARC 1055C, IAB 10/2/13, effective 1/1/14]

**481—67.22(231B,231C,231D) Public or confidential information.**

**67.22(1) Public information.**

*a. Public disclosure of findings.* The program shall post a notice stating that copies of the final report resulting from a monitoring are available via the department’s Web site at [https://dia-hfd.iowa.gov/DIA\\_HFD/Home.do](https://dia-hfd.iowa.gov/DIA_HFD/Home.do). The program shall post the notice in a prominent location on the premises of the program. Copies shall also be available upon request from the Department of Inspections and Appeals, Adult Services Bureau, Lucas State Office Building, 321 E. 12th Street, Des Moines, Iowa 50319-0083; telephone (515)281-6325.

*b. Open records.* The following records are open records available for inspection:

- (1) Certification applications, certification status, and accompanying materials;
- (2) Final findings of state monitorings, including a monitoring that results from a complaint or program-reported incident;
- (3) Reports from the state fire marshal;
- (4) Plans of correction submitted by a program;
- (5) Official notices of certification sanctions, including enforcement actions;
- (6) Findings of fact, conclusions of law, decisions and orders issued pursuant to rules 481—67.10(17A,231B,231C,231D), 481—67.12(17A,231B,231C,231D), and 481—67.13(17A,231B,231C,231D);
- (7) Waivers, including the department’s approval and denial letter and any letter requesting the waiver.

**67.22(2) Confidential information.** Confidential information includes the following:

*a.* Information that does not comprise a final report resulting from a monitoring, complaint investigation, or program-reported incident investigation. Information which does not comprise a final report may be made public in a legal proceeding concerning a denial, suspension or revocation of certification;

*b.* Names of all complainants;

*c.* Names of tenants of a program, identifying medical information, copies of documentation appointing a legal representative, and the address of anyone other than an owner or operator; and

*d.* Social security numbers or employer identification numbers (EIN).

**67.22(3) Redaction of confidential information.** If a record normally open for inspection contains confidential information, the confidential information shall be redacted before the records are provided for inspection.

[ARC 8174B, IAB 9/23/09, effective 1/1/10; ARC 1055C, IAB 10/2/13, effective 1/1/14]

**481—67.23(231B,231C,231D) Training related to Alzheimer’s disease and similar forms of irreversible dementia.** Effective July 1, 2010, or when administrative rules are adopted pursuant to Iowa Code section 231.62, whichever is later, all programs shall comply with the requirements set forth

in administrative rule to implement Iowa Code section 231.62 for Alzheimer's disease and dementia education.

[**ARC 8174B**, IAB 9/23/09, effective 1/1/10; **ARC 1055C**, IAB 10/2/13, effective 1/1/14]

These rules are intended to implement Iowa Code chapters 231B, 231C as amended by 2013 Iowa Acts, Senate File 394, and 231D.

[Filed ARC 8174B (Notice ARC 7877B, IAB 6/17/09), IAB 9/23/09, effective 1/1/10]

[Filed ARC 0961C (Notice ARC 0809C, IAB 6/26/13), IAB 8/21/13, effective 9/25/13]

[Filed ARC 0963C (Notice ARC 0808C, IAB 6/26/13), IAB 8/21/13, effective 9/25/13]

[Filed ARC 1050C (Notice ARC 0907C, IAB 8/7/13), IAB 10/2/13, effective 11/6/13]

[Filed ARC 1055C (Notice ARC 0941C, IAB 8/7/13), IAB 10/2/13, effective 1/1/14]

CHAPTER 95  
VITAL RECORDS: GENERAL ADMINISTRATION  
[Prior to 12/12/12, see [641] Ch 96, 98.1, Chs 103, 104]

**641—95.1(144) Definitions.** For the purpose of 641—Chapters 95 to 100, the following definitions shall apply:

*“Administrative costs”* means costs for the registration, collection, preservation, modification and certification of records, including but not limited to costs related to copying, regular mailing, searching, staffing, and maintenance of systems.

*“Advanced registered nurse practitioner”* or *“ARNP”* means an individual licensed pursuant to Iowa Code chapter 152.

*“Age of majority”* means the chronological moment when a child legally assumes majority control over the child’s own person and actions and decisions, thereby terminating the legal control and legal responsibilities of the child’s parents over and for the child. The period of minority extends to the age of 18 years, but every minor attains majority by marriage.

*“Amendment”* means a change made by the state registrar upon request from an entitled person as described in 641—95.8(144) to an obvious error, omission, or transposition of letters in a word of common knowledge one year or more after the event.

*“Birth center”* means a facility or institution, which is not an ambulatory surgical center or a hospital or in a hospital, in which births are planned to occur following a normal, uncomplicated, low-risk pregnancy.

*“Birthing institution”* means a private or public hospital licensed pursuant to Iowa Code chapter 135B that has a licensed obstetric unit or is licensed to provide obstetric services.

*“Burial-transit permit”* means a permit which is required to assume custody of a dead body or fetus pursuant to Iowa Code section 144.32.

*“Certificate”* means the written or electronic legal document containing the facts of an event; also used interchangeably with the term “record.”

*“Certificate of birth resulting in stillbirth,”* pursuant to Iowa Code section 144.31A, means a noncertified copy issued based upon a properly filed fetal death certificate to record the birth of a stillborn fetus.

*“Certified copy”* means an official copy of a registered vital record that is authenticated by the registrar in whose jurisdiction the record is registered. A certified copy contains a statement certifying the facts are true and accurate as recorded, is printed on security paper, and has authentication seals and signatures. A certified copy excludes all entries indicated as confidential or for statistical information.

*“Commemorative certificate,”* pursuant to Iowa Code section 144.45A, means a commemorative abstract of an Iowa birth or marriage record that has been properly filed.

*“Confidential information”* means data or information that is on a vital record, is not considered public information, and is restricted as to its release pursuant to Iowa Code chapter 144 or other provision of federal or state law.

*“Correction”* means a change made by the state registrar upon observation, upon query, or upon request from an entitled person as described in 641—95.8(144) to an obvious error, omission, or transposition of letters in a word of common knowledge within one year and prior to the first anniversary of the event.

*“County registrar”* means the county recorder with the authority to record vital records and issue certified copies. The county registrar operates under the state vital records laws and rules and the guidance of the state registrar pursuant to Iowa Code sections 144.5 and 144.9. Pursuant to Iowa Code section 331.601(4), if the office of the county recorder has been abolished, “county registrar” means the office to which the duties are assigned by the county board of supervisors.

*“County resident copy”* means a properly filed, clearly marked working copy of a decedent’s death certificate which is sent to and recorded by the county registrar of the county of the decedent’s residence in the event the death occurred outside the county of the decedent’s residence.

*“Court of competent jurisdiction”* means the appropriate court for the type of action. When used to refer to inspection of an original certificate of birth based upon an adoption, “court of competent jurisdiction” means the court in which the adoption was ordered.

*“Custody”* means guardianship or control of vital records, including both physical possession, referred to as physical custody, and legal responsibility, referred to as legal custody, unless one or the other is specified. The state registrar shall not transfer legal custody of vital records to another agency for purposes of granting public access until all the records have been purged of all confidential information.

*“Day”* means calendar day.

*“Dead human body”* means a lifeless human body or parts or bones of a body, if, from the state of the body, parts, or bones, it may reasonably be concluded that death recently occurred.

*“Death”* means the condition as defined in Iowa Code section 702.8.

*“Declaration of paternity registry”* means a registry for a putative father to declare paternity pursuant to Iowa Code section 144.12A. The declaration does not constitute an affidavit of paternity filed pursuant to Iowa Code section 252A.3A.

*“Delayed birth record”* means the registration of a live birth event occurring in Iowa one or more years after the date of birth which is clearly marked as delayed and shall show on its face the date of the delayed registration.

*“Delayed death record”* means the registration of a death event occurring in Iowa one or more years after the date of death which is clearly marked as delayed and shall show on its face the date of the delayed registration.

*“Delayed marriage record”* means the registration of a marriage event occurring in Iowa one or more years after the event which is clearly marked as delayed and shall show on its face the date of the delayed registration.

*“Department”* means the Iowa department of public health.

*“Disinterment permit”* means a permit which allows the removal of a dead human body or fetus from its original place of burial, entombment or interment for the purpose of autopsy or reburial.

*“Emancipated minor”* means a person younger than 18 years of age who has obtained the age of majority by court order.

*“Fetal death”* means a death prior to the complete expulsion or extraction from its mother of a product of human conception, irrespective of the duration of pregnancy which is not an induced termination of pregnancy. The death is indicated by the fact that, after such expulsion or extraction, the fetus does not breathe or show any other evidence of life such as beating of the heart, pulsation of the umbilical cord or definite movement of voluntary muscles. In determining a fetal death, heartbeats shall be distinguished from transient cardiac contractions, and respirations shall be distinguished from fleeting respiratory efforts or gasps.

*“Filing”* means the presentation of a certificate, report, or other record of a live birth, death, fetal death, adoption, marriage, dissolution, or annulment for registration pursuant to Iowa Code chapter 144.

*“Final disposition”* means the burial, interment, cremation, removal from the state, or other disposition of a dead body or fetus.

*“Foundling”* means a living infant of unknown parentage whose place of birth is where the infant is found and whose date of birth shall be determined by approximation.

*“Funeral director”* means a person licensed in Iowa to practice mortuary science pursuant to Iowa Code chapter 156.

*“Gestational surrogate arrangement”* or *“surrogate mother arrangement,”* as defined in Iowa Code section 710.11, means an arrangement whereby a female agrees to be artificially inseminated with the sperm of a donor, to bear a child, and to relinquish all rights regarding that child to the donor or donor couple.

*“Health care provider”* means an individual licensed under Iowa Code chapter 148, 148C, 148D, or 152 or any individual who provides medical services under the authorization of the licensee.

*“Induced termination of pregnancy”* means the use of any means to terminate the pregnancy of a woman known to be pregnant with the intent other than to produce a live birth or to remove a dead fetus as defined in Iowa Code section 144.29A(8).

*“Institution”* means a facility as defined in Iowa Code section 144.1(10), including “hospital” as defined in Iowa Code section 135B.1(3) but not including “birth center” as defined in Iowa Code section 135.61(2).

*“Institutional health facility”* means a hospital as defined in Iowa Code section 135B.1, including a facility providing medical or health services that is open 24 hours per day, seven days per week and that is a hospital emergency room or a health care facility as defined in Iowa Code section 135C.1.

*“Jurisdiction”* means the state or county to which legal authority for the system of vital statistics has been granted by statute.

*“Last name”* means surname.

*“Lineal consanguinity”* means the existence of a line of descent in which one person is descended in a direct lineal relationship to another: as between the registrant and the registrant’s parent, grandparent, great-grandparent, and so upward, in the direct ascending line; or between the registrant and the registrant’s child, grandchild, great-grandchild and so downward in the direct descending line; or any siblings of the registrant.

*“Live birth”* means the complete expulsion or extraction from its mother of a product of human conception, irrespective of the duration of pregnancy, which after such expulsion or extraction, breathes or shows any other evidence of life, such as beating of the heart, pulsation of the umbilical cord, or definite movement of voluntary muscles, whether or not the umbilical cord has been cut or the placenta is attached. In determining a live birth, heartbeats shall be distinguished from transient cardiac contractions, and respirations shall be distinguished from fleeting respiratory efforts or gasps.

*“Marriage license valid date”* means the day on which the marriage license becomes valid and on or after which the parties are authorized to marry. When the marriage license valid date is computed, the date of application shall be excluded. The marriage license shall become valid after the expiration of three calendar days after the date of application, unless earlier validated by a court of competent jurisdiction.

*“Medical certification”* means a statement which attests that the medical information reported on the certificate of death or fetal death is accurate to the best of the medical certifier’s knowledge.

*“Medical certifier”* means an Iowa-licensed physician, physician assistant, advanced registered nurse practitioner, or medical examiner who attests that the death event has taken place and who determines the cause and manner of death.

*“Medical examiner”* means the medical legal officer who makes the determination of the cause of death in nonroutine deaths such as non-natural, sudden, or unattended deaths or other deaths which affect the public interest.

*“Modification”* means any change made to a record that has been accepted and registered, such as a correction, an amendment, a change after adoption or paternity determination, or any other change.

*“Mutual consent voluntary adoption registry”* means a registry which authorizes adult adopted children, adult siblings, and the biological parents of adult adoptees to register to obtain identifying birth information.

*“Natural cause of death”* means a death due to a disease or the aging process and not due to external causes.

*“Newborn safe haven registration”* means the registration of the birth of a living infant of unknown parentage who has been abandoned or left at some unknown time after birth in a location other than the place of delivery.

*“Non-birthing institution”* means a private or public hospital licensed pursuant to Iowa Code chapter 135B that does not have a licensed obstetric unit or is not licensed to provide obstetric services but may provide obstetric services on an emergency basis.

*“Non-institution birth”* means a live birth that occurs outside of an institution and not en route to an institution.

*“Non-natural cause of death,”* pursuant to Iowa Code section 144.28(1) *“a,”* means the death is a direct or indirect result of physical, chemical, thermal, or electrical trauma, or drug or alcohol intoxication or other poisoning.

*“Notification of record search”* means the document issued to the applicant when the record requested cannot be located through a search of registered records. The document contains a certification statement, is printed on security paper, and has authentication seals and signatures.

*“Officiant”* means (1) a judge of the Iowa supreme court, court of appeals, or district court, including a district associate judge, an associate juvenile judge, or a judicial magistrate, and including a senior judge as defined in Iowa Code section 602.9202(3), or (2) a person ordained or designated as a leader of the person’s religious faith.

*“Physician”* means an individual licensed pursuant to Iowa Code chapter 148.

*“Physician assistant”* means an individual licensed pursuant to Iowa Code chapter 148C.

*“Presumptive death”* means a death event presumed to have occurred in Iowa where no human body is found and a court of competent jurisdiction has determined the death has occurred.

*“Putative father”* means a man who is alleged to be or who claims to be the biological father of a child born to a woman to whom the man is not married at the time of the conception or birth of the child or at any time during the period between the conception and birth of the child.

*“Record of death”* means the compilation of those entries of a death, whether electronic or paper, which are contained in indexed systems which record the death event occurring in Iowa. “Record of death” shall include the certificate of death.

*“Record of fetal death”* means the compilation of those entries of a fetal death, whether electronic or paper, which are contained in indexed systems which record a fetal death event occurring in Iowa. “Record of fetal death” shall include the certificate of fetal death.

*“Record of foreign born adoption”* means the compilation of those entries of a live birth event for a child born in a foreign country and adopted by an Iowa resident. “Record of foreign born adoption” shall include the certificate of foreign birth and shall not constitute U.S. citizenship.

*“Record of live birth”* means the compilation of those entries of a live birth event, whether electronic or paper, which are contained in indexed systems which record a live birth event occurring in Iowa. “Record of live birth” shall include the certificate of live birth.

*“Record of marriage”* means the compilation of those entries of a marriage event, whether electronic or paper, which are contained in indexed systems which record a marriage event occurring in Iowa. “Record of marriage” shall include the certificate of marriage.

*“Registrant”* means the person named on the certificate as the person who was born, died, or was married.

*“Registration”* means the process by which vital statistics records are completed, filed, and incorporated by the state registrar in the official records.

*“Report of dissolution or annulment”* means the statistical report of dissolution or annulment, whether electronic or paper, excluding all entries indicated as confidential or for statistical information only.

*“Report of termination of pregnancy”* means the aggregated compilation of the information received by the department on terminations of pregnancies for each information item listed, with the exception of the report tracking number, the health care provider code, and any set of information for which the number is so small that the confidentiality of any person to whom the information relates may be compromised.

*“Research”* means the systematic investigation designed primarily to develop or contribute to scientific, medical, public health or psychosocial disciplines and generalized knowledge and not for private gain.

*“Sealed”* means the removal from inspection of any copy of an original certificate in the custody of the county registrar and the state registrar.

*“Security paper”* means standardized paper for issuing certified copies of vital record events that meets, at a minimum, national requirements for security features embedded within the paper to deter

tampering, counterfeiting, photocopying, or imaging in order to help prevent fraudulent use of the certified copy and prevent identity theft.

*“Single parent birth”* means any record of live birth for which there is a reference or statement on the certificate or entry which directly indicates “no” regarding “born in wedlock” or “married”; or any record of live birth for which there is reference or statement on the certificate or entry that either parent is “unknown” or “anonymous”; or any certificate or entry which reflects the omission or absence of the name of the father of the child.

*“Spontaneous termination of pregnancy”* means the occurrence of an unintended termination of pregnancy at any time during the period from conception to 20 weeks’ gestation and is not a spontaneous termination of pregnancy at any time during the period from 20 weeks or greater which is reported to the department as a fetal death under Iowa Code section 144.29.

*“Standard birth registration”* means a vital record of a live birth event that occurred in Iowa which was submitted and accepted for registration within one year of the event.

*“State registrar”* means the director of the department or the director’s designee.

*“Stillbirth”* means an unintended fetal death occurring after a gestation period of 20 completed weeks or more or an unintended fetal death of a fetus with a weight of 350 or more grams.

*“System of vital statistics”* or *“system”* means the registration, collection, preservation, amendment, and certification of vital statistics records, and activities and records related thereto including the data processing, analysis, and publication of statistical data derived from such records.

*“Uncertified copy”* means an unofficial copy of a registered vital record which is not printed on security paper and which does not contain any authentication by the issuing jurisdiction. Uncertified copies shall contain an overstamp such as: “Not for Legal Purposes,” “Administrative Use Only,” “Deceased,” “For Genealogical Purposes Only,” “Working Copy,” or any other overstamp as authorized by the state registrar.

*“Vital records”* means certificates or reports of birth, death, fetal death, marriage, dissolution, annulment, and related data.

*“Vital statistics”* means data derived from reports, certificates, and records of live birth, death, fetal death, induced termination of pregnancy, marriage, dissolution of marriage or annulment, and data related thereto.

[ARC 0483C, IAB 12/12/12, effective 1/16/13; see Delay note at end of chapter]

**641—95.2(144) Vital records and statistics.** There is established a division in the department which shall install, maintain, and operate the system of vital statistics throughout the state. No system for the registration of births, deaths, fetal deaths, adoptions, marriages, dissolutions, and annulments shall be maintained in the state or any of its political subdivisions other than the one provided for in Iowa Code chapter 144, including, but not limited to, a system maintained by any agency or private entity.

**95.2(1)** No person shall prepare or issue any certificate which purports to be an original certified copy or a copy of a certificate of birth, death, fetal death, adoption, marriage, dissolution, or annulment or any subset of the data items taken from a certificate except as provided for in Iowa Code chapter 144 and authorized by the state registrar.

**95.2(2)** A vital record, index, or subset of data shall not be maintained in any other system or manner except as provided for in Iowa Code chapter 144 and authorized by the state registrar.

**95.2(3)** The state registrar and the county registrar shall not maintain or issue copies of any vital record of an event occurring outside the state registrar’s or county registrar’s jurisdiction except as provided for in Iowa Code chapter 144 and authorized by the state registrar.

**95.2(4)** To protect the integrity of vital records and to ensure their proper use, no vital record, index, or subset of data shall be posted to the World Wide Web or published in any other manner except as provided for in Iowa Code chapter 144 and pursuant to subrule 95.10(3) or as authorized by the state registrar.

[ARC 0483C, IAB 12/12/12, effective 1/16/13; see Delay note at end of chapter]

**641—95.3(144) Forms—property of department.** All forms, certificates and reports pertaining to the registration of vital events are the property of the department and shall be surrendered to the state registrar upon demand.

**95.3(1)** The forms supplied or approved for reporting vital events shall be used for official purposes as provided for by law, rules and instructions of the state registrar.

**95.3(2)** No forms, except those furnished or approved by the state registrar, shall be used in the reporting of vital events or the making of copies of vital records.

**95.3(3)** Security paper used to report vital events shall be maintained in a secure location accessible only to the state and county registrars and their employees for administrative purposes.

**95.3(4)** Security paper shall be used to issue certified copies of Iowa vital records and shall be maintained in a secure location accessible only to the state and county registrars and their employees for administrative purposes.

[ARC 0483C, IAB 12/12/12, effective 1/16/13; see Delay note at end of chapter]

**641—95.4(144) Information by others.**

**95.4(1)** Any person having knowledge of the facts shall furnish information that the person possesses regarding any birth, death, fetal death, adoption, marriage, dissolution, or annulment, upon demand of the state registrar.

**95.4(2)** Every person in charge of an institution, or the person's designee, shall maintain a record of personal particulars and data concerning each person admitted or confined to the institution pursuant to Iowa Code section 144.47. This record shall include information required by the standard certificate of birth, death, and fetal death forms issued under the direction of the state registrar. The record shall be made at the time of admission based on the information provided by such person, but when information cannot be obtained from the person, it shall be obtained from the most knowledgeable relative or person acquainted with the facts. The name and address of the person providing the information shall be a part of the record.

**95.4(3)** Records maintained under this rule shall be retained for a period of not less than ten years and shall be made available for inspection by the state registrar upon demand.

[ARC 0483C, IAB 12/12/12, effective 1/16/13; see Delay note at end of chapter]

**641—95.5(144) Handling of vital records.**

**95.5(1)** State equipment and state vital records shall not be handled or accessed except by the state registrar, the state registrar's employees, or other authorized personnel for administrative purposes.

**95.5(2)** The county registrar shall provide assistance to the public in accessing vital records designated as public records in the custody of the county registrar.

[ARC 0483C, IAB 12/12/12, effective 1/16/13; see Delay note at end of chapter]

**641—95.6(144) Fees.**

**95.6(1)** *Fees for services provided by state registrar or county registrar.* The following fees shall be charged and remitted for the various services provided by the state registrar or the county registrar.

*a.* The state registrar or county registrar, as applicable, shall charge a fee of \$20 to conduct a search for a record. On and after July 1, 2019, this fee will revert to \$15.

(1) The search fee shall include one certified copy of the record.

(2) For each additional certified copy of the same record, a \$20 fee shall be charged. On and after July 1, 2019, this fee will revert to \$15.

(3) If, following a search, no record is found, the \$20 fee shall be retained. On and after July 1, 2019, this fee will revert to \$15.

*b.* The state registrar shall charge a fee of \$20 to prepare an adoption certificate, to amend a certificate, to amend a certificate of live birth to reflect a legal change of name, to prepare a delayed certificate, to process other administrative or legal actions, or for the search and preparation of copies of supporting documents on file in the state registrar's office. On and after July 1, 2019, this fee will revert to \$15. No fee shall be charged for establishment of paternity.

c. The state registrar shall charge a fee of \$25 to file a completed application for the mutual consent voluntary adoption registry.

d. The state registrar shall charge a fee of \$5 to update applicant information maintained in the mutual consent voluntary adoption registry and the declaration of paternity registry.

e. The state registrar shall charge a fee of \$20 to amend an abstract or other legal documentation in support of the preparation of a new certificate. On and after July 1, 2019, this fee will revert to \$15.

f. The state registrar shall charge a fee of \$35 to conduct a search for a record for the purpose of issuing a commemorative copy of a certificate of birth or a certificate of marriage pursuant to Iowa Code section 144.45A. Fees collected shall be deposited in the emergency medical services fund established in Iowa Code section 135.25.

g. The state registrar shall charge a fee of \$20 to conduct a search for a certificate of fetal death for the purpose of issuing an uncertified copy of a certificate of birth resulting in stillbirth pursuant to Iowa Code section 144.31A. On and after July 1, 2019, this fee will revert to \$15.

**95.6(2) *Overpayments.*** Any overpayment of less than \$20 received by the state registrar for the copying of or search for vital records, or for the preparation or amending of a certificate, shall not be refunded. The state registrar shall retain the first \$14 of any overpayment with any remaining amount to be deposited in the general fund of the state. On and after July 1, 2019, the overpayment amount will revert to \$15 and the amount retained by the state registrar will revert to \$9.

**95.6(3) *Certified copy of modified vital record.*** When an individual is in possession of a previously issued certified copy of a vital record and the original record is subsequently modified, the individual may request and receive a certified copy of the modified record without charge if the certified copy prior to modification is relinquished to the registrar's office that issued the certified copy, unless otherwise directed by the state registrar.

**95.6(4) *Search of county registrar's records—fee for uncertified copy.*** A person who is requesting an uncertified copy of a record in the custody of the county registrar shall conduct the search of the county files to locate the record. If a copy is requested, the county registrar may charge a fee of no more than \$5 for an uncertified copy of the county record. The fee shall be retained by the county.

**95.6(5) *Distribution of fees.***

a. All fees collected by the county registrar and the state registrar shall be distributed as follows:

(1) For fees collected by a county registrar, with the exception of the fee in subrule 95.6(4), the county registrar shall retain \$4 of each \$20 fee collected by that office. On and after July 1, 2019, this \$20 fee will revert to \$15. Fees collected shall be divided as follows:

1. For a birth certificate or a marriage certificate, the state registrar shall receive \$13, and \$3 shall be deposited in the general fund of the state, except for the fee collected pursuant to paragraph 95.6(1) "f." On and after July 1, 2019, the amount received by the state registrar will revert to \$8.

2. For a death certificate, the state registrar shall receive \$11, the office of the state medical examiner shall receive \$3, and \$2 shall be deposited in the general fund of the state. On and after July 1, 2019, the amount received by the state registrar will revert to \$6.

(2) For fees collected by the state registrar, the state registrar shall retain all fees, with the exception of the fees in paragraph 95.6(1) "a," of which the state registrar shall retain \$14 of each \$20 fee collected for the issuance of certified copies. On and after July 1, 2019, the fee collected will revert to \$15 and the amount retained by the state registrar will revert to \$9. The \$6 balance of certified copy fees collected by the state registrar shall be divided as follows:

1. For a birth certificate or a marriage certificate, \$6 shall be deposited in the general fund of the state.

2. For a death certificate, the office of the state medical examiner shall receive \$3, and \$3 shall be deposited in the general fund of the state.

b. All fees retained by the state registrar shall be added to the vital records fund established by the department pursuant to Iowa Code section 144.46A.

c. All fees received by the office of the state medical examiner shall be added to the operating budget established for the operation of that office.

**95.6(6)** *Fee for search to verify vital statistics record.* A fee shall be charged by the state registrar for each search conducted for the purpose of providing verification of vital statistics data to an agency authorized to receive such data under subrule 95.12(2).

*a.* The amount of the fee shall be determined in an agreement with the department and shall be dependent on the nature and scope of the project and the resources required to obtain the data requested.

*b.* The state registrar shall retain the full amount of all fees collected under this subrule in the vital records fund established pursuant to Iowa Code section 144.46A.

**95.6(7)** *Fee for researcher access to vital statistics data.* A fee shall be charged to each researcher who is provided access to vital statistics data in accordance with Iowa Code section 144.44 and the required agreement executed with the department. The amount of the fee shall be based on the nature and scope of the research project and resources required to obtain the data requested.

*a.* The state registrar shall allocate the fees for copies of birth, marriage, and death certificates provided to researchers pursuant to the distribution of fees set forth in subrule 95.6(5).

*b.* The state registrar shall retain in the vital records fund established pursuant to Iowa Code section 144.46A the full amount of fees collected from researchers for searching files or records to create a data file.

**95.6(8)** *Service member who died while on active duty—waiver of fee.* The certified copy fee for a birth certificate or a death certificate of a service member, as defined in Iowa Code section 29A.90, who died while on active duty shall be waived for a period of one year from the date of death. Application for the certified copy shall be made by an entitled family member as described in 641—95.8(144) of the deceased service member or the entitled family member's legal representative. Documentation shall be submitted at the time of application to substantiate the date of death and active duty status.

[ARC 0483C, IAB 12/12/12, effective 1/16/13; see Delay note at end of chapter; ARC 1074C, IAB 10/2/13, effective 1/1/14]

**641—95.7(144) General public access of vital records in the custody of the county registrar.** A vital record may be in the custody of the county registrar if the event occurred in that county and the record is not excluded by statute or definition for purposes of confidentiality.

**95.7(1)** There shall be public access and the right to inspect in person all vital records in the custody of the county registrar after they are purged of confidential information.

**95.7(2)** Electronic devices, including but not limited to scanners, cameras, cell phones or laptops, shall not be used to secure information from county vital records.

**95.7(3)** Information inspected and copied shall not be published or used to establish an index or record of information at any other location except as authorized by Iowa Code chapter 144.

**95.7(4)** County registrars may issue uncertified copies of vital records held in the registrars' custody and accessible to the general public, except those records excluded by statute or at the direction of the state registrar.

*a.* Requests for uncertified copies shall be accepted solely through in-person application after the applicant has conducted the applicant's own search for the record at the county registrar's office.

*b.* Uncertified copies shall be issued on plain white paper and clearly stamped "not for legal purposes." Security paper provided by the state registrar shall not be used to produce records for uncertified copies.

**95.7(5)** County registrars shall not provide specific information from any vital record via telephone, fax, electronic file, Web site, written letter or verbally, except for administrative purposes with the state vital records office.

**95.7(6)** County registrars shall not produce lists of vital records for any agency, private business, or member of the general public.

**95.7(7)** Records of births prior to July 1, 1995, that have been determined to be single parent births shall not be in the custody of the county registrar or accessible to the public as a right under Iowa Code chapter 22.

**95.7(8)** Records of births on and after July 1, 1995, that have been determined to be single parent births shall be accessible to the public as a right under Iowa Code chapter 22.

**95.7(9)** For a record of death registered on or after April 5, 2012, for a decedent who died outside of the county of the decedent's residence, the state registrar shall send a clearly marked copy of the decedent's death certificate and any amendments to the county registrar of the county of the decedent's residence. The county registrar shall incorporate the clearly marked copy of the county resident death certificate in the vital records system maintained by the county. Certified or uncertified copies of county resident death certificates shall be clearly marked as "county resident copy."

[ARC 0483C, IAB 12/12/12, effective 1/16/13; see Delay note at end of chapter]

**641—95.8(144) Direct tangible interest in and entitlement to a vital record.** Certified copies of vital records may be issued by the state registrar or county registrar upon written application, payment of the required fee pursuant to paragraph 95.6(1) "a," and demonstration of a verifiable, direct tangible interest and entitlement.

**95.8(1)** The following persons shall be considered to have a direct tangible interest and entitlement and are authorized to obtain a certified copy of a vital record:

*a.* The registrant, if the registrant is of legal age, has reached the age of majority, or is an emancipated minor.

*b.* A member of the registrant's immediate legal family, including:

- (1) Current spouse or surviving spouse;
- (2) Children;
- (3) Mother or father if listed on the registrant's birth certificate;
- (4) Sibling, if sibling has reached the age of majority;
- (5) Maternal grandparents, or paternal grandparents if the father is listed on the birth certificate; or
- (6) Step-parent or step-child if:
  1. Legal parent and step-parent are currently married at the time of application; or
  2. Step-parent is the surviving spouse of the legal parent and not remarried.

*c.* The documented legal representative of the registrant or the registrant's immediate legal family, including:

- (1) An attorney;
- (2) A court-appointed guardian;
- (3) A foster parent;
- (4) A funeral director, for up to one year following the decedent's date of death; or
- (5) A legal executor.

*d.* Other persons who demonstrate a direct tangible interest and entitlement when it is shown that the certified copy is needed to determine or protect a personal or property interest.

**95.8(2)** The following persons shall not be deemed to have direct tangible interest and entitlement or be authorized to secure vital records:

*a.* Biological parents of adopted persons in the absence of a court order from the court of competent jurisdiction;

*b.* Biological family members of adopted persons;

*c.* Adopted persons requesting biological family records; or

*d.* Commercial firms or agencies requesting lists of vital record events, or lists of names, or lists of addresses.

[ARC 0483C, IAB 12/12/12, effective 1/16/13; see Delay note at end of chapter]

**641—95.9(144) Search and issuance of a certified copy of a vital record.** The search and issuance of a certified copy of a vital record shall be requested from the state registrar or county registrar.

**95.9(1)** Only entitled applicants as described in rule 641—95.8(144) may submit requests for certified copies of vital records.

**95.9(2)** A person requesting a search and issuance of a certified copy of a vital record shall provide in writing the following:

- a.* The name of the person or persons whose vital record is to be searched;
- b.* The purpose of such request;
- c.* The relationship to the registrant of the person making the request; and

*d.* The notarized signature and the address of the person making the request.

**95.9(3)** In addition to a completed written application, the applicant shall provide:

*a.* A current, legible government-issued photo identification of the applicant making the request or other identification documents acceptable to the state registrar; and

*b.* Payment of the required fee before the search is conducted.

**95.9(4)** The state registrar and county registrar shall have the authority to require additional supporting documents to prove direct tangible interest and entitlement pursuant to rule 641—95.8(144).

**95.9(5)** If, after the search is conducted, no record is on file, the state registrar or county registrar shall issue a “notification of record search” on certified paper, and the fee for the search shall be retained pursuant to paragraph 95.6(1) “*a.*”

[ARC 0483C, IAB 12/12/12, effective 1/16/13; see Delay note at end of chapter]

**641—95.10(144) Search and issuance for genealogy or family history.** The search and issuance of a vital record for genealogy may be requested from the state registrar or county registrar upon written application and payment of the required fee pursuant to paragraph 95.6(1) “*a.*”

**95.10(1)** The county registrar may issue certified copies of a vital record for genealogy or family history to an applicant who can satisfactorily demonstrate a line of direct lineal consanguinity and to aunts, uncles, and cousins not past twice removed.

**95.10(2)** The county registrar may issue uncertified copies of a vital record for genealogy or family history to any member of the general public except those records excluded by statute or at the direction of the state registrar. Requests for uncertified copies shall be accepted solely through in-person application after the applicant has conducted a search for the record at the county registrar’s office.

**95.10(3)** The state registrar may issue uncertified copies of a vital record for genealogy or family history to an applicant who is conducting genealogical research and can satisfactorily demonstrate a line of direct lineal consanguinity and to aunts, uncles, and cousins not past twice removed if the event occurred 125 years ago or more for birth records and 75 years ago or more for marriage and death records.

**95.10(4)** All copies issued for genealogy or family history shall be clearly marked “for genealogical purposes only.”

**95.10(5)** No copy shall be issued for genealogy or family history if the registrant is known to be living.

**95.10(6)** If, after the search is conducted, no record is on file, the state registrar or county registrar shall issue a “notification of record search” on certified paper, and the fee for the search shall be retained pursuant to paragraph 95.6(1) “*a.*”

[ARC 0483C, IAB 12/12/12, effective 1/16/13; see Delay note at end of chapter]

**641—95.11(144) Registrars’ responsibility for maintenance of confidentiality.**

**95.11(1)** The state registrar and county registrar shall maintain the confidentiality of the following material, records, and information:

*a.* Entries indicated as confidential or statistical in nature on the face of the record or otherwise confidential by law;

*b.* Records of fetal death or stillbirth, adoption, legal change of name, and single parent births occurring prior to July 1, 1995; and

*c.* Any record which is ordered sealed by the state registrar or pursuant to a court order.

**95.11(2)** The county registrar shall take all necessary steps to ensure that confidential information reflected on vital records has been redacted from general public access. If confidential information is included with accessible information, only accessible information shall be made available to the general public for examination.

**95.11(3)** The county registrar shall employ at a minimum all of the following methods to ensure confidentiality:

*a.* Permanently cover or remove, by appropriate means, confidential information;

*b.* Promptly process the notice to seal a record as directed by the state registrar; and

*c.* Seal and not reproduce confidential information when copies of vital records are made.

**95.11(4)** The county registrar may charge reasonable administrative costs to reflect the expenses for efforts required to allow general public access, examination and the assurance of confidentiality of this material and information pursuant to the authority of Iowa Code chapter 22.

*a.* The administrative cost is to be paid by persons who request the services provided by the county registrar, including supervising, copying or providing a suitable place for such work.

*b.* The county registrar shall retain all administrative costs collected to allow general public access, examination, and the assurance of confidentiality of the vital record and information pursuant to the authority of Iowa Code chapter 22.

[ARC 0483C, IAB 12/12/12, effective 1/16/13; see Delay note at end of chapter]

**641—95.12(144) Disclosure of data.**

**95.12(1)** The state registrar may disclose data from the system of vital statistics to federal, state, county or municipal agencies of government that request such data in the conduct of their official duties, subject to conditions the state registrar may impose to ensure that the use of the data is limited to official purposes.

*a.* The aforementioned agencies shall not provide the certified copy or a copy of the vital record, or release information contained therein, to the person named on the certificate, a member of the person's legal family, or the person's legal representative.

*b.* Certified copies issued to the aforementioned agencies shall be appropriately stamped, for example, "administrative purposes only" or "for veteran affairs purposes only."

**95.12(2)** Confidential verifications of the facts contained in vital records may be furnished by the state registrar to any federal, state, county or municipal government agency or other entity in the conduct of the agency's or entity's official duties, subject to conditions the state registrar may impose to ensure that the verification is limited to official purposes.

*a.* Such confidential verifications shall be on forms prescribed and furnished by the state registrar or on forms furnished by the requesting agency or entity and acceptable to the state registrar, or the state registrar may authorize the verification in other ways.

*b.* The aforementioned agencies and entities shall not provide the original or a copy of the verified certificate, or release information contained therein, to the person named on the certificate, a member of the person's legal family, or the person's legal representative.

**95.12(3)** The state registrar may permit the use of data from vital statistics for research purposes subject to conditions the state registrar may impose to ensure the use of the data is limited to such research purposes. No data shall be furnished from vital statistics for research purposes until the state registrar has prepared in writing the conditions under which the data may be used and has received an agreement signed by a responsible agent of the research organization agreeing to meet and conform to such conditions.

**95.12(4)** The state registrar may transmit to the county registrar data needed to produce certified copies of vital records pursuant to rule 641—95.8(144).

**95.12(5)** The state registrar may transmit to the statewide immunization registry information from birth certificates for the sole purpose of identifying those children in need of immunizations. The state registrar may impose conditions to ensure that the use of the information is limited to official purposes.

**95.12(6)** The state medical examiner or the county medical examiner may request an uncertified copy of a death certificate before the death certificate is accepted and filed at the county registrar's office.

*a.* The copy shall be clearly stamped "administrative purposes only."

*b.* The death certificate shall be for the sole use of the state medical examiner or county medical examiner and shall not be used as a legal document, be distributed, be copied or be maintained other than to be made a part of the investigatory file.

*c.* If the state medical examiner or any county medical examiner determines the death does not warrant further investigation, the state medical examiner or county medical examiner shall destroy the uncertified copy of the death certificate.

[ARC 0483C, IAB 12/12/12, effective 1/16/13; see Delay note at end of chapter]

**641—95.13(144) Preparation of certified copies.** Certified copies of vital records may be prepared and issued by the state registrar or the county registrar pursuant to rules 641—95.3(144) and 641—95.9(144).

**95.13(1)** Certified copies of vital records may be made by mechanical, electronic, or other reproductive processes, except for confidential information. Certified copies shall be issued using security paper that is prescribed by the state registrar.

**95.13(2)** When a certified copy is issued, each certification shall contain a statement certifying that the facts are the true facts recorded in the issuing office, the date issued, the name of the issuing office, the registrar's signature or an authorized copy thereof, and the seal of the issuing office.

**95.13(3)** No person shall prepare or issue any certificate which purports to be an original, certified copy, or copy of a certificate of birth, death, fetal death, or marriage.

[ARC 0483C, IAB 12/12/12, effective 1/16/13; see Delay note at end of chapter]

**641—95.14(144) Cancellation of fraudulent records.**

**95.14(1)** When the state registrar determines that a certificate was registered through fraud or misrepresentation, the state registrar shall give to the registrant a notice in writing of the state registrar's intention to cancel said certificate.

**95.14(2)** The notice of cancellation shall give the registrant an opportunity to appear and show cause why the certificate shall not be canceled.

*a.* The notice may be served on the registrant, or, in the case of a minor or incompetent person, on the parent or guardian, by the forwarding of the notice by certified mail to the last-known address on file in the office of the state registrar.

*b.* The certificate shall not be available for certification unless the registrant, parent or guardian within 30 days after the date of mailing the notice shows cause satisfactory to the state registrar why the certificate shall not be canceled.

**95.14(3)** Upon presentation to the state registrar of a court order stating a marriage certificate was registered through fraud or misrepresentation, the state registrar shall remove said record from the vital statistics system. The state registrar shall order the county registrar to remove any record related to the marriage.

[ARC 0483C, IAB 12/12/12, effective 1/16/13; see Delay note at end of chapter]

**641—95.15(144) Unlawful acts.**

**95.15(1) *Serious misdemeanors.*** Any person who reports information required under Iowa Code chapter 144 and who commits any of the following acts is guilty of a serious misdemeanor:

*a.* Willfully and knowingly makes any false statement in a report, record, or certificate required to be filed or in an application for an amendment or willfully and knowingly supplies false information intending that such information be used in the preparation or amendment of any such report, record, or certificate.

*b.* Without lawful authority and with the intent to deceive, makes, alters, amends, or mutilates any report, record, or certificate required to be filed or a certified copy of such report, record, or certificate.

*c.* Willfully and knowingly uses or attempts to use or furnish to another for use for any purpose of deception any certificate, record, or report or certified copy thereof.

*d.* Willfully and knowingly alters, amends, or mutilates any copy, certified copy, record or report.

*e.* Willfully, with the intent to deceive, uses or attempts to use any certificate of birth or certified copy of a record of birth knowing that such certificate or certified copy was issued based upon a record which is false in whole or in part or which relates to the birth of another person.

*f.* Willfully and knowingly furnishes a certificate of birth or certified copy of a record of birth with the intention that it be used by a person other than the person to whose birth the record relates.

*g.* Disinterring a body in violation of Iowa Code section 144.34.

*h.* Knowingly violates a provision of Iowa Code section 144.29A.

**95.15(2) *Simple misdemeanors.*** Any person committing any of the following acts is guilty of a simple misdemeanor:

*a.* Knowingly transports or accepts for transportation, interment, or other disposition a dead body without an accompanying permit as provided in Iowa Code sections 144.32, 144.33, and 144.34.

- b.* Refuses to provide information required by Iowa Code chapter 144.
- c.* Willfully violates any of the provisions of Iowa Code chapter 144 or refuses to perform any of the duties imposed upon the person.

[ARC 0483C, IAB 12/12/12, effective 1/16/13; see Delay note at end of chapter]

**641—95.16(144) Enforcement assistance.**

**95.16(1)** The department shall report cases of alleged violations to the proper county attorney, with a statement of the facts and circumstances, for such action as is appropriate.

**95.16(2)** Upon request of the department, the attorney general shall assist in the enforcement of the provisions of Iowa Code chapter 144.

[ARC 0483C, IAB 12/12/12, effective 1/16/13; see Delay note at end of chapter]

These rules are intended to implement Iowa Code chapter 144.

[Filed ARC 0483C (Notice ARC 0376C, IAB 10/3/12), IAB 12/12/12, effective 1/16/13]<sup>1</sup>

[Filed ARC 1074C (Notice ARC 0926C, IAB 8/7/13), IAB 10/2/13, effective 1/1/14]

<sup>1</sup> January 16, 2013, effective date of the rescission of Chapter 95 and the adoption of new Chapter 95 [ARC 0483C] delayed until adjournment of the 2013 General Assembly by the Administrative Rules Review Committee at its meeting held January 8, 2013; delay lifted at the meeting held March 8, 2013.



CHAPTER 96  
BIRTH REGISTRATION

[Prior to 12/12/12, see [641] 95.1 to 95.4, Ch 99, 100.3]

**641—96.1(144) Definitions.** For the purpose of this chapter, the definitions in 641—Chapter 95 shall apply.

[ARC 0483C, IAB 12/12/12, effective 1/16/13; see Delay note at end of chapter]

**641—96.2(144) Forms—property of department.** All forms, certificates and reports pertaining to the registration of vital events are the property of the department and shall be surrendered to the state registrar upon demand.

**96.2(1)** The forms supplied or approved for reporting birth events shall be used for official purposes as provided for by law, rules and instructions of the state registrar.

**96.2(2)** No forms, except those furnished or approved by the state registrar, shall be used in the reporting of birth events or the making of copies of vital records.

[ARC 0483C, IAB 12/12/12, effective 1/16/13; see Delay note at end of chapter]

**641—96.3(144) Standard birth registration—up to seven days.**

**96.3(1)** A certificate of live birth for each live birth which occurs in this state shall be filed as directed by the state registrar within seven days after the birth.

**96.3(2)** The person responsible for registering the certificate of live birth pursuant to rules 641—96.5(144), 641—96.6(144) and 641—96.7(144) shall:

*a.* Utilize the official birth worksheet to report all information and any additional documentation as needed to complete the standard form for a certificate of live birth; and

*b.* Submit all required fees and reports with the birth registration.

[ARC 0483C, IAB 12/12/12, effective 1/16/13; see Delay note at end of chapter]

**641—96.4(144) Standard birth registration—seven days to one year.**

**96.4(1)** After seven days but within one year, a certificate of live birth for each live birth which occurs in this state shall be filed as directed by the state registrar.

**96.4(2)** The person responsible for registering the certificate of live birth pursuant to rules 641—96.5(144), 641—96.6(144) and 641—96.7(144) shall:

*a.* Utilize the official birth worksheet to report all information and any additional documentation as needed to complete the standard form for a certificate of live birth; and

*b.* Submit all required fees and reports with the birth registration.

[ARC 0483C, IAB 12/12/12, effective 1/16/13; see Delay note at end of chapter]

**641—96.5(144) Birthing institutions.**

**96.5(1)** When a live birth occurs in an institution or en route to an institution, the person in charge of the institution or the person's designated representative, utilizing the official birth worksheet, shall within seven days:

*a.* Obtain the personal data;

*b.* Obtain the signature of the mother or her legal spouse or other signature as directed by the state registrar;

*c.* Provide the medical information required;

*d.* Certify that the child was born alive at the place, date, and time stated; and

*e.* File the certificate using the electronic birth registration system or as directed by the state registrar.

**96.5(2)** The birthing institution shall submit the fee report and remit the fees to the state registrar pursuant to rule 641—96.16(144).

**96.5(3)** The birthing institution shall maintain the birth worksheet for a minimum of ten years.

**96.5(4)** Upon demand of the state registrar, the birth worksheet and other information about the birth event shall be made available for inspection by the state registrar.

[ARC 0483C, IAB 12/12/12, effective 1/16/13; see Delay note at end of chapter; ARC 1075C, IAB 10/2/13, effective 11/6/13]

**641—96.6(144) Non-birthing institutions.**

**96.6(1)** Institutions that do not register birth records through the electronic birth registration system shall request instructions from the state registrar.

**96.6(2)** The person in charge of the non-birthing institution or the person's designee shall submit to the state registrar for registration of the live birth at a minimum the following:

*a.* A cover letter that is on business letterhead of the institution and that identifies the live birth submitted for registration, supports the facts of the live birth, and contains the original signature of the person responsible for registering the live birth;

*b.* A copy of the hospital delivery report, emergency department admittance, or physician notes;

*c.* The original Iowa official birth worksheet completed and signed by the mother, or her legal spouse, or as directed by the state registrar; and

*d.* Payment of the fees, which shall be included with the birth worksheet.

[ARC 0483C, IAB 12/12/12, effective 1/16/13; see Delay note at end of chapter; ARC 1075C, IAB 10/2/13, effective 11/6/13]

**641—96.7(144) Non-institution birth.**

**96.7(1)** In case of a non-institution Iowa live birth, the official non-institution birth worksheet shall be completed and filed with the state registrar by one of the following in the indicated order of priority:

*a.* The physician in attendance at or immediately after the live birth.

*b.* Any other person in attendance at or immediately after the live birth.

*c.* The mother or her legal spouse.

*d.* The person in charge of the premises where the live birth occurred.

**96.7(2)** Evidence in support of the facts of live birth shall be included in a cover letter, which shall contain the notarized signature of the person responsible for registering the birth. A certificate of live birth shall be completed and filed upon presentation of the following clear and convincing evidence by the individual responsible for filing the certificate:

*a.* Evidence of pregnancy including:

(1) Prenatal record;

(2) A statement from a physician, certified nurse midwife, or other health care provider qualified to determine pregnancy;

(3) A statement from a public health nurse or other health care provider documenting a prenatal home visit; or

(4) Other evidence acceptable to the state registrar.

*b.* Evidence the infant was born alive including:

(1) A statement from the physician, certified nurse midwife or other health care provider who saw or examined the infant;

(2) A statement from a public health nurse or other health care provider documenting a postnatal home visit; or

(3) Other evidence acceptable to the state registrar.

*c.* Clear and convincing evidence acceptable to the state registrar of the mother's presence in this state at the reported place and date of the live birth.

**96.7(3)** An Iowa-licensed certified nurse midwife may preregister with the state registrar by submitting a dated statement on business letterhead identifying the midwife's business name, if applicable, printed full name and original signature of the midwife, professional title, license number, address and telephone number.

*a.* Certified nurse midwives who are preregistered shall submit to the state registrar for registration of the live birth at a minimum the following:

(1) A cover letter that is on the business letterhead, that identifies the live birth submitted for registration, that supports the facts of the live birth, and that contains the original signature of the person responsible for registering the live birth;

(2) The original official non-institution birth worksheet completed and signed pursuant to subrule 96.7(5) or as directed by the state registrar; and

(3) Payment of fees, which shall be included with the birth worksheet.

*b.* It is the responsibility of the individual preregistering to update any information provided in the individual's original registration.

**96.7(4)** Certified nurse midwives not preregistered prior to submitting a certificate of live birth for registration shall follow subrules 96.7(1), 96.7(2) and 96.7(5) for all live births the midwives attend outside a birthing institution.

**96.7(5)** The official non-institution birth worksheet shall include a notarized signature of the mother or her legal spouse and shall be accompanied by a clear photocopy of that person's current government-issued photo identification. If photo identification is unavailable, other identifying documentation may be acceptable to the state registrar.

[ARC 0483C, IAB 12/12/12, effective 1/16/13; see Delay note at end of chapter; ARC 1075C, IAB 10/2/13, effective 11/6/13]

**641—96.8(144) Gestational surrogate arrangement birth registration.** Establishment of a certificate of live birth for a child born of a gestational surrogate arrangement shall conform to the process established pursuant to rule 641—99.15(144).

[ARC 0483C, IAB 12/12/12, effective 1/16/13; see Delay note at end of chapter]

**641—96.9(144) Foundling birth registration.**

**96.9(1)** The person assuming physical custody of a foundling shall, within one business day of finding the infant, contact the state registrar for specific directions and guidance for filing the certificate of live birth.

**96.9(2)** Foundling registration shall be completed in the standard manner by the state registrar pursuant to Iowa Code section 144.14. Within five days after assuming physical custody of the foundling, the custodian of the foundling shall provide on the official birth worksheet the following minimum birth data and other data required by the state registrar:

- a.* The date when and the place where the child was found;
- b.* The sex, color or race, and approximate age of the child;
- c.* The name and address of the person or institution that has assumed physical custody of the child;
- d.* The name given to the child by the custodian;
- e.* The name, title, and license number, if any, of the person acting as the certifier to the facts of the foundling registration;
- f.* Parentage information, if the parent is known;
- g.* A cover letter with supporting documentation; and
- h.* Any additional information known.

**96.9(3)** The place where the child was found shall be entered as the place of birth and the date of birth shall be determined by approximation. The information provided on the official birth worksheet shall constitute the certificate of live birth.

**96.9(4)** The record shall be on file only at the state registrar's office, and all supporting documentation shall be placed in a sealed file, which shall be opened only by order of a court of competent jurisdiction or for vital records administrative purposes.

**96.9(5)** Pursuant to Iowa Code section 144.14, if the child is properly identified after the registration, the certificate of live birth shall be reestablished as needed and all records pertaining to the foundling registration shall be sealed along with the original supporting documentation, which shall be opened only by order of a court of competent jurisdiction or for vital records administrative purposes.

[ARC 0483C, IAB 12/12/12, effective 1/16/13; see Delay note at end of chapter]

**641—96.10(144) Newborn safe haven registration.**

**96.10(1)** Newborn safe haven registration procedures shall apply to living infants who have been abandoned or left at an institutional health facility.

**96.10(2)** The person assuming physical custody of the living infant pursuant to Iowa Code section 233.2(2)“a” shall, within one business day of assuming custody, contact the state registrar for specific directions and guidance for registering the birth.

**96.10(3)** If the name of the parent is unknown, newborn safe haven registration shall be completed in the standard manner by the state registrar pursuant to Iowa Code section 144.14. Within five days after assuming physical custody of the infant, the custodian shall provide on the official birth worksheet the following minimum birth data and other data required by the state registrar:

- a.* The date when and the place where the child was found;
- b.* The sex, color or race, and approximate age of the child;
- c.* The name and address of the person or institution that has assumed physical custody of the child;
- d.* The name given to the child by the custodian;
- e.* The name, title, and license number, if any, of the person acting as the certifier to the facts of the newborn safe haven registration;
- f.* A cover letter with supporting documentation; and
- g.* Any additional information known.

**96.10(4)** If the name of the parent is disclosed to the institutional health facility, the facility shall file the certificate of live birth as required pursuant to Iowa Code sections 144.13 and 233.2(2) “c.”

**96.10(5)** Pursuant to Iowa Code section 144.14, if the child is properly identified after the newborn safe haven registration, the birth record shall be reestablished as needed and all records pertaining to the newborn safe haven registration shall be sealed along with the original supporting documentation, which shall be opened only by order of a court of competent jurisdiction or for vital records administrative purposes.

**96.10(6)** The record shall be on file only at the state registrar’s office, and all supporting documentation shall be placed in a sealed file which shall be opened only by order of a court of competent jurisdiction or for vital records administrative purposes. The confidentiality of the live birth certificate shall be maintained pursuant to Iowa Code sections 233.2(2) “c” and 144.43.

[ARC 0483C, IAB 12/12/12, effective 1/16/13; see Delay note at end of chapter]

**641—96.11(144) Birth registration following a foreign-born adoption.**

**96.11(1)** A certificate of foreign birth shall be established by the state registrar for a child born in a foreign nation upon the state registrar’s receipt of a completed Certificate of Adoption Report form from an Iowa court of competent jurisdiction or upon request of the resident adoptive parent or parents and the state registrar’s receipt of all of the following documents:

- a.* The authenticated adoption decree in both the foreign language and the English translation, which shall contain the official signature of the translator, or a certified copy of an adoption decree from an Iowa court of competent jurisdiction;
- b.* If the decree does not contain information to establish the certificate of foreign birth, the adoptee’s authenticated birth certificate in both the foreign language and the English translation, which shall contain the official signature of the translator;
- c.* Evidence of the adoptee’s permanent residence such as a passport or citizenship papers;
- d.* A certified copy of the certificate of live birth of each adoptive parent; and
- e.* A notarized statement that is on letterhead from the licensed adoption agency or certified adoption investigator and that establishes the parent or parents were residents of Iowa at the time the adoption was final in the foreign nation. The statement will not be required if the parent’s or parents’ Iowa address is shown in the adoption documents.

**96.11(2)** The certificate of foreign birth shall not constitute U.S. citizenship.

**96.11(3)** The state registrar shall charge the adoptive parent or parents the appropriate fee for the registration of a certificate of foreign birth for a foreign-born child adopted by a parent who resided in Iowa at the time of adoption pursuant to Iowa Code section 144.13A.

**96.11(4)** Administrative and certified copy fees shall be charged and remitted as provided in rule 641—95.6(144).

**96.11(5)** The evidence presented shall be on file only at the state registrar's office, and all supporting documentation shall be placed in a sealed file which shall be opened only by order of a court of competent jurisdiction or for vital records administrative purposes.

[ARC 0483C, IAB 12/12/12, effective 1/16/13; see Delay note at end of chapter]

**641—96.12(144) Birth registration fees.** A fee is required for each birth registered pursuant to Iowa Code sections 144.13, 144.13A, 144.15, 144.18, 144.23, 144.25A, and 600.15.

**96.12(1)** The parents shall be charged and the person responsible for filing the certificate of live birth shall remit to the state registrar the \$20 fee for the standard registration of a certificate of live birth and the \$15 fee for a certified copy of the birth certificate pursuant to Iowa Code section 144.13A.

**96.12(2)** The individual filing a delayed certificate of live birth shall be charged and shall remit to the state registrar the \$20 fee for the registration of a delayed certificate of live birth for a registrant 17 years of age or younger pursuant to Iowa Code sections 144.13A, 144.15, and 144.18.

**96.12(3)** The adoptive parents shall be charged and shall remit to the state registrar the \$20 fee for the registration of a certificate of foreign birth pursuant to Iowa Code sections 144.13A and 144.25A.

[ARC 0483C, IAB 12/12/12, effective 1/16/13; see Delay note at end of chapter]

**641—96.13(144) Fee collection.** If a person responsible for the registration of a certificate of live birth under Iowa Code section 144.13 is not the parent, the person shall collect the fees from the parent and remit the fees to the state registrar.

**96.13(1)** The person collecting the fee on behalf of the state registrar shall not charge an administrative fee for collection of the registration and certified copy fees pursuant to Iowa Code section 144.13A(3).

**96.13(2)** A person is discharged from the duty to collect and remit the fees when the person has made a good-faith effort to collect the fees from the parent or has established that the fees are to be waived pursuant to Iowa Code section 144.13A(3).

[ARC 0483C, IAB 12/12/12, effective 1/16/13; see Delay note at end of chapter]

**641—96.14(144) Waivers.** The registration fee and certified copy fee are waived if the expenses of the birth are reimbursed under the medical assistance program established by Iowa Code chapter 249A or if the parent is indigent and unable to pay the expenses of the birth and no other means of payment is available to the parent.

[ARC 0483C, IAB 12/12/12, effective 1/16/13; see Delay note at end of chapter]

**641—96.15(144) Fee deposit.** Birth registration and certified copy fees collected on behalf of the state registrar and forwarded to the state registrar shall be remitted to the treasurer of state for deposit in the appropriate state fund.

[ARC 0483C, IAB 12/12/12, effective 1/16/13; see Delay note at end of chapter]

**641—96.16(144) Responsibilities of institutions.** Institutions responsible for filing certificates of live birth shall collect both the registration fee and the certified copy fee from the parent.

**96.16(1)** The institution shall complete the Summary of Fee Report for Birth Registration and Certified Copy form. The institution shall submit the completed form and the total fee amount by check or money order, to the state registrar, within seven days of the live birth or as directed by the state registrar. All live births shall be reported and indicate for each birth that:

- a. The fee was collected for the registration and certified copy;
- b. The fee was waived, as applicable, and the reason for waiver; or
- c. No fee was collected after a good-faith effort was made.

**96.16(2)** If a late birth registration fee is received, it shall be noted on the original Summary of Fee Report for Birth Registration and Certified Copy form.

**96.16(3)** The institution shall maintain copies of the submitted Summary of Fee Report for Birth Registration and Certified Copy form for three state fiscal years.

[ARC 0483C, IAB 12/12/12, effective 1/16/13; see Delay note at end of chapter]

**641—96.17(144) Responsibility for births occurring in non-institutions and non-birthing institutions.**

**96.17(1)** The state registrar shall collect the registration and certified copy fees and complete a Summary of Fee Report for Birth Registration and Certified Copy form.

**96.17(2)** If a late birth registration fee is received, it shall be noted on the original Summary of Fee Report for Birth Registration and Certified Copy form.

[ARC 0483C, IAB 12/12/12, effective 1/16/13; see Delay note at end of chapter]

**641—96.18(144) Delayed birth registration—one year or more after event.** All Iowa births registered one year or more after the date of the birth shall be prepared on a Delayed Certificate of Live Birth form. The state registrar shall require documentary evidence to prove the facts of the birth pursuant to subrule 96.18(2). The delayed birth record shall be registered and maintained solely at the state registrar's office.

**96.18(1) Application—certificate form.** A completed Delayed Certificate of Live Birth form shall be signed before a notary and filed with the state registrar by the following applicants in the indicated order of priority:

*a.* The registrant, if 18 years of age or older, whose birth occurred in Iowa but was not recorded within one year of the birth;

*b.* The registrant's parent or current legal court-appointed guardian; or

*c.* If no parent or legal guardian exists, a member of the registrant's family who has direct tangible interest and entitlement and who is competent to affirm to the accuracy of the information.

**96.18(2) Facts to be established.**

*a.* The applicant shall submit a notification of record search certified by the state registrar, which shall indicate that no prior certificate of live birth is on file for the person whose delayed birth record is to be filed. The notification of record search shall be returned to the applicant and shall not be exchanged for a certified copy of delayed certificate of live birth.

*b.* The applicant shall substantiate the following with documentary evidence:

(1) The full name of the registrant at the time of the birth, except that the delayed certificate may reflect the name established by adoption or legitimation when such evidence is submitted;

(2) The date and place of the birth;

(3) The full name of the mother prior to any marriage as it is listed on her birth certificate;

(4) The full name of the mother at the time of the birth; and

(5) The full name of the mother's legal spouse. However, if the mother was not married at the time of conception or birth or at any time during the period between conception and birth, the name of a second parent shall not be entered on the delayed certificate unless the child has been adopted or legitimated or parentage has been determined by a court of competent jurisdiction.

**96.18(3) Documentary evidence.**

*a.* To be acceptable for purposes of registration, the name of the registrant and the date and place of birth entered on a Delayed Certificate of Live Birth form shall be supported at a minimum by the following documentary evidence:

(1) Two pieces of dated documentary evidence if the Delayed Certificate of Live Birth form is filed within seven years after the registrant's date of birth; or

(2) Three pieces of dated documentary evidence if the Delayed Certificate of Live Birth form is filed seven years or more after the registrant's date of birth.

*b.* Each piece of documentary evidence must be from an independent source. Facts of parentage shall be supported by at least one of the documents.

*c.* Documentary evidence shall be in the form of the original record, a certified copy thereof, or a notarized statement from the custodian of the record or document on the custodian's letterhead.

*d.* All documentary evidence submitted shall consistently support the facts of birth to be established.

*e.* All documentary evidence shall have been executed at least five years prior to the date of filing or shall have been established prior to the registrant's seventh birthday.

*f.* Documents not acceptable to establish a delayed certificate of live birth include, but are not limited to:

- (1) Baptismal record,
- (2) Confirmation record,
- (3) Family bible entries,
- (4) Hospital commemorative birth certificate,
- (5) Crib card,
- (6) Cradle roll,
- (7) Baby book memento, and
- (8) Personal affidavit.

**96.18(4) *Abstraction and certification by the state registrar.*** The state registrar shall abstract on the Delayed Certificate of Live Birth form a description of each document submitted to support the facts of birth. This description shall include:

- a.* The title or description of the document;
- b.* The name and address of the custodian who has attested to the fact on the original documents in the custodian's custody;
- c.* The date of the original filing of the document being abstracted; and
- d.* The information regarding the registrant's birth and parentage.

**96.18(5) *Acceptance of documentary evidence for registration.***

- a.* The state registrar shall by signature certify that:
  - (1) No prior certificate of live birth is on file for the person whose birth is to be recorded;
  - (2) The evidence has been reviewed and substantiates the alleged facts of the birth; and
  - (3) The abstract of the evidence appearing on the Delayed Certificate of Live Birth form accurately reflects the nature and content of the documents.

*b.* All documents submitted in support of the delayed registration of live birth shall be returned to the applicant after review, abstraction, and registration.

**96.18(6) *Denial of registration.***

*a.* When the applicant does not submit substantiating evidence or the state registrar finds reason to question the validity or adequacy of the evidence submitted to establish a delayed certificate of live birth, the state registrar shall not register the delayed certificate of live birth. The written notice of refusal from the state registrar shall include:

- (1) The rejected form;
- (2) The Delayed Birth Evidence Refusal form; and
- (3) Information related to the applicant's right of appeal to the district court pursuant to Iowa Code sections 144.17 and 144.18.

*b.* The application to establish a delayed certificate of live birth shall be dismissed if not actively pursued within six months of the date the notice of refusal was sent to the applicant.

**96.18(7) *Duties of the county registrar.*** The county registrar may assist the registrant, registrant's parent, or current court-appointed guardian in the completion and notarization of the delayed form, excluding the portion restricted for state use only. The county registrar may forward the form, documents and fees to the state registrar for final review and possible acceptance.

**96.18(8) *Fees.*** Administrative and certified copy fees shall be charged as provided in rule 641—95.6(144).

[ARC 0483C, IAB 12/12/12, effective 1/16/13; see Delay note at end of chapter; ARC 1075C, IAB 10/2/13, effective 11/6/13]

These rules are intended to implement Iowa Code sections 144.12, 144.13, 144.13A, 144.14, 144.15, 144.17, 144.18, 233.2(2) "c" and 600.15.

[Filed ARC 0483C (Notice ARC 0376C, IAB 10/3/12), IAB 12/12/12, effective 1/16/13]<sup>1</sup>

[Filed ARC 1075C (Notice ARC 0925C, IAB 8/7/13), IAB 10/2/13, effective 11/6/13]

<sup>1</sup> January 16, 2013, effective date of the rescission of Chapter 96 and the adoption of new Chapter 96 [ARC 0483C] delayed until adjournment of the 2013 General Assembly by the Administrative Rules Review Committee at its meeting held January 8, 2013; delay lifted at the meeting held March 8, 2013.



CHAPTER 99  
VITAL RECORDS MODIFICATIONS  
[Prior to 12/12/12, see [641] Chs 100, 102]

**641—99.1(144) Definitions.** For the purpose of this chapter, the definitions in 641—Chapter 95 shall apply.

[ARC 0483C, IAB 12/12/12, effective 1/16/13; see Delay note at end of chapter]

**641—99.2(144) Forms—property of department.** All forms, certificates and reports pertaining to the registration of vital events are the property of the department and shall be surrendered to the state registrar upon demand.

**99.2(1)** The forms supplied or approved for reporting vital events shall be used for official purposes as provided for by law, rules and instructions of the state registrar.

**99.2(2)** No forms, except those furnished or approved by the state registrar, shall be used in the reporting or modification of vital events or the making of copies of vital records.

[ARC 0483C, IAB 12/12/12, effective 1/16/13; see Delay note at end of chapter]

**641—99.3(144) Forms used in the establishment of new records.** The standard certificate form for reporting of live birth, death, fetal death, or marriage in use at the time of the event shall be used to prepare a new certificate.

[ARC 0483C, IAB 12/12/12, effective 1/16/13; see Delay note at end of chapter]

**641—99.4(144) Corrections of minor error in vital record—within one year of event.**

**99.4(1)** Corrections of minor errors may be made by the state registrar within one year and prior to the first anniversary of the date of the event upon observation, upon request of the data provider, upon query, or upon request from an entitled person. Minor errors include obvious errors, omissions, or transpositions of letters in words of common knowledge.

**99.4(2)** For a certificate of live birth, entitled persons include in the following descending order of priority:

- a. Either parent as shown on the child's certificate of live birth; or
- b. The legal guardian or agency having legal custody of the child.

**99.4(3)** For a certificate of death or fetal death other than the medical certification, entitled persons include in the following descending order of priority:

- a. The surviving spouse as shown on the certificate of death;
- b. A parent as shown on the certificate of death or fetal death;
- c. The informant as shown on the certificate; or
- d. The data provider in the case of a data entry error.

**99.4(4)** For a certificate of marriage, entitled persons include:

- a. The county registrar that issued the license to marry; or
- b. Either of the parties married.

**99.4(5)** Entitled persons requesting a correction shall submit to the state registrar:

- a. A notarized statement and a legible copy of current government-issued photo identification or other identification documents acceptable to the state registrar; and
- b. Supporting evidence if requested by the state registrar.

(1) The state registrar shall determine a priority of best evidence and may, at the state registrar's discretion, require additional documentary evidence to support the requested correction.

(2) The state registrar shall evaluate the evidence submitted in support of any correction, and when there is reason to question the validity or adequacy of the evidence, the state registrar may reject the request for correction and shall advise the applicant of the reasons for this action.

**99.4(6)** Only the state registrar shall make corrections on a vital record. The source of information and the date of correction shall be documented on the record but shall not appear on the certified copy.

**99.4(7)** There are no administrative fees required to correct a certificate pursuant to this rule.

**99.4(8)** Certificates corrected pursuant to this rule shall not be marked "amended."

**99.4(9)** Any certified copies of the incorrect certificate shall be surrendered to the state registrar for replacement at no cost pursuant to 641—subrule 95.6(3). Additional certified copies of the corrected certificate may be obtained upon receipt of a notarized application, legible copy of a current government-issued photo identification or other identification documents acceptable to the state registrar and payment of the fee pursuant to 641—paragraph 95.6(1) “a.”

**99.4(10)** The corrected certificate shall be on file at the county registrar’s office pursuant to rule 641—95.7(144).

[ARC 0483C, IAB 12/12/12, effective 1/16/13; see Delay note at end of chapter; ARC 1075C, IAB 10/2/13, effective 11/6/13]

**641—99.5(144) Amendment of certificate of live birth to add first or middle given name—within one year of event.**

**99.5(1)** The first or middle given name for a child whose birth was reported without a first or middle given name may be amended to add the first or middle given name within one year and prior to the first anniversary of the date of the live birth based upon a completed and notarized Affidavit to Add Child’s Given Name form as provided by the department pursuant to Iowa Code section 144.38. The affidavit shall be submitted to the state registrar by entitled persons in the following descending order of priority:

- a. The single parent or both parents as shown on the child’s certificate of live birth;
- b. The mother, in the case of the death or incapacity of the second parent;
- c. The second parent if listed on the birth certificate, in the case of the death or incapacity of the mother; or
- d. The legal guardian or agency having legal custody of the child.

**99.5(2)** A first or middle given name may be added to the certificate of live birth once in this manner. Thereafter, a first or middle given name shall be changed only upon submission of a court order for a legal change of name from a court of competent jurisdiction pursuant to Iowa Code chapter 674.

**99.5(3)** An administrative fee shall be charged and remitted pursuant to 641—paragraph 95.6(1) “b.”

**99.5(4)** The original certificate shall be marked “amended” and shall be endorsed on the certified copy. The date of amendment and a summary description of the evidence submitted in support of the amendment shall be made a part of the record.

**99.5(5)** The certificate shall be on file at the county registrar’s office pursuant to rule 641—95.7(144).

**99.5(6)** Any certified copies of the incorrect certificate shall be surrendered for replacement at no cost. Additional certified copies of the amended certificate may be obtained upon the state registrar’s receipt of a notarized application, legible copy of a current government-issued photo identification or other identification documents acceptable to the state registrar, and payment of the fee pursuant to rule 641—95.6(144).

[ARC 0483C, IAB 12/12/12, effective 1/16/13; see Delay note at end of chapter; ARC 1075C, IAB 10/2/13, effective 11/6/13]

**641—99.6(144) Amendment of vital record—one year or more after the event.**

**99.6(1)** Amendments of vital records may be made by the state registrar one year or more after the date of the event upon request from an entitled person. Amendments include the correction of obvious errors, omissions, or transposition of letters in words of common knowledge.

**99.6(2)** For a certificate of live birth, entitled persons include in the following descending order of priority:

- a. Either parent as shown on the child’s certificate of live birth;
- b. The mother, in the case of the death or incapacity of the second parent;
- c. The second parent if listed on the birth certificate, in the case of the death or incapacity of the mother; or
- d. The legal guardian or agency having legal custody of the child.

**99.6(3)** For a certificate of death or fetal death other than the medical certification, entitled persons include:

- a. The surviving spouse as shown on the certificate of death;
- b. A parent as shown on the certificate of death or fetal death; or
- c. The informant as shown on the certificate of death or fetal death.

**99.6(4)** Amendment of a medical certification of cause of death or fetal death shall be requested solely by the medical certifier listed on the certificate of death or fetal death.

**99.6(5)** For a certificate of marriage, entitled persons include either of the parties married.

**99.6(6)** Entitled persons requesting an amendment shall submit the following to the state registrar:

*a.* A completed and notarized amendment request on the applicable form as follows:

- (1) Amendment to Certificate of Live Birth form.
- (2) Amendment to Certificate of Death or Fetal Death form.
- (3) Amendment to Certificate of Marriage form;

*b.* A legible copy of a current government-issued photo identification or other identification documents acceptable to the state registrar;

*c.* Certified copies of one or more pieces of documentary evidence supporting the amendment; and

*d.* The required fees pursuant to rule 641—95.6(144).

**99.6(7)** The documentary evidence shall have been established at least five years prior to the date of the application or within seven years of the date of the event.

*a.* The state registrar shall determine a priority of best evidence and may, at the state registrar's discretion, require additional documentary evidence to support the requested amendment.

*b.* The state registrar shall evaluate the evidence submitted in support of any amendment, and when there is reason to question the validity or adequacy of the evidence, the state registrar may reject the amendment and shall advise the applicant of the reasons for this action.

**99.6(8)** An administrative fee shall be charged and remitted pursuant to rule 641—95.6(144).

**99.6(9)** The original certificate shall be clearly marked "amended" and the date of the amendment shall be endorsed on the certified copy. A summary description of the evidence submitted in support of the amendment shall be made a part of the record.

**99.6(10)** The amended certificate shall be on file at the county registrar's office pursuant to rule 641—95.7(144).

**99.6(11)** Any certified copies of the incorrect certificate shall be surrendered for replacement at no cost. Additional certified copies of the amended certificate may be obtained upon the state registrar's receipt of a notarized application, legible copy of a current government-issued photo identification or other identification documents acceptable to the state registrar and payment of the fee pursuant to rule 641—95.6(144).

[ARC 0483C, IAB 12/12/12, effective 1/16/13; see Delay note at end of chapter; ARC 1075C, IAB 10/2/13, effective 11/6/13]

#### **641—99.7(144) Method of amendment of vital records.**

**99.7(1)** Records not on the electronic vital records system shall be amended by drawing a single line through the incorrect item and inserting the correct or missing data immediately above or to the side of the item or by completing a blank item. In all cases in which a line must be drawn through an original entry, the line must not obliterate the original entry. The following shall be endorsed on or made a part of the record:

*a.* The word "amended" and the date of the amendment action; and

*b.* A summary of the evidence submitted in support of the amendment.

**99.7(2)** Records on the electronic vital records system shall be amended by correction of the incorrect item. The following shall be endorsed on or made a part of the record:

*a.* The word "amended" and the date of the amendment action;

*b.* A statement identifying the amendment; and

*c.* A summary of the evidence submitted in support of the amendment.

[ARC 0483C, IAB 12/12/12, effective 1/16/13; see Delay note at end of chapter]

**641—99.8(144) Correction or amendment of same item more than once.** After a correction or an amendment is made on a vital record, that entry shall not be corrected again unless:

**99.8(1)** It can be proven that an error was made in processing the first correction or amendment; or

**99.8(2)** A court order is received from a court of competent jurisdiction to correct or amend the item. If a court order for a correction or an amendment is received, an administrative fee shall be charged and remitted pursuant to rule 641—95.6(144).

[ARC 0483C, IAB 12/12/12, effective 1/16/13; see Delay note at end of chapter]

**641—99.9(144) Other amendments to certificate of live birth.**

**99.9(1)** The parent's name or both parents' names as reported by the parent or parents on the birth worksheet used to establish the certificate of live birth shall not be corrected or amended except by an order from a court of competent jurisdiction.

**99.9(2)** Certificates of live birth of deceased persons shall not be amended.

[ARC 0483C, IAB 12/12/12, effective 1/16/13; see Delay note at end of chapter]

**641—99.10(144) Correction or amendment to medical certification of cause of death.**

**99.10(1)** Corrections or amendments to the medical certification of cause of death shall be requested solely by the medical certifier listed on the certificate of death or fetal death.

**99.10(2)** The medical certifier may correct the medical certification of cause of death within 90 days following the date of death or fetal death. The request shall be submitted on official letterhead signed and dated by the medical certifier listed on the certificate of death or fetal death.

**99.10(3)** Any amendment after 90 days following the date of death or fetal death shall be made by order of a court of competent jurisdiction. However, the medical certification of cause of death may be amended at any time upon submission of a report of autopsy or toxicological findings or additional findings by the county or state medical examiner.

**99.10(4)** No fee shall be charged for correction or amendment made pursuant to this rule.

[ARC 0483C, IAB 12/12/12, effective 1/16/13; see Delay note at end of chapter]

**641—99.11(144) Correction or amendment to a certificate of marriage.**

**99.11(1)** The request to correct a certificate of marriage during the first year may be made by the county registrar that issued the license to marry. The written request shall be submitted to the state registrar with supporting evidence.

**99.11(2)** The request to correct or amend a certificate of marriage may be made by either of the parties married. The written request shall be submitted to the state registrar with supporting evidence.

**99.11(3)** The correction or amendment process shall not be used to change a legal name after marriage.

[ARC 0483C, IAB 12/12/12, effective 1/16/13; see Delay note at end of chapter]

**641—99.12(144) Correction to a report of dissolution of marriage or annulment.**

**99.12(1)** A written notice to correct a report of dissolution of marriage or annulment may be submitted to the state registrar by the clerk of district court maintaining the record from which the original report was prepared. The notice shall state in what manner the report shall be corrected.

**99.12(2)** Those items appearing on the Report of Dissolution of Marriage or Annulment form that are not a part of the divorce decree may be corrected either by query or upon application of either party to the dissolution of marriage or annulment or the legal representative.

**99.12(3)** Corrections to the report of dissolution of marriage or annulment shall be accepted only within the first year from the date of dissolution of marriage or annulment.

[ARC 0483C, IAB 12/12/12, effective 1/16/13; see Delay note at end of chapter]

**641—99.13(144) Minimum information required to establish a new certificate of live birth.**

**99.13(1)** A request to establish a new certificate of live birth shall be submitted to the state registrar and include at a minimum the following information:

- a. The full name of the child as stated on the original certificate of live birth;
- b. The full name of the child to be listed on the new certificate of live birth;
- c. The date and place of birth as stated on the original certificate of live birth;
- d. The full name of the parent or parents as listed on the original certificate of live birth; and

*e.* The full name, place of birth, date of birth, and complete residential address of the parent or parents to be listed on the new certificate of live birth.

**99.13(2)** The new certificate of live birth shall contain the same state file number and registration file date as were assigned to the original certificate of live birth.  
[ARC 0483C, IAB 12/12/12, effective 1/16/13; see Delay note at end of chapter]

**641—99.14(144) Establishment of new certificate of live birth following adoption.**

**99.14(1)** Upon receipt of a completed Certificate of Adoption Report form or a certified copy of the decree of adoption from a court of competent jurisdiction and the information required pursuant to rule 641—99.13(144), the state registrar shall establish a new certificate of live birth for a person who was born in Iowa and has been adopted.

**99.14(2)** The new certificate of live birth shall not be marked “amended.”

**99.14(3)** When a new certificate of live birth is established, the actual date and place of birth shall be shown on the certificate.

**99.14(4)** The county registrar and state registrar shall seal the original certificate of live birth. The state registrar shall place the original certificate of live birth and all related adoption information in a sealed file, and the file shall not be opened and inspected except by the state registrar for administrative purposes or upon an order from a court of competent jurisdiction pursuant to Iowa Code section 144.24.

**99.14(5)** The new certificate of live birth after adoption shall not be on file at the county registrar’s office.

**99.14(6)** The state registrar shall reveal the date of the adoption and the name and address of the court that issued the adoption decree upon the receipt of a completed, notarized Revelation of County of Adoption form from an adult adopted person, a biological parent, an adoptive parent, or the legal representative of the adult adopted person, the biological parent, or the adoptive parent pursuant to Iowa Code section 144.24.

**99.14(7)** Administrative and certified copy fees shall be charged and remitted pursuant to rule 641—95.6(144).  
[ARC 0483C, IAB 12/12/12, effective 1/16/13; see Delay note at end of chapter]

**641—99.15(144) Establishment of new certificate of live birth following a birth by gestational surrogate arrangement.**

**99.15(1)** All live births shall be considered the product of the woman who delivered the live infant and shall be filed in the standard manner, with that woman named as the birth mother on the original record submitted for registration.

**99.15(2)** For the purpose of filing for registration the record of a live birth by a gestational surrogate, the institution’s or non-institution’s person responsible for filing the certificate of live birth shall:

- a.* Notify the state registrar of the birth of a child pursuant to a gestational surrogate arrangement;
- b.* Follow directives for completion of the official birth worksheet;
- c.* Submit the birth record for registration based on the birth mother’s information; and
- d.* Notify the state registrar when the birth record has been submitted for registration.

**99.15(3)** In addition, the institution’s or non-institution’s person responsible for filing the record for registration shall:

- a.* Provide the prenatal and medical data on the medical portion of the birth worksheet pertinent to the pregnancy and the birth mother’s prenatal care;
- b.* Waive all birth registration and copy fees as collected on behalf of the state registrar;
- c.* Indicate on the registration that the birth mother does not have custody of the infant;
- d.* Assist in advising the intended parents of the procedures required to file the original birth record for registration and to reestablish the record to reflect the intended parents’ information; and
- e.* Advise the birth mother to complete the mother’s portion of the birth worksheet and to mark “no” for the social security card for the child.

**99.15(4)** Two intended parents—both intended parents are biological parents to the child. If the intended mother is the egg donor and the intended father is the sperm donor to the child being carried by the gestational surrogate:

*a.* After the birth of the child, the intended parents shall petition a court of competent jurisdiction to establish legal paternity and maternity of the child.

*b.* The court shall enter an order requiring the state registrar to reestablish the certificate of live birth naming the intended mother and father as the legal mother and father and requiring the state registrar to seal the original birth certificate and all related documentation.

*c.* The court order shall:

- (1) Identify the child's full name as stated on the original certificate of live birth;
- (2) State the child's date of birth and place of birth;
- (3) Identify the full names of the birth mother and her legal spouse, if married;
- (4) Disestablish the birth mother and her legal spouse, if married, as the legal parents of the child;

and

(5) Identify the intended parents' full names prior to any marriage, full current legal names, dates of birth, birthplaces, social security numbers, and full current residential address including county.

*d.* The intended parents or their legal representative shall:

- (1) Submit a certified copy of the court order to the state registrar;
- (2) Remit administrative and certified copy fees pursuant to rule 641—95.6(144); and
- (3) Include a notarized written request with mailing instructions for the certified copy of the certificate of live birth.

**99.15(5)** Two intended parents—intended mother is biological mother to the child; her legal spouse is not a biological parent. If the intended mother is the egg donor but her legal spouse is not the sperm donor, the intended mother shall petition a court of competent jurisdiction after the birth of the child to establish legal maternity.

*a.* The court shall enter an order requiring the state registrar to reestablish the certificate of live birth naming the intended mother as the legal mother and shall require the state registrar to seal the original certificate of live birth and all related documents.

*b.* The court order establishing legal maternity shall:

- (1) Identify the child's full name as stated on the original certificate of live birth;
- (2) State the child's date of birth and place of birth;
- (3) Identify the full names of the birth mother and her legal spouse, if married;
- (4) Disestablish the birth mother and her legal spouse, if married, as the legal parents of the child;

and

(5) Identify the intended mother's full name prior to any marriage, full current name, date of birth, birthplace, social security number, and full current residential address including county.

*c.* The intended mother or her legal representative shall:

- (1) Submit a certified copy of the court order to the state registrar;
- (2) Remit administrative and certified copy fees pursuant to rule 641—95.6(144); and
- (3) Include a notarized written request with mailing instructions for the certified copy of the certificate of live birth.

**99.15(6)** Two intended parents—intended father is biological father to the child; his legal spouse is not a biological parent.

*a.* If the surrogate birth mother is unmarried and the intended father is the sperm donor, the unmarried surrogate birth mother and the intended father may complete a Voluntary Paternity Affidavit form after the child's birth to place the intended father's name and information on the certificate of live birth.

*b.* If the surrogate birth mother is married and the intended father is the sperm donor, the married surrogate birth mother and the intended father shall by court order disestablish the surrogate birth mother's legal spouse as the legal parent and may complete a Voluntary Paternity Affidavit form pursuant to Iowa Code section 144.13.

*c.* The court order that disestablishes the married surrogate birth mother's legal spouse and the completed Voluntary Paternity Affidavit form shall be submitted to the state registrar.

*d.* If a certified copy of the certificate of live birth is requested, a notarized written request shall also be submitted to the state registrar with the certified copy fee and mailing instructions.

- e.* There is no administrative fee to process the completed Voluntary Paternity Affidavit form.
- f.* Adoption laws shall be followed to reestablish the certificate of live birth by establishing the nonbiological parent on the certificate of live birth pursuant to Iowa Code chapter 600.

**99.15(7)** Two intended parents—neither biological parent to the child. If the intended parents are neither the egg donor nor sperm donor, adoption laws shall be followed to reestablish the certificate of live birth by disestablishing the birth mother and her legal spouse, if any, and establishing the nonbiological parents on the certificate of live birth pursuant to Iowa Code chapter 600.

**99.15(8)** One female intended parent—biological mother to the child. If the intended mother is the egg donor to the child being carried by the gestational surrogate:

*a.* After the birth of the child, the intended mother shall petition a court of competent jurisdiction to establish legal maternity of the child.

*b.* The court shall enter an order requiring the state registrar to reestablish the certificate of live birth naming the intended mother as the legal mother and requiring the state registrar to seal the original certificate of live birth and all related documentation.

*c.* The court order shall:

- (1) Identify the child's full name as stated on the original certificate of live birth;
- (2) State the child's date of birth and place of birth;
- (3) Identify the full names of the birth mother and her legal spouse, if married;
- (4) Disestablish the birth mother and her legal spouse, if married, as the legal parents of the child;

and

(5) Identify the intended parent's full name prior to any marriage, full current legal name, date of birth, birthplace, social security number, and full current residential address including county.

*d.* The intended parent or her legal representative shall:

- (1) Submit a certified copy of the court order to the state registrar;
- (2) Remit administrative and certified copy fees pursuant to rule 641—95.6(144); and
- (3) Include a notarized written request with mailing instructions for the certified copy of the certificate of live birth.

**99.15(9)** One male intended parent—biological father to the child.

*a.* If the surrogate birth mother is unmarried and the intended father is the sperm donor, the unmarried surrogate birth mother and the intended father may complete a Voluntary Paternity Affidavit form after the child's birth to place the intended father's name and information on the certificate of live birth.

*b.* If the surrogate birth mother is married and the intended father is the sperm donor, the married surrogate birth mother and the intended father shall by court order disestablish the surrogate birth mother's legal spouse as the legal parent and may complete a Voluntary Paternity Affidavit form pursuant to Iowa Code section 144.13.

*c.* The court order that disestablishes the married surrogate birth mother's legal spouse and the completed Voluntary Paternity Affidavit form shall be submitted to the state registrar.

*d.* If a certified copy of the certificate of live birth is requested, a notarized written request shall also be submitted to the state registrar with the certified copy fee and mailing instructions.

*e.* There is no administrative fee to process the completed Voluntary Paternity Affidavit form.

*f.* If the intended father has been established as the legal father pursuant to paragraph 99.15(9) "a" or "b" and the surrogate birth mother and the intended father wish to remove the surrogate birth mother as the legal mother from the certificate of live birth, the parties shall seek a court order. The court order disestablishing legal maternity shall:

- (1) Identify the child's full name as stated on the original certificate of live birth;
- (2) State the child's date of birth and place of birth;
- (3) Identify the full name of the birth mother; and
- (4) Disestablish the birth mother as the legal parent of the child.

*g.* The intended parent or his legal representative shall:

- (1) Submit a certified copy of the court order to the state registrar;
- (2) Remit administrative and certified copy fees pursuant to rule 641—95.6(144); and

(3) Include a notarized written request with mailing instructions for the certified copy of the certificate of live birth.

**99.15(10)** One intended parent—not biological parent to the child. If the intended parent is neither the egg donor nor sperm donor, adoption laws shall be followed to reestablish the certificate of live birth by disestablishing the birth mother and her legal spouse, if any, and establishing the nonbiological parent on the certificate of live birth pursuant to Iowa Code chapter 600.

**99.15(11)** The state registrar shall seal the original certificate of live birth. The state registrar shall place the original certificate of live birth and all related documents in a sealed file, and the file shall not be opened and inspected except by the state registrar for administrative purposes or upon an order from a court of competent jurisdiction pursuant to Iowa Code section 144.24.

**99.15(12)** The new certificate of live birth shall not be marked “amended.”

**99.15(13)** The new certificate of live birth shall not be on file at the county registrar’s office pursuant to rule 641—95.7(144).

**99.15(14)** A certified copy fee and an administrative fee to replace a parent’s information on a certificate of live birth shall be charged and remitted pursuant to rule 641—95.6(144).

[ARC 0483C, IAB 12/12/12, effective 1/16/13; see Delay note at end of chapter; ARC 1075C, IAB 10/2/13, effective 11/6/13]

**641—99.16(144) Certificate of live birth following voluntary paternity affidavit.**

**99.16(1)** If the birth mother was legally married at the time of conception or birth or at any time during the period between conception and birth, the name of her spouse shall be entered on the certificate of live birth as a parent pursuant to Iowa Code section 144.13.

**99.16(2)** If the birth mother was not legally married at the time of conception or birth or at any time during the period between conception and birth, the birth mother and the alleged biological father may:

- a. Complete a Voluntary Paternity Affidavit form after the birth of the child; and
- b. Submit the completed form to the state registrar.

**99.16(3)** If the birth mother was legally married at the time of conception or birth or at any time during the period between conception and birth, and her legal spouse is not the biological father, the birth mother and the alleged biological father may:

- a. Complete a Voluntary Paternity Affidavit form after the birth of the child;
- b. Obtain a court order that disestablishes her legal spouse as a parent; and
- c. Submit the completed form and a certified copy of the court order to the state registrar.

**99.16(4)** If the birth mother and the biological father of an Iowa-born child subsequently marry each other after a voluntary affidavit of paternity has been processed, the parents may submit a second completed Voluntary Paternity Affidavit form with a certified copy of the parents’ certificate of marriage to establish a new certificate changing the child’s last name to that of the father.

**99.16(5)** If another man is shown as the father on the original certificate of live birth, a new certificate of live birth may be established only when a determination of paternity is made by a court of competent jurisdiction.

**99.16(6)** There is no age limitation and no fee for filing a completed Voluntary Paternity Affidavit form.

**99.16(7)** The county registrar and the state registrar shall seal the original certificate of live birth. The state registrar shall place the original certificate of live birth and all related documents in a sealed file, and the file shall not be opened and inspected except by the state registrar for administrative purposes or upon an order from a court of competent jurisdiction pursuant to Iowa Code section 144.24.

**99.16(8)** A copy of the completed and processed Voluntary Paternity Affidavit form may be acquired by either parent or either parent’s legal representative upon notarized application and payment of the fee pursuant to rule 641—95.6(144). The notarized application shall include at a minimum the following items:

- a. The child’s full name;
- b. The child’s date and place of birth;
- c. The mother’s full name prior to any marriage; and
- d. The full name and mailing address of the applicant.

**99.16(9)** The new certificate of live birth shall not be marked “amended.”

**99.16(10)** The new certificate of live birth shall be on file at the county registrar’s office pursuant to rule 641—95.7(144).

**99.16(11)** The birth mother and the biological father shall surrender any incorrect certified copies of the child’s certificate of live birth for replacement at no cost. Additional certified copies of the new certificate of live birth shall be acquired upon receipt of a notarized application, legible copy of a current government-issued photo identification or other identification documents acceptable to the state registrar and payment of the fee pursuant to rule 641—95.6(144).

[ARC 0483C, IAB 12/12/12, effective 1/16/13; see Delay note at end of chapter; ARC 1075C, IAB 10/2/13, effective 11/6/13]

**641—99.17(144) Certificate of live birth following court determination of paternity.**

**99.17(1)** If the birth mother was married at the time of conception or birth or at any time during the period between conception and birth, the name of her spouse shall be entered on the certificate of live birth as a parent unless paternity has been determined otherwise by a court of competent jurisdiction pursuant to Iowa Code section 144.13.

**99.17(2)** Upon receipt of a certified copy of the court determination of paternity order from a court of competent jurisdiction or the completed Abstract From Court Determination of Paternity form, the state registrar shall establish a new certificate of live birth to be filed in place of the original certificate of live birth.

**99.17(3)** The new certificate of live birth shall list the name of the child as stated in the court determination of paternity order.

**99.17(4)** The state child support recovery unit may not change the child’s name.

**99.17(5)** After a court determination of paternity has been completed, the parents as listed on the court order may submit a completed Voluntary Paternity Affidavit form to change the child’s last name to that of the established father.

**99.17(6)** The county registrar and the state registrar shall seal the original certificate of live birth. The state registrar shall place the original certificate of live birth and all related documents in a sealed file, and the file shall not be opened and inspected except by the state registrar for administrative purposes or upon an order from a court of competent jurisdiction pursuant to Iowa Code section 144.24.

**99.17(7)** The new certificate of live birth shall not be marked “amended.”

**99.17(8)** The new certificate of live birth shall be on file at the county registrar’s office pursuant to rule 641—95.7(144).

**99.17(9)** There are no administrative fees required to establish a new certificate of live birth following a court determination of paternity.

**99.17(10)** Any incorrect certified copy of the child’s certificate of live birth shall be surrendered for replacement at no cost. Additional certified copies of the new certificate of live birth shall be acquired upon receipt of a notarized application, legible copy of a current government-issued photo identification or other identification documents acceptable to the state registrar and payment of the fee pursuant to rule 641—95.6(144).

[ARC 0483C, IAB 12/12/12, effective 1/16/13; see Delay note at end of chapter; ARC 1075C, IAB 10/2/13, effective 11/6/13]

**641—99.18(144) Certificate of live birth following rescision of paternity affidavit or disestablishment of paternity.**

**99.18(1)** An application to rescind a voluntary paternity affidavit shall be made on the Rescision of Paternity Affidavit form by either the birth mother or the putative father who originally completed and signed the Voluntary Paternity Affidavit form pursuant to Iowa Code section 252A.3A.

*a.* The completed Rescision of Paternity Affidavit form shall be notarized and received by the state registrar within the earlier of either 60 days from the latest notarized parental signature on the original Voluntary Paternity Affidavit form or entry of a court order regarding the child by the Iowa child support recovery unit pursuant to Iowa Code section 252A.3A.

*b.* Acceptance of the completed Rescision of Paternity Affidavit form shall remove the alleged biological father’s information from the certificate of live birth and rescind the voluntary paternity affidavit.

*c.* The child's last name shall revert to the last name as it was listed on the certificate of live birth prior to the voluntary paternity affidavit.

*d.* The state registrar shall send a written notice of the rescision to the last-known address of the signatory of the voluntary paternity affidavit who did not sign the Rescision of Paternity Affidavit form.

*e.* After the completed Rescision of Paternity Affidavit form has been accepted and processed, the state registrar shall not accept any subsequent Voluntary Paternity Affidavit forms signed by the same mother and putative father relating to the same child pursuant to Iowa Code section 252A.3A.

**99.18(2)** Upon receipt of a court-ordered disestablishment of paternity, the father's information shall be removed from the certificate of live birth. The child's last name shall revert to the last name as it was listed on the certificate of live birth prior to the establishment of paternity.

**99.18(3)** An administrative fee shall be charged and remitted pursuant to rule 641—95.6(144).

**99.18(4)** The county registrar and the state registrar shall seal the original certificate of live birth. The state registrar shall place the rescision of paternity information in the same sealed file as the original certificate of live birth and all previous related documents. The file shall not be opened and inspected except by the state registrar for administrative purposes or upon an order from a court of competent jurisdiction pursuant to Iowa Code section 144.24.

**99.18(5)** The new certificate of live birth shall not be marked "amended."

**99.18(6)** The new certificate of live birth shall be on file at the county registrar's office pursuant to rule 641—95.7(144).

**99.18(7)** Any incorrect certified copies of the child's certificate of live birth shall be surrendered for replacement at no cost. Additional certified copies of the new certificate of live birth shall be acquired upon receipt of a notarized application, legible copy of a current government-issued photo identification or other identification documents acceptable to the state registrar and payment of the fee pursuant to rule 641—95.6(144).

[ARC 0483C, IAB 12/12/12, effective 1/16/13; see Delay note at end of chapter]

**641—99.19(144) Certificate of live birth following court-ordered change of name.**

**99.19(1)** For a court-ordered name change, a certified copy of an order from a court of competent jurisdiction pursuant to Iowa Code chapter 674 or an Abstract to Change Registrant's Legal Name form completed by the clerk of district court changing the name shall be submitted to the state registrar.

**99.19(2)** Only the person named on the record, parent or parents if the registrant is a minor child, legal guardian, or legal representative may request a court-ordered change of name.

**99.19(3)** The court order or abstract shall contain:

*a.* The registrant's full name as it appears on the original certificate of live birth;

*b.* The registrant's date and place of birth;

*c.* The mother's full maiden name and father's full name as it appears on the original certificate of live birth;

*d.* The registrant's full new name; and

*e.* The certification of the clerk of district court.

**99.19(4)** The certified copy of a certificate of live birth after a legal change of name shall be clearly marked "legal change of name" and note the following:

*a.* The registrant's full name as shown on the original certificate;

*b.* Any previous legal name changes;

*c.* The registrant's full new name according to the court order;

*d.* The date the legal change of name order was granted; and

*e.* The name of the court that ordered the name change pursuant to Iowa Code chapter 674.

**99.19(5)** A parent cannot be added to the certificate of live birth with a court-ordered change of name.

**99.19(6)** The county registrar and the state registrar shall seal the original certificate of live birth. The state registrar shall place the original certificate of live birth and all related documents in a sealed file, and the file shall not be opened and inspected except by the state registrar for administrative purposes or upon an order from a court of competent jurisdiction pursuant to Iowa Code section 144.24.

**99.19(7)** After the court-ordered change of name, the certificate of live birth shall not be on file at the county registrar's office pursuant to rule 641—95.7(144).

**99.19(8)** An administrative fee shall be charged and remitted pursuant to rule 641—95.6(144).

**99.19(9)** Any incorrect certified copies of the certificate shall be surrendered for replacement at no cost. Additional certified copies of the new certificate shall be acquired upon receipt of a notarized application, legible copy of a current government-issued photo identification or other identification documents acceptable to the state registrar and payment of the fee pursuant to rule 641—95.6(144).  
[ARC 0483C, IAB 12/12/12, effective 1/16/13; see Delay note at end of chapter]

**641—99.20(144) Certificate of live birth following sex designation change.**

**99.20(1)** After surgery or other treatment to change a sex designation, the registrant shall submit to the state registrar a notarized affidavit from the physician and surgeon, or osteopathic physician and surgeon, completing the sex designation treatment stating the following:

- a. The sex designation has been permanently changed by surgery or other treatment;
- b. Description of the medical procedures; and
- c. The physician and surgeon or osteopathic physician and surgeon's full name, address, state of medical license, and medical license number.

**99.20(2)** The medical affidavit shall be accompanied by a completed and notarized Amendment to Certificate of Live Birth form.

**99.20(3)** If the registrant's name is to be changed on the certificate of live birth, the registrant shall submit to the state registrar a certified copy of the court-ordered change of name.

**99.20(4)** Pursuant to Iowa Code section 144.23, the state registrar may make further investigation or require further information necessary to determine whether a sex change has occurred.

**99.20(5)** The county registrar and the state registrar shall seal the original certificate of live birth. The state registrar shall place the original certificate of live birth and all related documents in a sealed file, and the file shall not be opened and inspected except by the state registrar for administrative purposes or upon an order from a court of competent jurisdiction pursuant to Iowa Code section 144.24.

**99.20(6)** The certificate of live birth after the sex designation change shall not be on file at the county registrar's office pursuant to rule 641—95.7(144).

**99.20(7)** The new certificate of live birth shall not be marked "amended."

**99.20(8)** Administrative fees shall be charged and remitted pursuant to rule 641—95.6(144).

**99.20(9)** Any incorrect certified copies of the certificate shall be surrendered for replacement at no cost. Additional certified copies of the new certificate shall be acquired upon receipt of a notarized application, legible copy of a current government-issued photo identification or other identification documents acceptable to the state registrar and payment of the fee pursuant to rule 641—95.6(144).  
[ARC 0483C, IAB 12/12/12, effective 1/16/13; see Delay note at end of chapter]

These rules are intended to implement Iowa Code sections 144.19 to 144.21, 144.23, 144.24, 144.25A, 144.38 to 144.41, 252A.3A, 600.15, 600.16A, 674.2, 674.7 and 674.9.

[Filed ARC 0483C (Notice ARC 0376C, IAB 10/3/12), IAB 12/12/12, effective 1/16/13]<sup>1</sup>

[Filed ARC 1075C (Notice ARC 0925C, IAB 8/7/13), IAB 10/2/13, effective 11/6/13]

<sup>1</sup> January 16, 2013, effective date of the rescission of Chapter 99 and the adoption of new Chapter 99 [ARC 0483C] delayed until adjournment of the 2013 General Assembly by the Administrative Rules Review Committee at its meeting held January 8, 2013; delay lifted at the meeting held March 8, 2013.



CHAPTER 134  
TRAUMA CARE FACILITY CATEGORIZATION  
AND VERIFICATION

**641—134.1(147A) Definitions.** For the purpose of these rules, the following definitions shall apply:

“*Categorization*” means a preliminary determination by the department that a hospital or emergency care facility is capable of providing trauma care at Level I, II, III or IV care capabilities.

“*Certificate of verification*” means a document awarded by the department that identifies a hospital or emergency care facility’s level and term of verification as a trauma care facility.

“*Department*” means the Iowa department of public health.

“*Director*” means the director of the Iowa department of public health.

“*Emergency care facility*” means a physician’s office, clinic, or other health care center which provides emergency medical care in conjunction with other primary care services.

“*Emergency medical care provider*” means emergency medical care provider as defined in 641—131.1(147A).

“*Hospital*” means any hospital licensed under Iowa Code chapter 135B.

“*On-site verification survey*” means an on-site survey conducted by the department to assess a hospital or emergency care facility’s ability to meet the level of categorization requested.

“*Trauma*” means a single or multisystem life-threatening or limb-threatening injury, or an injury requiring immediate medical or surgical intervention or treatment to prevent death or permanent disability.

“*Trauma care facility*” means a hospital or emergency care facility which provides trauma care and has been verified by the department as having Resource (Level I), Regional (Level II), Area (Level III) or Community (Level IV) care capabilities and has been issued a certificate of verification pursuant to Iowa Code section 147A.23, subsection 2, paragraph “c.”

“*Trauma care system*” means an organized approach to providing personnel, facilities, and equipment for effective and coordinated trauma care.

“*Verification*” means a process by which the department certifies a hospital or emergency care facility’s capacity to provide trauma care in accordance with criteria established for Resource (Level I), Regional (Level II), Area (Level III) or Community (Level IV) trauma care facilities and these rules.

[ARC 1079C, IAB 10/2/13, effective 1/6/14]

**641—134.2(147A) Trauma care facility categorization and verification.** Categorization and verification of hospitals and emergency care facilities shall be made by the department based upon the hospitals’ or emergency care facilities’ resources available for providing trauma care services.

**134.2(1) Categorization.**

a. Categorization as a trauma care facility shall be determined by the department from self-reported information provided to the department by a hospital or emergency care facility through a self-assessment categorization application provided by the department.

b. Categorization applications shall be submitted by all hospitals. New hospitals shall submit a categorization application no later than 90 days after licensing by the department of inspections and appeals, health facilities division. Categorization applications may be submitted by emergency care facilities. New emergency care facilities may submit a categorization application no later than 90 days after opening or reopening.

c. Categorization applications may be obtained from the department upon written request to: Iowa Department of Public Health, Bureau of Emergency Medical Services, Lucas State Office Building, Des Moines, Iowa 50319-0075.

**134.2(2) Categorization levels for trauma care facilities shall be identified as:**

- a. Resource (Level I).
- b. Regional (Level II).
- c. Area (Level III).
- d. Community (Level IV).

**134.2(3)** Adoption by reference.

*a.* “Resources for Optimal Care of the Injured Patient” (2006) published by the American College of Surgeons Committee on Trauma is incorporated and adopted by reference for Resource (Level I) hospital and emergency care facility categorization criteria. “Iowa Trauma System Regional (Level II) Hospital and Emergency Care Facility Categorization Criteria” (2013) is incorporated and adopted by reference for Regional (Level II) hospital and emergency care facility categorization criteria. “Iowa Trauma System Area (Level III) Hospital and Emergency Care Facility Categorization Criteria” (2013) is incorporated and adopted by reference for Area (Level III) hospital and emergency care facility categorization criteria. “Iowa Trauma System Community (Level IV) Hospital and Emergency Care Facility Categorization Criteria” (2013) is incorporated and adopted by reference for Community (Level IV) hospital and emergency care categorization criteria. For any differences which may occur between the adopted references and these administrative rules, the administrative rules shall prevail.

*b.* “Iowa Trauma System Regional (Level II) Hospital and Emergency Care Facility Categorization Criteria” (2013), “Iowa Trauma System Area (Level III) Hospital and Emergency Care Facility Categorization Criteria” (2013) and “Iowa Trauma System Community (Level IV) Hospital and Emergency Care Facility Categorization Criteria” (2013) are available through the Iowa Department of Public Health, Bureau of EMS, Lucas State Office Building, Des Moines, Iowa 50319-0075, or the bureau of EMS Web site ([www.idph.state.ia.us/ems](http://www.idph.state.ia.us/ems)).

**134.2(4)** Categorization shall not be construed to imply any guarantee on the part of the department as to the level of trauma care services available at a hospital or emergency care facility.

**134.2(5)** A hospital, emergency care facility, or trauma care facility may apply to the department for a change in level of categorization through submission of a self-assessment categorization application.

**134.2(6)** Verification. Verification of a trauma care facility shall be determined by the department upon successful completion of the categorization application and completion of a verification survey. All categorized hospitals and emergency care facilities shall be verified.

**134.2(7)** The department shall conduct a verification survey for categorized hospitals or emergency care facilities.

*a.* A verification survey shall assess the ability of the hospital or emergency care facility to meet criteria for the level of categorization pursuant to 134.2(3).

*b.* The department shall approve trauma care facility verification when the department is satisfied that the proposed facility will provide services and be operated in compliance with Iowa Code section 147A.23 and these administrative rules.

*c.* The department shall notify the applicant, in writing, as to the approval or denial of verification as a trauma care facility within 90 days after the completion of a verification survey.

*d.* Verification shall not be construed to imply any guarantee on the part of the department as to the level of trauma care services available at a hospital or emergency care facility.

*e.* Trauma care facility verification is valid for a period of three years from the effective date unless otherwise specified on the certificate of verification or unless sooner suspended or revoked.

*f.* Trauma care facilities shall be fully operational at their verified level upon the effective date specified on the certificate of verification. Trauma care facilities shall meet all requirements of Iowa Code section 147A.23 and these administrative rules.

*g.* As part of the verification and renewal process, the department may conduct periodic on-site reviews of the services and facilities of trauma care facilities.

*h.* Trauma care facilities that are unable to maintain their categorization or verification, or both, shall notify the department within 48 hours.

*i.* The director, pursuant to rule, may grant a variance from the requirements of rules adopted under this chapter for any hospital or emergency care facility provided that the variance is related to undue hardships in complying with this chapter or the rules adopted pursuant to this chapter.

*j.* Hospitals currently verified by the American College of Surgeons shall be accepted as equivalent for categorization and verification as a trauma care facility in Iowa provided that all policy, reporting, and administrative rules have been met. Documentation shall be provided to the department including, but not limited to, a current copy of the ACS verification certification, the hospital’s

completed ACS verification application or a completed Self-Assessment Categorization Application (SACA).

**134.2(8)** Prohibited acts. A hospital or emergency care facility that imparts or conveys, or causes to be imparted or conveyed, that it is a trauma care facility, or that uses any other term to indicate or imply that the hospital or emergency care facility is a trauma care facility without having obtained a certificate of verification by the department is subject to civil penalty not to exceed \$100 per day for each offense. The director may apply to the district court for a writ of injunction to restrain the use of the term “trauma care facility.”

**134.2(9)** Nothing in Iowa Code section 147A.23 or these administrative rules shall be construed to restrict a hospital or emergency care facility from providing any services for which it is duly authorized. [ARC 9445B, IAB 4/6/11, effective 5/11/11; ARC 1079C, IAB 10/2/13, effective 1/6/14]

**641—134.3(147A) Complaints and investigations and appeals—denial, citation and warning, probation, suspension, and revocation of verification as a trauma care facility.**

**134.3(1)** The department may deny verification as a trauma care facility or may give a citation and warning, place on probation, suspend, or revoke existing verification if the department finds reason to believe that the facility has not been or will not be operated in compliance with Iowa Code section 147A.23 and these administrative rules or that there is insufficient assurance of adequate protection for the public. The denial, citation and warning, period of probation, suspension, or revocation shall be effected and may be appealed in accordance with the requirements of Iowa Code section 17A.12.

**134.3(2)** All complaints regarding the operation of a trauma care facility, or those purporting to be or operating as the same, shall be reported to the department. The address is: Iowa Department of Public Health, Bureau of Emergency Medical Services, Lucas State Office Building, Des Moines, Iowa 50319-0075.

**134.3(3)** An EMS provider who has knowledge of a hospital, emergency care facility or trauma care facility that has violated Iowa Code section 147A.23, or these administrative rules, shall immediately report such information to the department. The address is: Iowa Department of Public Health, Bureau of Emergency Medical Services, Lucas State Office Building, Des Moines, Iowa 50319-0075.

**134.3(4)** Complaints and the investigative process shall be treated as confidential to the extent they are protected by Iowa Code section 22.7.

**134.3(5)** Complaint investigations may result in the department’s issuance of a notice of denial, citation and warning, probation, suspension or revocation.

**134.3(6)** Notice of denial, citation and warning, probation, suspension or revocation shall be effected in accordance with the requirements of Iowa Code section 17A.12. Notice to the alleged violator of denial, citation and warning, probation, suspension, or revocation shall be served by certified mail, return receipt requested, or by personal service.

**134.3(7)** Any request for a hearing concerning the denial, citation and warning, probation, suspension or revocation shall be submitted by the aggrieved party in writing to the department by certified mail, return receipt requested, within 20 days of the receipt of the department’s notice to take action. The address is: Iowa Department of Public Health, Bureau of Emergency Medical Services, Lucas State Office Building, Des Moines, Iowa 50319-0075. If the request is made within the 20-day time period, the notice to take action shall be deemed to be suspended pending the hearing. Prior to or at the hearing, the department may rescind the notice upon satisfaction that the reason for the denial, citation and warning, probation, suspension or revocation has been or will be removed. If no request for a hearing is received within the 20-day time period, the department’s notice of denial, citation and warning, probation, suspension or revocation shall become the department’s final agency action.

**134.3(8)** Upon receipt of a request for hearing, the request shall be forwarded within five working days to the department of inspections and appeals pursuant to the rules adopted by that agency regarding the transmission of contested cases. The information upon which the adverse action is based and any additional information which may be provided by the aggrieved party shall also be provided to the department of inspections and appeals.

**134.3(9)** The hearing shall be conducted according to the procedural rules of the department of inspections and appeals found in 481—Chapter 10, Iowa Administrative Code.

**134.3(10)** When the administrative law judge makes a proposed decision and order, it shall be served by certified mail, return receipt requested, or delivered by personal service. That proposed decision and order then becomes the department's final agency action without further proceedings ten days after it is received by the aggrieved party unless an appeal to the director is taken.

**134.3(11)** Any appeal to the director for review of the proposed decision and order of the administrative law judge shall be filed in writing and mailed to the director by certified mail, return receipt requested, or delivered by personal service within ten days after the receipt of the administrative law judge's proposed decision and order by the aggrieved party. A copy of the appeal shall also be mailed to the administrative law judge. Any request for an appeal shall state the reason for appeal.

**134.3(12)** Upon receipt of an appeal request, the administrative law judge shall prepare the record of the hearing for submission to the director. The record shall include the following:

- a. All pleadings, motions, and rules.
- b. All evidence received or considered and all other submissions by recording or transcript.
- c. A statement of all matters officially noticed.
- d. All questions and offers of proof, objections and rulings on them.
- e. All proposed findings and exceptions.
- f. The proposed decision and order of the administrative law judge.

**134.3(13)** The decision and order of the director becomes the department's final agency action upon receipt by the aggrieved party and shall be delivered by certified mail, return receipt requested, or by personal service.

**134.3(14)** It is not necessary to file an application for a rehearing to exhaust administrative remedies when appealing to the director or the district court as provided in Iowa Code section 17A.19. The aggrieved party to the final agency action of the department who has exhausted all administrative remedies may petition for judicial review of that action pursuant to Iowa Code chapter 17A.

**134.3(15)** Any petition for judicial review of a decision and order shall be filed in the district court within 30 days after the decision and order becomes final. A copy of the notice of appeal shall be sent to the department by certified mail, return receipt requested, or by personal service. The address is: Iowa Department of Public Health, Bureau of Emergency Medical Services, Lucas State Office Building, Des Moines, Iowa 50319-0075.

**134.3(16)** The party who appeals a final agency action to the district court shall pay the cost of the preparation of a transcript of the contested case hearing for the district court.

**134.3(17)** Final decisions of the department relating to disciplinary proceedings may be transmitted to the appropriate professional associations, news media or employer.

These rules are intended to implement Iowa Code section 147A.23.

[Filed 11/14/96, Notice 10/9/96—published 12/4/96, effective 1/8/97]

[Filed 1/18/01, Notice 11/15/00—published 2/7/01, effective 3/14/01]

[Filed 1/10/02, Notice 11/28/01—published 2/6/02, effective 3/13/02]

[Filed 1/13/05, Notice 11/24/04—published 2/2/05, effective 3/9/05]

[Filed ARC 9445B (Notice ARC 9344B, IAB 1/26/11), IAB 4/6/11, effective 5/11/11]

[Filed ARC 1079C (Notice ARC 0772C, IAB 5/29/13), IAB 10/2/13, effective 1/6/14]

CHAPTER 135  
TRAUMA TRIAGE AND TRANSFER PROTOCOLS

**641—135.1(147A) Definitions.** For the purpose of these rules, the following definitions shall apply:

“*Department*” means the Iowa department of public health.

“*Director*” means the director of the Iowa department of public health.

“*Out-of-Hospital Trauma Triage Destination Decision Protocol*” means written directives to assist in the decision making, established and approved by the department, that address the method of transport and trauma care facility destination to be followed by the service program.

“*Service program*” or “*service*” means any medical care ambulance service or nontransport service that has received authorization by the department.

“*Transfer*” means the process of a patient being transferred from the scene of an injury to a trauma care facility or from one trauma care facility to another.

“*Trauma care facility*” means a hospital or emergency care facility which provides trauma care and has been verified by the department as having Resource (Level I), Regional (Level II), Area (Level III) or Community (Level IV) care capabilities and has been issued a certificate of verification pursuant to Iowa Code section 147A.23, subsection 2, paragraph “c.”

“*Trauma system advisory council*” means an advisory council established pursuant to Iowa Code section 147A.24 to advise the department on issues and strategies to achieve optimal trauma care delivery throughout the state.

“*Trauma triage and transfer*” means to determine trauma care facility destination and mode of transportation.

“*TSAC*” means trauma system advisory council.

[ARC 1080C, IAB 10/2/13, effective 2/1/14]

**641—135.2(147A) Trauma triage and transfer protocols.**

**135.2(1)** Trauma triage and transfer protocols approved by the department shall be utilized to assist personnel from each service program and trauma care facility. This requirement shall not preclude service programs or trauma care facilities from making emergency revisions of the approved triage and transfer protocols when an incident overburdens medical care resources causing unnecessary delay in patient care.

*a.* Adoption by reference. The “Out-of-Hospital Trauma Triage Destination Decision Protocol” (Adult, 2013) and the “Out-of-Hospital Trauma Triage Destination Decision Protocol” (Pediatric, 2013) are incorporated by reference and adopted as the out-of-hospital trauma triage destination decision protocols. For any differences which may occur between the adopted references and these administrative rules, the administrative rules shall prevail.

*b.* The protocols adopted by reference in paragraph 135.2(1)“*a*” are available through the Iowa Department of Public Health, Bureau of EMS, Lucas State Office Building, Des Moines, Iowa 50319-0075, or the bureau of EMS Web site ([www.idph.state.ia.us/ems](http://www.idph.state.ia.us/ems)).

*c.* Revisions and modifications to the protocols adopted by reference in paragraph 135.2(1)“*a*” may be made upon recommendation to the department from the trauma system advisory council (TSAC). Revisions and modifications shall be approved by the department.

*d.* The director, pursuant to rule, may grant a variance from the requirements of rules adopted under this chapter for any hospital, emergency care facility, or service program provided that the variance is related to undue hardships in complying with this chapter or the rules adopted pursuant to this chapter.

**135.2(2)** Reserved.

[ARC 1080C, IAB 10/2/13, effective 2/1/14]

**641—135.3(147A) Offenses and penalties.**

**135.3(1)** The department may deny verification as a trauma care facility or deny authorization as a service program or may give a citation and warning, place on probation, suspend, or revoke existing trauma care facility verification or service program authorization if the department finds reason to believe that the facility or service program has not been or will not be operated in compliance with Iowa Code

section 147A.27 and these administrative rules. The denial, citation and warning, period of probation, suspension, or revocation shall be effected and may be appealed in accordance with the requirements of Iowa Code section 17A.12.

**135.3(2)** All complaints regarding the operation of a trauma care facility or service program, or those purporting to be or operating as the same, shall be reported to the department. The address is: Iowa Department of Public Health, Bureau of Emergency Medical Services, Lucas State Office Building, Des Moines, Iowa 50319-0075.

**135.3(3)** Complaints and the investigative process shall be treated as confidential to the extent they are protected by Iowa Code section 22.7.

**135.3(4)** Complaint investigations may result in the department's issuance of a notice of denial, citation and warning, probation, suspension or revocation.

**135.3(5)** Notice of denial, citation and warning, probation, suspension or revocation shall be effected in accordance with the requirements of Iowa Code section 17A.12. Notice to the alleged violator of denial, citation and warning, probation, suspension, or revocation shall be served by certified mail, return receipt requested, or by personal service.

**135.3(6)** Any request for a hearing concerning the denial, citation and warning, probation, suspension or revocation shall be submitted by the aggrieved party in writing to the department by certified mail, return receipt requested, within 20 days of the receipt of the department's notice to take action. The address is: Iowa Department of Public Health, Bureau of Emergency Medical Services, Lucas State Office Building, Des Moines, Iowa 50319-0075. If the request is made within the 20-day time period, the notice to take action shall be deemed to be suspended pending the hearing. Prior to or at the hearing, the department may rescind the notice upon satisfaction that the reason for the denial, citation and warning, probation, suspension or revocation has been or will be removed. If no request for a hearing is received within the 20-day time period, the department's notice of denial, citation and warning, probation, suspension or revocation shall become the department's final agency action.

**135.3(7)** Upon receipt of a request for hearing, the request shall be forwarded within five working days to the department of inspections and appeals pursuant to the rules adopted by that agency regarding the transmission of contested cases. The information upon which the adverse action is based and any additional information which may be provided by the aggrieved party shall also be provided to the department of inspections and appeals.

**135.3(8)** The hearing shall be conducted according to the procedural rules of the department of inspections and appeals found in 481—Chapter 10, Iowa Administrative Code.

**135.3(9)** When the administrative law judge makes a proposed decision and order, it shall be served by certified mail, return receipt requested, or delivered by personal service. That proposed decision and order then becomes the department's final agency action without further proceedings ten days after it is received by the aggrieved party unless an appeal to the director is taken.

**135.3(10)** Any appeal to the director for review of the proposed decision and order of the administrative law judge shall be filed in writing and mailed to the director by certified mail, return receipt requested, or delivered by personal service within ten days after the receipt of the administrative law judge's proposed decision and order by the aggrieved party. A copy of the appeal shall also be mailed to the administrative law judge. Any request for an appeal shall state the reason for appeal.

**135.3(11)** Upon receipt of an appeal request, the administrative law judge shall prepare the record of the hearing for submission to the director. The record shall include the following:

- a. All pleadings, motions, and rules.
- b. All evidence received or considered and all other submissions by recording or transcript.
- c. A statement of all matters officially noticed.
- d. All questions and offers of proof, objections and rulings on them.
- e. All proposed findings and exceptions.
- f. The proposed decision and order of the administrative law judge.

**135.3(12)** The decision and order of the director becomes the department's final agency action upon receipt by the aggrieved party and shall be delivered by certified mail, return receipt requested, or personal service.

**135.3(13)** It is not necessary to file an application for a rehearing to exhaust administrative remedies when appealing to the director or the district court as provided in Iowa Code section 17A.19. The aggrieved party to the final agency action of the department who has exhausted all administrative remedies may petition for judicial review of that action pursuant to Iowa Code chapter 17A.

**135.3(14)** Any petition for judicial review of a decision and order shall be filed in the district court within 30 days after the decision and order becomes final. A copy of the notice of appeal shall be sent to the department by certified mail, return receipt requested, or by personal service. The address is: Iowa Department of Public Health, Bureau of Emergency Medical Services, Lucas State Office Building, Des Moines, Iowa 50319-0075.

**135.3(15)** The party who appeals a final agency action to the district court shall pay the cost of the preparation of a transcript of the contested case hearing for the district court.

**135.3(16)** Final decisions of the department relating to disciplinary proceedings may be transmitted to the appropriate professional associations, news media or employer.

These rules are intended to implement Iowa Code section 147A.23.

[Filed 11/14/96, Notice 10/9/96—published 12/4/96, effective 1/8/97]

[Filed 1/18/01, Notice 11/15/00—published 2/7/01, effective 3/14/01]

[Filed 1/10/02, Notice 11/28/01—published 2/6/02, effective 3/13/02]

[Filed 1/13/05, Notice 11/24/04—published 2/2/05, effective 3/9/05]

[Filed ARC 1080C (Notice ARC 0774C, IAB 5/29/13), IAB 10/2/13, effective 2/1/14]



CHAPTER 137  
TRAUMA EDUCATION AND TRAINING

**641—137.1(147A) Definitions.** For the purpose of these rules, the following definitions shall apply:

“*ACLS course*” means advanced cardiac life support course.

“*Advanced emergency medical technician*” or “*AEMT*” means advanced emergency medical technician as defined in 641—131.1(147A).

“*Advanced registered nurse practitioner*” or “*ARNP*” means a nurse pursuant to 655—7.1(152) with current licensure as a registered nurse in Iowa who is registered in Iowa to practice in an advanced role. The ARNP is prepared for an advanced role by virtue of additional knowledge and skills gained through a formal advanced practice education program of nursing in a specialty area approved by the board. In the advanced role, the nurse practices nursing assessment, intervention, and management within the boundaries of the nurse-client relationship. Advanced nursing practice occurs in a variety of settings within an interdisciplinary health care team, which provide for consultation, collaborative management, or referral. The ARNP may perform selected medically delegated functions when a collaborative practice agreement exists.

“*Advanced trauma life support course*®” or “*ATLS*®” means a course for physicians with an emphasis on the first hour of initial assessment and primary management of the injured patient, starting at the point in time of injury continuing through initial assessment, life-saving intervention, reevaluation, stabilization, and transfer when appropriate.

“*Department*” means the Iowa department of public health.

“*Director*” means the director of the Iowa department of public health.

“*Emergency care facility*” means a physician’s office, clinic, or other health care center which provides emergency medical care in conjunction with other primary care services.

“*Emergency medical care provider*” means emergency medical care provider as defined in 641—131.1(147A).

“*Emergency medical services*” or “*EMS*” means emergency medical services as defined in 641—132.1(147A).

“*Emergency medical technician*” or “*EMT*” means emergency medical technician as defined in 641—131.1(147A).

“*Emergency medical technician-ambulance*” or “*EMT-A*” means emergency medical technician-ambulance as defined in 641—131.1(147A).

“*Emergency medical technician-basic*” or “*EMT-B*” means emergency medical technician-basic as defined in 641—131.1(147A).

“*Emergency medical technician-defibrillation*” or “*EMT-D*” means emergency medical technician-defibrillation as defined in 641—131.1(147A).

“*Emergency medical technician-intermediate*” or “*EMT-I*” means emergency medical technician-intermediate as defined in 641—131.1(147A).

“*Emergency medical technician-paramedic*” or “*EMT-P*” means emergency medical technician-paramedic as defined in 641—131.1(147A).

“*First responder*” or “*FR*” means first responder as defined in 641—131.1(147A).

“*First responder-defibrillation*” or “*FR-D*” means first responder-defibrillation as defined in 641—131.1(147A).

“*Formal education*” means education in standardized educational settings with a curriculum.

“*Hospital*” means a facility licensed under Iowa Code chapter 135B, or comparable emergency care facility located and licensed in another state.

“*Licensed practical nurse*” or “*LPN*” means an individual licensed pursuant to Iowa Code chapter 152.

“*NRP course*” means neonatal resuscitation provider course.

“*PALS course*” means pediatric advanced life support course.

“*Paramedic*” means paramedic as defined in 641—131.1(147A).

“*Paramedic specialist*” or “*PS*” means paramedic specialist as defined in 641—131.1(147A).

*“Physician”* means an individual licensed under Iowa Code chapter 148, 150 or 150A.

*“Physician assistant”* or *“PA”* means an individual licensed pursuant to Iowa Code chapter 148C.

*“Practitioner”* means a person who practices medicine or one of the associated health care professions.

*“Registered nurse”* or *“RN”* means an individual licensed pursuant to Iowa Code chapter 152.

*“Service program”* or *“service”* means service program as defined in 641—132.1(147A).

*“Trauma”* means a single or multisystem life-threatening or limb-threatening injury, or an injury requiring immediate medical or surgical intervention or treatment to prevent death or disability.

*“Trauma care facility”* means a hospital or emergency care facility which provides trauma care and has been verified by the department as having Resource (Level I), Regional (Level II), Area (Level III) or Community (Level IV) care capabilities and has been issued a certificate of verification pursuant to Iowa Code section 147A.23, subsection 2, paragraph “c.”

*“Trauma care system”* means an organized approach to providing personnel, facilities, and equipment for effective and coordinated trauma care.

*“Trauma nursing course objectives”* means the trauma nursing course objectives recommended to the department by the trauma system advisory council and adopted by reference in these rules.

*“Trauma patient”* means a victim of an external cause of injury that results in major or minor tissue damage or destruction caused by intentional or unintentional exposure to thermal, mechanical, electrical or chemical energy, or by the absence of heat or oxygen (ICD9 Codes E800.0 - E999.9).

*“Trauma system advisory council”* or *“TSAC”* means the council established by the department pursuant to Iowa Code section 147A.24 to advise the department on issues and strategies to achieve optimal trauma care delivery throughout the state, to assist the department in the implementation of an Iowa trauma care plan, to develop criteria for the categorization of all hospitals and emergency care facilities according to their trauma care capabilities, to develop a process for verification of the trauma care capacity of each facility and the issuance of a certificate of verification, to develop standards for medical direction, trauma care, triage and transfer protocols, and trauma registries, to promote public information and education activities for injury prevention, to review rules adopted under this division, and to make recommendations to the director for changes to further promote optimal trauma care.

*“Trauma team”* means a team of multidisciplinary health care providers established and defined by a hospital or emergency care facility that provides trauma care commensurate with the level of trauma care facility verification.

*“Verification”* means a process by which the department certifies a hospital or emergency care facility’s capacity to provide trauma care in accordance with criteria established for Resource (Level I), Regional (Level II), Area (Level III) or Community (Level IV) trauma care facilities and these rules.

[ARC 1081C, IAB 10/2/13, effective 11/6/13]

**641—137.2(147A) Initial trauma education for Iowa’s trauma system.** Initial trauma education is required of physicians, physician assistants, advanced registered nurse practitioners, registered nurses, and licensed practical nurses who are identified or defined as trauma team members by a trauma care facility and who participate directly in the initial resuscitation of the trauma patient.

**137.2(1)** General requirements for initial trauma education.

a. Completion of initial trauma education shall be done within three years of the trauma care facility’s initial verification or within one year of the practitioner’s joining the trauma care facility’s trauma team.

b. Trauma nursing course objectives (2007) are incorporated and adopted by reference for all trauma care facilities. For any differences which may occur between the adopted references and these administrative rules, the administrative rules shall prevail.

c. Trauma nursing course objectives are available from the Department of Public Health, Bureau of Emergency Medical Services, Lucas State Office Building, Des Moines, Iowa 50319-0075, or the bureau of EMS Web site ([www.idph.state.ia.us/ems](http://www.idph.state.ia.us/ems)).

**137.2(2)** Specific requirements for initial trauma education for each provider category are as follows:

a. Physicians, PAs and ARNPs: current ATLS® certification.

*b.* RNs and LPNs: successful completion of trauma nursing course objectives (2007) recommended by TSAC.

[ARC 1081C, IAB 10/2/13, effective 11/6/13]

**641—137.3(147A) Continuing trauma education for Iowa's trauma system.** Continuing trauma education is required every four years of physicians, physician assistants, advanced registered nurse practitioners, registered nurses, and licensed practical nurses who are identified or defined as trauma team members by a trauma care facility and who participate directly in the initial resuscitation of the trauma patient.

**137.3(1)** Topics for all or part of the continuing trauma education hours may be recommended to the department by TSAC based on trauma care system outcomes.

**137.3(2)** General requirements for continuing trauma education.

*a.* Sixteen hours of the required continuing trauma education hours may be informal, determined and approved by a trauma care facility from any of the following:

1. Multidisciplinary trauma case reviews;
2. Multidisciplinary trauma conferences;
3. Multidisciplinary trauma mortality and morbidity reviews;
4. Multidisciplinary trauma committee meetings;
5. Trauma peer review meetings;
6. Any trauma care facility committee meeting with a focus on trauma care evaluation; and
7. Critical care education such as ACLS course, PALS course, NRP course, or equipment inservices.

*b.* Eight hours of the required continuing trauma education hours shall be obtained through any formalized continuing education programs.

**137.3(3)** Specific requirements for each provider category are as follows:

*a.* Physicians: 24 hours of continuing trauma education is required, with a minimum of 8 hours as formal education.

(1) Physicians who treat trauma patients in the emergency department but are not board-certified in emergency medicine must maintain current ATLS® certification.

(2) Surgeons who are not board-certified in general surgery must maintain current ATLS® certification.

(3) The designated trauma service medical director, regardless of board certification, must maintain current ATLS® certification.

*b.* PA and ARNP: 24 hours of continuing trauma education is required, with a minimum of 8 hours as formal education. Of the 8 hours of formal education, current ATLS® certification is required.

*c.* RN and LPN: 16 hours of continuing trauma education is required, with a minimum of 4 hours as formal education based upon the trauma nursing course objectives (2007) recommended by TSAC.

**137.3(4)** Continuing trauma education is required of certified emergency medical care providers every two years as follows:

- a.* EMR, FR or FR-D: 2 continuing education hours.
- b.* EMT, EMT-A, EMT-B, EMT-D: 4 continuing education hours.
- c.* AEMT, EMT-I: 4 continuing education hours.
- d.* EMT-P, PS, Paramedic: 6 continuing education hours.

[ARC 1081C, IAB 10/2/13, effective 11/6/13]

**641—137.4(147A) Offenses and penalties.**

**137.4(1)** The department may deny verification as a trauma care facility or deny authorization as a service program, may give a citation and warning, or may place on probation, suspend, or revoke existing trauma care facility verification or service program authorization if the department finds reason to believe that the facility or service program has not been or will not be operated in compliance with Iowa Code sections 147A.27 and these administrative rules. The denial, citation and warning, period of probation, suspension, or revocation shall be effected and may be appealed in accordance with the requirements of Iowa Code section 17A.12.

**137.4(2)** All complaints regarding the operation of a trauma care facility or service program, or those purporting to be or operating as the same, shall be reported to the department. The address is Iowa Department of Public Health, Bureau of Emergency Medical Services, Lucas State Office Building, Des Moines, Iowa 50319-0075.

**137.4(3)** Complaints and the investigative process shall be treated as confidential to the extent they are protected by Iowa Code section 22.7.

**137.4(4)** Complaint investigations may result in the department's issuance of a notice of denial, citation and warning, probation, suspension or revocation.

**137.4(5)** Notice of denial, citation and warning, probation, suspension or revocation shall be effected in accordance with the requirements of Iowa Code section 17A.12. Notice to the alleged violator of denial, citation and warning, probation, suspension, or revocation shall be served by certified mail, return receipt requested, or by personal service.

**137.4(6)** Any request for a hearing concerning the denial, citation and warning, probation, suspension or revocation shall be submitted by the aggrieved party in writing to the department by certified mail, return receipt requested, within 20 days of the receipt of the department's notice to take action. The address is Iowa Department of Public Health, Bureau of Emergency Medical Services, Lucas State Office Building, Des Moines, Iowa 50319-0075. If the request is made within the 20-day time period, the notice to take action shall be deemed to be suspended pending the hearing. Prior to or at the hearing, the department may rescind the notice upon satisfaction that the reason for the denial, citation and warning, probation, suspension or revocation has been or will be removed. If no request for a hearing is received within the 20-day time period, the department's notice of denial, citation and warning, probation, suspension or revocation shall become the department's final agency action.

**137.4(7)** A request for a hearing shall be forwarded within five working days of receipt of the request to the department of inspections and appeals pursuant to the rules adopted by that agency regarding the transmission of contested cases. The information upon which the adverse action is based and any additional information which may be provided by the aggrieved party shall also be provided to the department of inspections and appeals.

**137.4(8)** The hearing shall be conducted according to the procedural rules of the department of inspections and appeals found in 481—Chapter 10, Iowa Administrative Code.

**137.4(9)** When the administrative law judge makes a proposed decision and order, it shall be served by certified mail, return receipt requested, or delivered by personal service. That proposed decision and order then becomes the department's final agency action without further proceedings ten days after it is received by the aggrieved party unless an appeal to the director is taken.

**137.4(10)** Any appeal to the director for review of the proposed decision and order of the administrative law judge shall be filed in writing and mailed to the director by certified mail, return receipt requested, or delivered by personal service within ten days after the receipt of the administrative law judge's proposed decision and order by the aggrieved party. A copy of the appeal shall also be mailed to the administrative law judge. Any request for an appeal shall state the reason for appeal.

**137.4(11)** Upon receipt of an appeal request, the administrative law judge shall prepare the record of the hearing for submission to the director. The record shall include the following:

- a. All pleadings, motions, and rules.
- b. All evidence received or considered and all other submissions by recording or transcript.
- c. A statement of all matters officially noticed.
- d. All questions and offers of proof, objections and rulings on them.
- e. All proposed findings and exceptions.
- f. The proposed decision and order of the administrative law judge.

**137.4(12)** The decision and order of the director becomes the department's final agency action upon receipt by the aggrieved party and shall be delivered by certified mail, return receipt requested, or personal service.

**137.4(13)** It is not necessary to file an application for a rehearing to exhaust administrative remedies when appealing to the director or the district court as provided in Iowa Code section 17A.19. The

aggrieved party to the final agency action of the department who has exhausted all administrative remedies may petition for judicial review of that action pursuant to Iowa Code chapter 17A.

**137.4(14)** Any petition for judicial review of a decision and order shall be filed in the district court within 30 days after the decision and order becomes final. A copy of the notice of appeal shall be sent to the department by certified mail, return receipt requested, or by personal service. The address is Department of Public Health, Bureau of Emergency Medical Services, Lucas State Office Building, Des Moines, Iowa 50319-0075.

**137.4(15)** The party who appeals a final agency action to the district court shall pay the cost of the preparation of a transcript of the contested case hearing for the district court.

**137.4(16)** Final decisions of the department relating to disciplinary proceedings may be transmitted to the appropriate professional associations, news media or employer.

These rules are intended to implement Iowa Code chapter 147A.

[Filed 5/14/99, Notice 2/10/99—published 6/2/99, effective 7/7/99]

[Filed 1/13/05, Notice 11/24/04—published 2/2/05, effective 3/9/05]

[Filed ARC 1081C (Notice ARC 0773C, IAB 5/29/13), IAB 10/2/13, effective 11/6/13]



## **MEDICINE BOARD[653]**

[Prior to 5/4/88, see Health Department[470], Chs 135 and 136, renamed Medical Examiners Board[653] under the "umbrella" of Public Health Department[641] by 1986 Iowa Acts, ch 1245]  
[Prior to 7/4/07, see Medical Examiners Board[653]; renamed by 2007 Iowa Acts, Senate File 74]

### CHAPTER 1

#### ADMINISTRATIVE AND REGULATORY AUTHORITY

- 1.1(17A,147) Definitions
- 1.2(17A) Purpose of board
- 1.3(17A) Organization of board
- 1.4(17A) Official communications
- 1.5(17A) Office hours
- 1.6(17A) Meetings
- 1.7(17A,147) Petition to promulgate, amend or repeal a rule
- 1.8(17A) Public hearings prior to the adoption, amendment or repeal of any rule
- 1.9(17A) Declaratory orders
- 1.10(68B) Selling of goods or services by members of the board or Iowa physician health committee (IPHC)

### CHAPTER 2

#### PUBLIC RECORDS AND FAIR INFORMATION PRACTICES

(Uniform Rules)

- 2.1(17A,22) Definitions
- 2.3(17A,22) Requests for access to records
- 2.6(17A,22) Procedure by which additions, dissents, or objections may be entered into certain records
- 2.7(17A,22) Consent to disclosure by the subject of a confidential record
- 2.9(17A,22) Disclosures without the consent of the subject
- 2.10(17A,22) Routine use
- 2.11(17A,22) Consensual disclosure of confidential records
- 2.12(17A,22) Release to subject
- 2.13(17A,22) Availability of records
- 2.14(17A,22) Personally identifiable information
- 2.15(17A,22) Other groups of records
- 2.16(17A,22) Data processing system
- 2.17(17A,22) Applicability

### CHAPTER 3

#### WAIVERS AND VARIANCES

- 3.1(17A,147,148) Definition
- 3.2(17A,147,148) Scope of chapter
- 3.3(17A,147,148) Applicability of chapter
- 3.4(17A,147,148) Criteria for waiver or variance
- 3.5(17A,147,148) Filing of petition
- 3.6(17A,147,148) Content of petition
- 3.7(17A,147,148) Additional information
- 3.8(17A,147,148) Notice
- 3.9(17A,147,148) Hearing procedures
- 3.10(17A,147,148) Ruling
- 3.11(17A,147,148) Public availability
- 3.12(17A,147,148) Summary reports
- 3.13(17A,147,148) Cancellation of a waiver
- 3.14(17A,147,148) Violations

- 3.15(17A,147,148) Defense
- 3.16(17A,147,148) Judicial review
- 3.17(17A,147,148) Sample petition for waiver

## CHAPTERS 4 to 7

Reserved

## CHAPTER 8

## FEES

- 8.1(147,148,272C) Definitions
- 8.2(147,148,272C) Application and licensure fees for acupuncturists
- 8.3(147,148,272C) Examination fees for physicians
- 8.4(147,148,272C) Application and licensure fees to practice medicine and surgery or osteopathic medicine and surgery
- 8.5(147,148,272C) Fees for verification of physician licensure and certification of examination scores
- 8.6(147,148,272C) Public records
- 8.7(147,148,272C) Purchase of a licensee data list
- 8.8(147,148,272C) Returned checks
- 8.9(147,148,272C) Copies of the laws and rules
- 8.10(147,148,272C) Refunds
- 8.11(17A,147,148,272C) Waiver or variance prohibited
- 8.12(8,147,148,272C) Request for reports
- 8.13(8,147,148,272C) Monitoring fee

## CHAPTER 9

## PERMANENT PHYSICIAN LICENSURE

- 9.1(147,148) Definitions
- 9.2(147,148) General licensure provisions
- 9.3(147,148) Eligibility for permanent licensure
- 9.4(147,148) Licensure by examination
- 9.5(147,148) Licensure by endorsement
- 9.6(147,148) Licensure by expedited endorsement
- 9.7(147,148) Licensure examinations
- 9.8(147,148) Permanent licensure application review process
- 9.9(147,148) Licensure application cycle
- 9.10(147,148) Discretionary board actions on licensure applications
- 9.11(147,148) Issuance of a permanent license
- 9.12(147,148) Notification required to change the board's data system
- 9.13(147,148) Renewal of a permanent license
- 9.14(147,148) Inactive status and reinstatement of a permanent license
- 9.15(147,148) Reinstatement of an unrestricted Iowa license
- 9.16(147,148) Reinstatement of a restricted Iowa license
- 9.17(147,148) Denial of licensure
- 9.18(17A,147,148,272C) Waiver or variance requests

## CHAPTER 10

## RESIDENT, SPECIAL AND TEMPORARY PHYSICIAN LICENSURE

- 10.1(147,148) Definitions
- 10.2(148) Licensure required
- 10.3(147,148) Resident physician licensure
- 10.4(147,148) Special licensure

- 10.5(147,148) Temporary licensure
- 10.6(17A,147,148,272C) Waiver or variance requests

CHAPTER 11  
CONTINUING EDUCATION AND  
TRAINING REQUIREMENTS

- 11.1(272C) Definitions
- 11.2(272C) Continuing education credit and alternatives
- 11.3(272C) Accreditation of providers
- 11.4(272C) Continuing education and training requirements for renewal or reinstatement
- 11.5(272C) Failure to fulfill requirements for continuing education and training for identifying and reporting abuse
- 11.6(17A,147,148E,272C) Waiver or variance requests

CHAPTER 12  
NONPAYMENT OF STATE DEBT

- 12.1(272D) Definitions
- 12.2(272D) Issuance or renewal of a license—denial
- 12.3(272D) Suspension or revocation of a license

CHAPTER 13  
STANDARDS OF PRACTICE AND PRINCIPLES OF MEDICAL ETHICS

- 13.1(148,272C) Standards of practice—packaging, labeling and records of prescription drugs dispensed by a physician
- 13.2(148,272C) Standards of practice—appropriate pain management
- 13.3 Reserved
- 13.4(148) Supervision of pharmacists engaged in collaborative drug therapy management
- 13.5(147,148) Standards of practice—chelation therapy
- 13.6(79GA,HF726) Standards of practice—automated dispensing systems
- 13.7(147,148,272C) Standards of practice—office practices
- 13.8(148,272C) Standards of practice—medical directors at medical spas—delegation and supervision of medical aesthetic services performed by qualified licensed or certified nonphysician persons
- 13.9(147,148,272C) Standards of practice—interventional chronic pain management
- 13.10(147,148,272C) Standards of practice—physicians who prescribe or administer abortion-inducing drugs
- 13.11 to 13.19 Reserved
- 13.20(147,148) Principles of medical ethics
- 13.21(17A,147,148,272C) Waiver or variance prohibited

CHAPTER 14  
IOWA PHYSICIAN HEALTH COMMITTEE

- 14.1(272C) Iowa physician health committee
- 14.2(272C) Definitions
- 14.3(272C) Purpose
- 14.4(272C) Organization of the committee
- 14.5(272C) Eligibility
- 14.6(272C) Type of program
- 14.7(272C) Terms of participation
- 14.8(272C) Limitations
- 14.9(272C) Confidentiality
- 14.10(28E) Authority for 28E agreements
- 14.11(272C) Board referrals to the Iowa physician health committee

CHAPTER 15  
CHILD SUPPORT NONCOMPLIANCE

- 15.1(252J) Definitions
- 15.2(252J) Issuance or renewal of a license—denial
- 15.3(252J) Suspension or revocation of a license

CHAPTER 16  
STUDENT LOAN DEFAULT OR NONCOMPLIANCE

- 16.1(261) Definitions
- 16.2(261) Issuance or renewal of a license—denial
- 16.3(261) Service of denial notice
- 16.4(261) Suspension or revocation of a license
- 16.5(261) Share information

CHAPTER 17  
LICENSURE OF ACUPUNCTURISTS

- 17.1(148E) Purpose
- 17.2(148E) Licensure exceptions
- 17.3(148E) Definitions
- 17.4(147,148E) Eligibility for licensure
- 17.5(147,148E) Application requirements
- 17.6(147,148E) Display of license and disclosure of information to patients
- 17.7(147,148E,272C) Biennial renewal of license required
- 17.8(147,272C) Reinstatement of an inactive license
- 17.9(272C) Continuing education requirements—course approval
- 17.10(147,148E,272C) General provisions
- 17.11(147,148E,272C) General disciplinary provisions
- 17.12(147,148E,272C) Grounds for discipline
- 17.13(272C) Procedure for peer review
- 17.14(272C) Reporting duties and investigation of reports
- 17.15(272C) Complaints, immunities and privileged communications
- 17.16(272C) Confidentiality of investigative files
- 17.17 to 17.28 Reserved
- 17.29(17A,147,148E,272C) Disciplinary procedures
- 17.30(147,148E,272C) Waiver or variance prohibited

CHAPTERS 18 to 20  
Reserved

CHAPTER 21  
PHYSICIAN SUPERVISION OF A PHYSICIAN ASSISTANT

- 21.1(148,272C) Ineligibility determinants
- 21.2(148,272C) Exemptions from this chapter
- 21.3(148) Board notification
- 21.4(148,272C) Grounds for discipline
- 21.5(148,272C) Disciplinary sanction
- 21.6(148,272C) Communication with physician assistant supervisees
- 21.7(17A,147,148,272C) Waiver or variance requests

CHAPTER 22  
MANDATORY REPORTING

- 22.1(272C) Mandatory reporting—judgments or settlements
- 22.2(272C) Mandatory reporting—wrongful acts or omissions

- 22.3(272C) Mandatory reporting—disciplinary action in another jurisdiction
- 22.4(272C) Mandatory reporting—child abuse and dependent adult abuse
- 22.5(272C) Mandatory reporting—hospital disciplinary action

#### CHAPTER 23

##### GROUND FOR DISCIPLINE

- 23.1(272C) Grounds for discipline

#### CHAPTER 24

##### COMPLAINTS AND INVESTIGATIONS

- 24.1(17A,147,148,272C) Complaints
- 24.2(17A,147,148,272C) Processing complaints and investigations
- 24.3(272C) Peer review
- 24.4(272C) Order for physical, mental, or clinical competency evaluation

#### CHAPTER 25

##### CONTESTED CASE PROCEEDINGS

- 25.1(17A) Definitions
- 25.2(17A) Scope and applicability
- 25.3(17A) Combined statement of charges and settlement agreement
- 25.4(17A) Statement of charges
- 25.5(17A) Legal representation
- 25.6(17A) Presiding officer in a disciplinary contested case
- 25.7(17A) Presiding officer in a nondisciplinary contested case
- 25.8(17A) Disqualification
- 25.9(17A) Consolidation—severance
- 25.10(17A) Pleadings
- 25.11(17A) Service and filing
- 25.12(17A) Discovery
- 25.13(17A,272C) Subpoenas in a contested case
- 25.14(17A) Motions
- 25.15(17A) Prehearing conferences
- 25.16(17A) Continuances
- 25.17(272C) Settlement agreements
- 25.18(17A) Hearing procedures
- 25.19(17A) Evidence
- 25.20(17A) Default
- 25.21(17A) Ex parte communication
- 25.22(17A) Recording costs
- 25.23(17A) Interlocutory appeals
- 25.24(17A) Decisions
- 25.25(272C) Disciplinary sanctions
- 25.26(17A) Application for rehearing
- 25.27(17A) Stays of agency actions
- 25.28(17A) No factual dispute contested cases
- 25.29(17A) Emergency adjudicative proceedings
- 25.30(17A) Appeal of license denial
- 25.31(17A) Judicial review and appeal
- 25.32(17A) Open record
- 25.33(272C) Disciplinary hearings—fees and costs

CHAPTER 26

REINSTATEMENT AFTER DISCIPLINARY ACTION

26.1(17A)

Reinstatement

CHAPTER 13  
STANDARDS OF PRACTICE AND PRINCIPLES OF MEDICAL ETHICS

[Prior to 5/4/88, see 470—135.251 to 470—135.402]

**653—13.1(148,272C) Standards of practice—packaging, labeling and records of prescription drugs dispensed by a physician.**

**13.1(1)** A physician shall dispense a prescription drug only in a container which meets the requirements of the Poison Prevention Packaging Act of 1970, 15 U.S.C. ss. 1471-1476 (2001), unless otherwise requested by the patient, and of Section 502G of the Federal Food, Drug and Cosmetic Act, 21 U.S.C. ss. 301 et seq. (2001).

**13.1(2)** A label shall be affixed to a container in which a prescription drug is dispensed by a physician which shall include:

1. The name and address of the physician.
2. The name of the patient.
3. The date dispensed.
4. The directions for administering the prescription drug and any cautionary statement deemed appropriate by the physician.
5. The name and strength of the prescription drug in the container.

**13.1(3)** The provisions of subrules 13.1(1) and 13.1(2) shall not apply to packaged drug samples.

**13.1(4)** A physician shall keep a record of all prescription drugs dispensed by the physician to a patient which shall contain the information required by subrule 13.1(2) to be included on the label. Noting such information on the patient's chart or record maintained by the physician is sufficient.

This rule is intended to implement Iowa Code sections 147.55, 148.6, 272C.3 and 272C.4.

**653—13.2(148,272C) Standards of practice—appropriate pain management.** This rule establishes standards of practice for the management of acute and chronic pain. The board encourages the use of adjunct therapies such as acupuncture, physical therapy and massage in the treatment of acute and chronic pain. This rule focuses on prescribing and administering controlled substances to provide relief and eliminate suffering for patients with acute or chronic pain.

1. This rule is intended to encourage appropriate pain management, including the use of controlled substances for the treatment of pain, while stressing the need to establish safeguards to minimize the potential for substance abuse and drug diversion.

2. The goal of pain management is to treat each patient's pain in relation to the patient's overall health, including physical function and psychological, social and work-related factors. At the end of life, the goals may shift to palliative care.

3. The board recognizes that pain management, including the use of controlled substances, is an important part of general medical practice. Unmanaged or inappropriately treated pain impacts patients' quality of life, reduces patients' ability to be productive members of society, and increases patients' use of health care services.

4. Physicians should not fear board action for treating pain with controlled substances as long as the physicians' prescribing is consistent with appropriate pain management practices. Dosage alone is not the sole measure of determining whether a physician has complied with appropriate pain management practices. The board recognizes the complexity of treating patients with chronic pain or a substance abuse history. Generally, the board is concerned about a pattern of improper pain management or a single occurrence of willful or gross overtreatment or undertreatment of pain.

5. The board recognizes that the undertreatment of pain is a serious public health problem that results in decreases in patients' functional status and quality of life, and that adequate access by patients to proper pain treatment is an important objective of any pain management policy.

6. Inappropriate pain management may include nontreatment, undertreatment, overtreatment, and the continued use of ineffective treatments. Inappropriate pain management is a departure from the acceptable standard of practice in Iowa and may be grounds for disciplinary action.

**13.2(1) Definitions.** For the purposes of this rule, the following terms are defined as follows:

“*Acute pain*” means the normal, predicted physiological response to a noxious chemical, thermal or mechanical stimulus and typically is associated with invasive procedures, trauma and disease. Generally, acute pain is self-limited, lasting no more than a few weeks following the initial stimulus.

“*Addiction*” means a primary, chronic, neurobiologic disease, with genetic, psychosocial, and environmental factors influencing its development and manifestations. It is characterized by behaviors that include the following: impaired control over drug use, craving, compulsive use, and continued use despite harm. Physical dependence and tolerance are normal physiological consequences of extended opioid therapy for pain and are not the same as addiction.

“*Chronic pain*” means persistent or episodic pain of a duration or intensity that adversely affects the functioning or well-being of a patient when (1) no relief or cure for the cause of pain is possible; (2) no relief or cure for the cause of pain has been found; or (3) relief or cure for the cause of pain through other medical procedures would adversely affect the well-being of the patient. If pain persists beyond the anticipated healing period of a few weeks, patients should be thoroughly evaluated for the presence of chronic pain.

“*Pain*” means an unpleasant sensory and emotional experience associated with actual or potential tissue damage or described in terms of such damage. Pain is an individual, multifactorial experience influenced by culture, previous pain events, beliefs, mood and ability to cope.

“*Physical dependence*” means a state of adaptation that is manifested by drug class-specific signs and symptoms that can be produced by abrupt cessation, rapid dose reduction, decreasing blood level of the drug, or administration of an antagonist. Physical dependence, by itself, does not equate with addiction.

“*Pseudoaddiction*” means an iatrogenic syndrome resulting from the misinterpretation of relief-seeking behaviors as though they are drug-seeking behaviors that are commonly seen with addiction. The relief-seeking behaviors resolve upon institution of effective analgesic therapy.

“*Substance abuse*” means the use of a drug, including alcohol, by the patient in an inappropriate manner that may cause harm to the patient or others, or the use of a drug for an indication other than that intended by the prescribing clinician. An abuser may or may not be physically dependent on or addicted to the drug.

“*Tolerance*” means a physiological state resulting from regular use of a drug in which an increased dosage is needed to produce a specific effect, or a reduced effect is observed with a constant dose over time. Tolerance may or may not be evident during opioid treatment and does not equate with addiction.

“*Undertreatment of pain*” means the failure to properly assess, treat and manage pain or the failure to appropriately document a sound rationale for not treating pain.

**13.2(2)** *Laws and regulations governing controlled substances.* Nothing in this rule relieves a physician from fully complying with applicable federal and state laws and regulations governing controlled substances.

**13.2(3)** *Undertreatment of pain.* The undertreatment of pain is a departure from the acceptable standard of practice in Iowa. Undertreatment may include a failure to recognize symptoms and signs of pain, a failure to treat pain within a reasonable amount of time, a failure to allow interventions, e.g., analgesia, to become effective before invasive steps are taken, a failure to address pain needs in patients with reduced cognitive status, a failure to use controlled substances for terminal pain due to the physician’s concern with addicting the patient, or a failure to use an adequate level of pain management.

**13.2(4)** *Assessment and treatment of acute pain.* Appropriate assessment of the etiology of the pain is essential to the appropriate treatment of acute pain. Acute pain is not a diagnosis; it is a symptom. Prescribing controlled substances for the treatment of acute pain should be based on clearly diagnosed and documented pain. Appropriate management of acute pain should include an assessment of the mechanism, type and intensity of pain. The patient’s medical record should clearly document a medical history, a pain history, a clinical examination, a medical diagnosis and a treatment plan.

**13.2(5)** *Effective management of chronic pain.* Prescribing controlled substances for the treatment of chronic pain should only be accomplished within an established physician-patient relationship and should be based on clearly diagnosed and documented unrelieved pain. To ensure that chronic pain is properly assessed and treated, a physician who prescribes or administers controlled substances to a

patient for the treatment of chronic pain shall exercise sound clinical judgment and establish an effective pain management plan in accordance with the following:

*a. Patient evaluation.* A patient evaluation that includes a physical examination and a comprehensive medical history shall be conducted prior to the initiation of treatment. The evaluation shall also include an assessment of the pain, physical and psychological function, diagnostic studies, previous interventions, including medication history, substance abuse history and any underlying or coexisting conditions. Consultation/referral to a physician with expertise in pain medicine, addiction medicine or substance abuse counseling or a physician who specializes in the treatment of the area, system, or organ perceived to be the source of the pain may be warranted depending upon the expertise of the physician and the complexity of the presenting patient. Interdisciplinary evaluation is strongly encouraged.

*b. Treatment plan.* The physician shall establish a comprehensive treatment plan that tailors drug therapy to the individual needs of the patient. To ensure proper evaluation of the success of the treatment, the plan shall clearly state the objectives of the treatment, for example, pain relief or improved physical or psychosocial functioning. The treatment plan shall also indicate if any further diagnostic evaluations or treatments are planned and their purposes. The treatment plan shall also identify any other treatment modalities and rehabilitation programs utilized. The patient's short- and long-term needs for pain relief shall be considered when drug therapy is prescribed. The patient's ability to request pain relief as well as the patient setting shall be considered. For example, nursing home patients are unlikely to have their pain control needs assessed on a regular basis, making prn (on an as-needed basis) drugs less effective than drug therapy prescribed for routine administration that can be supplemented if pain is found to be worse. The patient should receive prescriptions for controlled substances from a single physician and a single pharmacy whenever possible.

*c. Informed consent.* The physician shall document discussion of the risks and benefits of controlled substances with the patient or person representing the patient.

*d. Periodic review.* The physician shall periodically review the course of drug treatment of the patient and the etiology of the pain. The physician should adjust drug therapy to the individual needs of each patient. Modification or continuation of drug therapy by the physician shall be dependent upon evaluation of the patient's progress toward the objectives established in the treatment plan. The physician shall consider the appropriateness of continuing drug therapy and the use of other treatment modalities if periodic reviews indicate that the objectives of the treatment plan are not being met or that there is evidence of diversion or a pattern of substance abuse. Long-term opioid treatment is associated with the development of tolerance to its analgesic effects. There is also evidence that opioid treatment may paradoxically induce abnormal pain sensitivity, including hyperalgesia and allodynia. Thus, increasing opioid doses may not improve pain control and function.

*e. Consultation/referral.* A specialty consultation may be considered at any time if there is evidence of significant adverse effects or lack of response to the medication. Pain, physical medicine, rehabilitation, general surgery, orthopedics, anesthesiology, psychiatry, neurology, rheumatology, oncology, addiction medicine, or other consultation may be appropriate. The physician should also consider consultation with, or referral to, a physician with expertise in addiction medicine or substance abuse counseling, if there is evidence of diversion or a pattern of substance abuse. The board encourages a multidisciplinary approach to chronic pain management, including the use of adjunct therapies such as acupuncture, physical therapy and massage.

*f. Documentation.* The physician shall keep accurate, timely, and complete records that detail compliance with this subrule, including patient evaluation, diagnostic studies, treatment modalities, treatment plan, informed consent, periodic review, consultation, and any other relevant information about the patient's condition and treatment.

*g. Pain management agreements.* A physician who treats patients for chronic pain with controlled substances shall consider using a pain management agreement with each patient being treated that specifies the rules for medication use and the consequences for misuse. In determining whether to use a pain management agreement, a physician shall evaluate each patient, taking into account the risks to the patient and the potential benefits of long-term treatment with controlled substances. A physician who

prescribes controlled substances to a patient for more than 90 days for treatment of chronic pain shall utilize a pain management agreement if the physician has reason to believe a patient is at risk of drug abuse or diversion. If a physician prescribes controlled substances to a patient for more than 90 days for treatment of chronic pain and chooses not to use a pain management agreement, then the physician shall document in the patient's medical records the reason(s) why a pain management agreement was not used. Use of pain management agreements is not necessary for hospice or nursing home patients. A sample pain management agreement and prescription drug risk assessment tools may be found on the board's Web site at [www.medicalboard.iowa.gov](http://www.medicalboard.iowa.gov).

*h. Substance abuse history or comorbid psychiatric disorder.* A patient's prior history of substance abuse does not necessarily contraindicate appropriate pain management. However, treatment of patients with a history of substance abuse or with a comorbid psychiatric disorder may require extra care and communication with the patient, monitoring, documentation, and consultation with or referral to an expert in the management of such patients. The board strongly encourages a multidisciplinary approach for pain management of such patients that incorporates the expertise of other health care professionals.

*i. Drug testing.* A physician who prescribes controlled substances to a patient for more than 90 days for the treatment of chronic pain shall consider utilizing drug testing to ensure that the patient is receiving appropriate therapeutic levels of prescribed medications or if the physician has reason to believe that the patient is at risk of drug abuse or diversion.

*j. Termination of care.* The physician shall consider termination of patient care if there is evidence of noncompliance with the rules for medication use, drug diversion, or a repeated pattern of substance abuse.

**13.2(6) Pain management for terminal illness.** The provisions of this subrule apply to patients who are at the stage in the progression of cancer or other terminal illness when the goal of pain management is comfort care. When the goal of treatment shifts to comfort care rather than cure of the underlying condition, the board recognizes that the dosage level of opiates or controlled substances to control pain may exceed dosages recommended for chronic pain and may come at the expense of patient function. The determination of such pain management should involve the patient, if possible, and others the patient has designated for assisting in end-of-life care.

**13.2(7) Prescription monitoring program.** The Iowa board of pharmacy has established a prescription monitoring program pursuant to Iowa Code sections 124.551 to 124.558 to assist prescribers and pharmacists in monitoring the prescription of controlled substances to patients. The board recommends that physicians utilize the prescription monitoring program when prescribing controlled substances to patients if the physician has reason to believe that a patient is at risk of drug abuse or diversion. A link to the prescription monitoring program may be found at the board's Web site at [www.medicalboard.iowa.gov](http://www.medicalboard.iowa.gov).

**13.2(8) Pain management resources.** The board strongly recommends that physicians consult the following resources regarding the proper treatment of chronic pain. This list is provided for the convenience of licensees, and the publications included are not intended to be incorporated in the rule by reference.

*a.* American Academy of Hospice and Palliative Medicine or AAHPM is the American Medical Association-recognized specialty society of physicians who practice in hospice and palliative medicine in the United States. The mission of the AAHPM is to enhance the treatment of pain at the end of life.

*b.* American Academy of Pain Medicine or AAPM is the American Medical Association-recognized specialty society of physicians who practice pain medicine in the United States. The mission of the AAPM is to enhance pain medicine practice by promoting a climate conducive to the effective and efficient practice of pain medicine.

*c.* American Pain Society or APS is the national chapter of the International Association for the Study of Pain, an organization composed of physicians, nurses, psychologists, scientists and other professionals who have an interest in the study and treatment of pain. The mission of the APS is to serve people in pain by advancing research, education, treatment and professional practice.

*d.* DEA Policy Statement: Dispensing Controlled Substances for the Treatment of Pain. On August 28, 2006, the Drug Enforcement Agency (DEA) issued a policy statement establishing

guidelines for practitioners who dispense controlled substances for the treatment of pain. This policy statement may be helpful to practitioners who treat pain with controlled substances.

*e.* Interagency Guideline on Opioid Dosing for Chronic Non-cancer Pain. In March 2007, the Washington State Agency Medical Directors' Group published an educational pilot to improve care and safety of patients with chronic, noncancer pain who are treated with opioids. The guidelines include opioid dosing recommendations.

*f.* Responsible Opioid Prescribing: A Physician's Guide. In 2007, in collaboration with author Scott Fishman, M.D., the Federation of State Medical Boards' (FSMB) Research and Education Foundation published a book on responsible opioid prescribing based on the FSMB Model Policy for the Use of Controlled Substances for the Treatment of Pain.

*g.* World Health Organization: Pain Relief Ladder. Cancer pain relief and palliative care. Technical report series 804. Geneva: World Health Organization.  
[ARC 9599B, IAB 7/13/11, effective 8/17/11]

**653—13.3(147) Supervision of pharmacists who administer adult immunizations.** Rescinded ARC 1033C, IAB 10/2/13, effective 11/6/13.

**653—13.4(148) Supervision of pharmacists engaged in collaborative drug therapy management.** A supervising physician may only delegate aspects of drug therapy management to an authorized pharmacist pursuant to a written protocol with a pharmacist pursuant to the requirements of this rule. The physician is considered the supervisor and retains the ultimate responsibility for the care of the patient. The authorized pharmacist retains full responsibility for proper execution of pharmacy practice.

**13.4(1) Definitions.**

*"Authorized pharmacist"* means an Iowa-licensed pharmacist who meets the training requirements of the Iowa board of pharmacy (IBP) as specified in the drug therapy management criteria in 657—8.34(155A).

*"Board"* means the board of medicine of the state of Iowa.

*"Collaborative drug therapy management"* means participation by a physician and an authorized pharmacist in the management of drug therapy pursuant to a written community practice protocol or a written hospital practice protocol.

*"Collaborative practice"* means that a physician may delegate aspects of drug therapy management for the physician's patients to an authorized pharmacist through a written community practice protocol. "Collaborative practice" also means that a P&T committee may authorize hospital pharmacists to perform drug therapy management for inpatients and the hospital's clinic patients through a hospital practice protocol when the clinic and the pharmacist are under the direct authority of the hospital's P&T committee.

*"Community practice protocol"* means a written, executed agreement entered into voluntarily between a physician and an authorized pharmacist establishing drug therapy management for one or more of the physician's patients residing in a community setting. A community practice protocol shall comply with the requirements of subrule 13.4(2).

*"Community setting"* means a location outside a hospital inpatient, acute care setting or a hospital clinic setting. A community setting may include, but is not limited to, a home, group home, assisted living facility, correctional facility, hospice, or long-term care facility.

*"Hospital clinic"* means an outpatient care clinic operated and affiliated with a hospital and under the direct authority of the hospital's P&T committee.

*"Hospital pharmacist"* means an Iowa-licensed pharmacist who meets the requirements for participating in a hospital practice protocol as determined by the hospital's P&T committee.

*"Hospital practice protocol"* means a written plan, policy, procedure, or agreement that authorizes drug therapy management between physicians and hospital pharmacists within a hospital and its clinics as developed and determined by its P&T committee. Such a protocol may apply to all physicians and hospital pharmacists at a hospital or the hospital's clinics under the direct authority of the hospital's

P&T committee or only to those physicians and pharmacists who are specifically recognized. A hospital practice protocol shall comply with the requirements of subrule 13.4(3).

“*IBP*” means the Iowa board of pharmacy.

“*P&T committee*” means a committee of the hospital composed of physicians, pharmacists, and other health professionals that evaluates the clinical use of drugs within the hospital, develops policies for managing drug use and administration in the hospital, and manages the hospital drug formulary system.

“*Physician*” means a person who is currently licensed in Iowa to practice medicine and surgery or osteopathic medicine and surgery. A physician who executes a written protocol with an authorized pharmacist shall supervise the pharmacist’s activities involved in the overall management of patients receiving medications or disease management services under the protocol. The physician may delegate only drug therapies that are in areas common to the physician’s practice.

“*Therapeutic interchange*” means an authorized exchange of therapeutic alternate drug products in accordance with a previously established and approved written protocol.

**13.4(2) Community practice protocol.**

a. A physician shall engage in collaborative drug therapy management with a pharmacist only under a written protocol that is identified by topic and has been submitted to the IBP or a committee authorized by the IBP. A protocol executed after July 1, 2008, will no longer be required to be submitted to the IBP; however, written protocols executed or renewed after July 1, 2008, shall be made available upon request of the board or the IBP.

b. The community practice protocol shall include:

(1) The name, signature, date and contact information for each authorized pharmacist who is a party to the protocol and is eligible to manage the drug therapy of a particular patient. If more than one authorized pharmacist is a party to the agreement, the pharmacists shall work for a single licensed pharmacy and a principal pharmacist shall be designated in the protocol.

(2) The name, signature, date and contact information for each physician who may prescribe drugs and is responsible for supervising a patient’s drug therapy management. The physician who initiates a protocol shall be considered the main caregiver for the patient respective to that protocol and shall be noted in the protocol as the principal physician.

(3) The name and contact information of the principal physician and the principal authorized pharmacist who are responsible for development, training, administration, and quality assurance of the protocol.

(4) A detailed written protocol pursuant to which the authorized pharmacist will base drug therapy management decisions for patients. The protocol shall authorize one or more of the following:

1. Prescription drug orders. The protocol may authorize therapeutic interchange or modification of drug dosages based on symptoms or laboratory or physical findings defined in the protocol. The protocol shall include information specific to the dosage, frequency, duration and route of administration of the drug authorized by the patient’s physician. The protocol shall not authorize the pharmacist to change a Schedule II drug or initiate a drug not included in the established protocol.

2. Laboratory tests. The protocol may authorize the pharmacist to obtain or conduct specific laboratory tests as long as the tests relate directly to the drug therapy management.

3. Physical findings. The protocol may authorize the pharmacist to check certain physical findings, e.g., vital signs, oximetry, or peak flows, that enable the pharmacist to assess and adjust the drug therapy, detect adverse drug reactions or determine if the patient should be referred back to the patient’s physician for follow-up.

4. Patient activities. The protocol may authorize the pharmacist to monitor specific patient activities.

(5) Procedures for the physician to secure the patient’s written consent. If the physician does not secure the patient’s written consent, the pharmacist shall secure such and notify the patient’s physician within 24 hours.

(6) Circumstances that shall cause the pharmacist to initiate communication with the physician, including but not limited to the need for new prescription orders and reports of the patient’s therapeutic response or adverse reaction.

(7) A detailed statement identifying the specific drugs, laboratory tests and physical findings upon which the pharmacist shall base drug therapy management decisions.

(8) A provision for the collaborative drug therapy protocol to be reviewed, updated and reexecuted or discontinued at least every two years.

(9) A description of the method the pharmacist shall use to document the pharmacist's decisions or recommendations for the physician.

(10) A description of the types of reports the physician requires the pharmacist to provide and the schedule by which the pharmacist is to submit these reports. The schedule shall include a time frame in which a pharmacist shall report any adverse reaction to the physician.

(11) A statement of the medication categories and the type of initiation and modification of drug therapy that the physician authorizes the pharmacist to perform.

(12) A description of the procedures or plan that the pharmacist shall follow if the pharmacist modifies a drug therapy.

(13) Procedures for record keeping, record sharing and long-term record storage.

(14) Procedures to follow in emergency situations.

(15) A statement that prohibits the pharmacist from delegating drug therapy management to anyone other than another authorized pharmacist who has signed the applicable protocol.

(16) A statement that prohibits a physician from delegating collaborative drug therapy management to any unlicensed or licensed person other than another physician or authorized pharmacist.

(17) A description of the mechanism for the pharmacist and physician to communicate with each other and for documentation by the pharmacist of the implementation of collaborative drug therapy.

*c.* Collaborative drug therapy management is valid only when initiated by a written protocol executed by at least the patient's physician and one authorized pharmacist.

*d.* A collaborative drug therapy management protocol must be filed with the IBP, kept on file in the pharmacy and made available to the board or IBP upon request. A protocol executed after July 1, 2008, will no longer be required to be submitted to the IBP; however, written protocols executed or renewed after July 1, 2008, shall be made available upon request of the board or the IBP.

*e.* A physician may terminate or amend the collaborative drug therapy management protocol with an authorized pharmacist if the physician notifies, in writing, the pharmacist and the IBP. Notification shall include the name of the authorized pharmacist, the desired change, and the proposed effective date of the change. After July 1, 2008, the physician shall no longer be required to notify the IBP of changes in the protocol.

*f.* Patient consent for community practice protocols. The physician or pharmacist who initiates a protocol with a patient is responsible for securing a patient's written consent to participate in drug therapy management and for transmitting a copy of the consent to the other party within 24 hours. The consent shall indicate which protocol is involved. Any variation in the protocol for a specific patient needs to be communicated to the other party at the time of securing the patient's consent. The patient's physician shall maintain the patient consent in the patient's medical record.

**13.4(3) Hospital practice protocol.**

*a.* A hospital's P&T committee shall determine the scope and extent of collaborative drug therapy management practices that may be conducted by its hospital pharmacists in the hospital and its clinics. Hospital clinics are restricted to outpatient care clinics operated and affiliated with a hospital and under the direct authority of the hospital's P&T committee.

*b.* Collaborative drug therapy management within a hospital setting or the hospital's clinic setting is valid only when approved by the hospital's P&T committee.

*c.* The hospital practice protocol shall include:

(1) The names or groups of physicians and pharmacists who are authorized by the P&T committee to participate in collaborative drug therapy management.

(2) A plan for development, training, administration, and quality assurance of the protocol.

(3) A detailed written protocol pursuant to which the hospital pharmacist shall base drug therapy management decisions for patients. The protocol shall authorize one or more of the following:

1. Medication orders and prescription drug orders. The protocol may authorize therapeutic interchange or modification of drug dosages based on symptoms or laboratory or physical findings defined in the protocol. The protocol shall include information specific to the dosage, frequency, duration and route of administration of the drug authorized by the physician. The protocol shall not authorize the hospital pharmacist to change a Schedule II drug or initiate a drug not included in the established protocol.

2. Laboratory tests. The protocol may authorize the hospital pharmacist to obtain or conduct specific laboratory tests as long as the tests relate directly to the drug therapy management.

3. Physical findings. The protocol may authorize the hospital pharmacist to check certain physical findings, e.g., vital signs, oximetry, or peak flows, that enable the pharmacist to assess and adjust the drug therapy, detect adverse drug reactions or determine if the patient should be referred back to the physician for follow-up.

(4) Circumstances that shall cause the hospital pharmacist to initiate communication with the patient's physician, including but not limited to the need for new medication orders and prescription drug orders and reports of a patient's therapeutic response or adverse reaction.

(5) A statement of the medication categories and the type of initiation and modification of drug therapy that the protocol authorizes the hospital pharmacist to perform.

(6) A description of the procedures or plan that the hospital pharmacist shall follow if the hospital pharmacist modifies a drug therapy.

(7) A description of the mechanism for the hospital pharmacist and the patient's physician to communicate and for the hospital pharmacist to document implementation of the collaborative drug therapy.

This rule is intended to implement Iowa Code chapter 148.

**653—13.5(147,148) Standards of practice—chelation therapy.** Chelation therapy or disodium ethylene diamine tetra acetic acid (EDTA) may only be used for the treatment of heavy metal poisoning or in the clinical setting when a licensee experienced in clinical investigations conducts a carefully controlled clinical investigation of its effectiveness in treating other diseases or medical conditions under a research protocol that has been approved by an institutional review board of the University of Iowa or Des Moines University—Osteopathic Medical Center.

This rule is intended to implement Iowa Code chapters 147 and 148.

**653—13.6(79GA, HF726) Standards of practice—automated dispensing systems.** A physician who dispenses prescription drugs via an automated dispensing system or a dispensing system that employs technology may delegate nonjudgmental dispensing functions to staff assistants in the absence of a pharmacist or physician provided that the physician utilizes an internal quality control assurance plan that ensures that the medication dispensed is the medication that was prescribed. The physician shall be physically present to determine the accuracy and completeness of any medication that is reconstituted prior to dispensing.

**13.6(1)** An internal quality control assurance plan shall include the following elements:

- a. The name of the physician responsible for the internal quality assurance plan and testing;
- b. Methods that the dispensing system employs, e.g., bar coding, to ensure the accuracy of the patient's name and medication, dosage, directions and amount of medication prescribed;
- c. Standards that the physician expects to be met to ensure the accuracy of the dispensing system and the training and qualifications of staff members assigned to dispense via the dispensing system;
- d. The procedures utilized to ensure that the physician(s) dispensing via the automated system provide(s) patients counseling regarding the prescription drugs being dispensed;
- e. Staff training and qualifications for dispensing via the dispensing system;
- f. A list of staff members who meet the qualifications and who are assigned to dispense via the dispensing system;
- g. A plan for testing the dispensing system and each staff member assigned to dispense via the dispensing system;

- h.* The results of testing that show compliance with the standards prior to implementation of the dispensing system and prior to approval of each staff member to dispense via the dispensing system;
- i.* A plan for interval testing of the accuracy of dispensing, at least annually; and
- j.* A plan for addressing inaccuracies, including discontinuing dispensing until the accuracy level can be reattained.

**13.6(2)** Those dispensing systems already in place shall show evidence of a plan and testing within two months of August 31, 2001.

**13.6(3)** The internal quality control assurance plan shall be submitted to the board of medicine upon request.

This rule is intended to implement Iowa Code section 147.107 and 2001 Iowa Acts, House File 726, section 5(10), paragraph “i.”

**653—13.7(147,148,272C) Standards of practice—office practices.**

**13.7(1)** *Termination of the physician-patient relationship.* A physician may choose whom to serve. Having undertaken the care of a patient, the physician may not neglect the patient. A physician shall provide a patient written notice of the termination of the physician-patient relationship. A physician shall ensure that emergency medical care is available to the patient during the 30-day period following notice of the termination of the physician-patient relationship.

**13.7(2)** *Patient referrals.* A physician shall not pay or receive compensation for patient referrals.

**13.7(3)** *Confidentiality.* A physician shall maintain the confidentiality of all patient information obtained in the practice of medicine. Information shall be divulged by the physician when authorized by law or the patient or when required for patient care.

**13.7(4)** *Sexual conduct.* It is unprofessional and unethical conduct, and is grounds for disciplinary action, for a physician to engage in conduct which violates the following prohibitions:

*a.* In the course of providing medical care, a physician shall not engage in contact, touching, or comments of a sexual nature with a patient, or with the patient’s parent or guardian if the patient is a minor.

*b.* A physician shall not engage in any sexual conduct with a patient when that conduct occurs concurrent with the physician-patient relationship, regardless of whether the patient consents to that conduct.

*c.* A physician shall not engage in any sexual conduct with a former patient unless the physician-patient relationship was completely terminated before the sexual conduct occurred. In considering whether that relationship was completely terminated, the board will consider the duration of the physician-patient relationship, the nature of the medical services provided, the lapse of time since the physician-patient relationship ended, the degree of dependence in the physician-patient relationship, and the extent to which the physician used or exploited the trust, knowledge, emotions, or influence derived from the physician-patient relationship.

*d.* A psychiatrist, or a physician who provides mental health counseling to a patient, shall never engage in any sexual conduct with a current or former patient, or with that patient’s parent or guardian if the patient was a minor, regardless of whether the patient consents to that conduct.

**13.7(5)** *Disruptive behavior.* A physician shall not engage in disruptive behavior. Disruptive behavior is defined as a pattern of contentious, threatening, or intractable behavior that interferes with, or has the potential to interfere with, patient care or the effective functioning of health care staff.

**13.7(6)** *Sexual harassment.* A physician shall not engage in sexual harassment. Sexual harassment is defined as verbal or physical conduct of a sexual nature which interferes with another health care worker’s performance or creates an intimidating, hostile or offensive work environment.

**13.7(7)** *Transfer of medical records.* A physician must provide a copy of all medical records generated by the physician in a timely manner to the patient or another physician designated by the patient, upon written request when legally requested to do so by the subject patient or by a legally designated representative of the subject patient, except as otherwise required or permitted by law.

**13.7(8)** *Retention of medical records.* The following paragraphs become effective on January 1, 2004.

a. A physician shall retain all medical records, not appropriately transferred to another physician or entity, for at least seven years from the last date of service for each patient, except as otherwise required by law.

b. A physician must retain all medical records of minor patients, not appropriately transferred to another physician or entity, for a period consistent with that established by Iowa Code section 614.8.

c. Upon a physician's death or retirement, the sale of a medical practice or a physician's departure from the physician's medical practice:

(1) The physician or the physician's representative must ensure that all medical records are transferred to another physician or entity that is held to the same standards of confidentiality and agrees to act as custodian of the records.

(2) The physician shall notify all active patients that their records will be transferred to another physician or entity that will retain custody of their records and that, at their written request, the records will be sent to the physician or entity of the patient's choice.

**653—13.8(148,272C) Standards of practice—medical directors at medical spas—delegation and supervision of medical aesthetic services performed by qualified licensed or certified nonphysician persons.** This rule establishes standards of practice for a physician or surgeon or osteopathic physician or surgeon who serves as a medical director at a medical spa.

**13.8(1) Definitions.** As used in this rule:

*"Alter"* means to change the cellular structure of living tissue.

*"Capable of"* means any means, method, device or instrument which, if used as intended or otherwise to its greatest strength, has the potential to alter or damage living tissue below the superficial epidermal cells.

*"Damage"* means to cause a harmful change in the cellular structure of living tissue.

*"Delegate"* means to entrust or transfer the performance of a medical aesthetic service to qualified licensed or certified nonphysician persons.

*"Medical aesthetic service"* means the diagnosis, treatment, or correction of human conditions, ailments, diseases, injuries, or infirmities of the skin, hair, nails and mucous membranes by any means, methods, devices, or instruments including the use of a biological or synthetic material, chemical application, mechanical device, or displaced energy form of any kind if it alters or damages or is capable of altering or damaging living tissue below the superficial epidermal cells, with the exception of hair removal. Medical aesthetic service includes, but is not limited to, the following services: ablative laser therapy; vaporizing laser therapy; nonsuperficial light device therapy; injectables; tissue alteration services; nonsuperficial light-emitting diode therapy; nonsuperficial intense pulse light therapy; nonsuperficial radiofrequency therapy; nonsuperficial ultrasonic therapy; nonsuperficial exfoliation; nonsuperficial microdermabrasion; nonsuperficial dermaplane exfoliation; nonsuperficial lymphatic drainage; botox injections; collagen injections; and tattoo removal.

*"Medical director"* means a physician who assumes the role of, or holds oneself out as, medical director or a physician who serves as a medical advisor for a medical spa. The medical director is responsible for implementing policies and procedures to ensure quality patient care and for the delegation and supervision of medical aesthetic services to qualified licensed or certified nonphysician persons.

*"Medical spa"* means any entity, however organized, which is advertised, announced, established, or maintained for the purpose of providing medical aesthetic services. Medical spa shall not include a dermatology practice which is wholly owned and controlled by one or more Iowa-licensed physicians if at least one of the owners is actively practicing at each location.

*"Nonsuperficial"* means that the therapy alters or damages or is capable of altering or damaging living tissue below the superficial epidermal cells.

*"Qualified licensed or certified nonphysician person"* means any person who is not licensed to practice medicine and surgery or osteopathic medicine and surgery but who is licensed or certified by another licensing board in Iowa and qualified to perform medical aesthetic services under the supervision of a qualified physician.

“*Supervision*” means the oversight of qualified licensed or certified nonphysician persons who perform medical aesthetic services delegated by a medical director.

**13.8(2) *Practice of medicine.*** The performance of medical aesthetic services is the practice of medicine. A medical aesthetic service shall only be performed by qualified licensed or certified nonphysician persons if the service has been delegated by the medical director who is responsible for supervision of the services performed. A medical director shall not delegate medical aesthetic services to nonphysician persons who are not appropriately licensed or certified in Iowa.

**13.8(3) *Medical director.*** A physician who serves as medical director at a medical spa shall:

- a. Hold an active unrestricted Iowa medical license to supervise each delegated medical aesthetic service;
- b. Possess the appropriate education, training, experience and competence to safely supervise each delegated medical aesthetic service;
- c. Retain responsibility for the supervision of each medical aesthetic service performed by qualified licensed or certified nonphysician persons;
- d. Ensure that advertising activities do not include false, misleading, or deceptive representations; and
- e. Be clearly identified as the medical director in all advertising activities, Internet Web sites and signage related to the medical spa.

**13.8(4) *Delegated medical aesthetic service.*** When a medical director delegates a medical aesthetic service to qualified licensed or certified nonphysician persons, the service shall be:

- a. Within the medical director’s scope of practice and medical competence to supervise;
- b. Of the type that a reasonable and prudent physician would conclude is within the scope of sound medical judgment to delegate; and
- c. A routine and technical service, the performance of which does not require the skill of a licensed physician.

**13.8(5) *Supervision.*** A medical director who delegates performance of a medical aesthetic service to qualified licensed or certified nonphysician persons is responsible for providing appropriate supervision. The medical director shall:

- a. Ensure that all licensed or certified nonphysician persons are qualified and competent to safely perform each medical aesthetic service by personally assessing the person’s education, training, experience and ability;
- b. Ensure that a qualified licensed or certified nonphysician person does not perform any medical aesthetic services which are beyond the scope of that person’s license or certification unless the person is supervised by a qualified supervising physician;
- c. Ensure that all qualified licensed or certified nonphysician persons receive direct, in-person, on-site supervision from the medical director or other qualified licensed physician at least four hours each week and that the regular supervision is documented;
- d. Provide on-site review of medical aesthetic services performed by qualified licensed or certified nonphysician persons each week and review at least 10 percent of patient charts for medical aesthetic services performed by qualified licensed or certified nonphysician persons;
- e. Be physically located, at all times, within 60 miles of the location where qualified licensed or certified nonphysician persons perform medical aesthetic services;
- f. Be available, in person or electronically, at all times, to consult with qualified licensed or certified nonphysician persons who perform medical aesthetic services, particularly in case of injury or an emergency;
- g. Assess the legitimacy and safety of all equipment or other technologies being used by qualified licensed or certified nonphysician persons who perform medical aesthetic services;
- h. Develop and implement protocols for responding to emergencies or other injuries suffered by persons receiving medical aesthetic services performed by qualified licensed or certified nonphysician persons;
- i. Ensure that all qualified licensed or certified nonphysician persons maintain accurate and timely medical records for the medical aesthetic services they perform;

*j.* Ensure that each patient provides appropriate informed consent for medical aesthetic services performed by the medical director or other qualified licensed physician and all qualified licensed or certified nonphysician persons and that such informed consent is timely documented in the patient's medical record;

*k.* Ensure that the identity and licensure and certification of the medical director, other qualified licensed physicians and all licensed or certified nonphysician persons are visibly displayed at each medical spa and provided in writing to each patient receiving medical aesthetic services at a medical spa; and

*l.* Ensure that the board receives written verification of the education and training of all qualified licensed or certified nonphysician persons who perform medical aesthetic services at a medical spa, within 14 days of a request by the board.

**13.8(6) Exceptions.** This rule is not intended to apply to physicians who serve as medical directors of licensed medical facilities, clinics or practices that provide medical aesthetic services as part of or incident to their other medical services.

**13.8(7) Physician assistants.** Nothing in these rules shall be interpreted to contradict or supersede the rules established in 645—Chapters 326 and 327.

[ARC 9088B, IAB 9/22/10, effective 10/27/10]

**653—13.9(147,148,272C) Standards of practice—interventional chronic pain management.** This rule establishes standards of practice for the practice of interventional chronic pain management. The purpose of this rule is to assist physicians who consider interventional techniques to treat patients with chronic pain.

**13.9(1) Definition.** As used in this rule:

“*Interventional chronic pain management*” means the diagnosis and treatment of pain-related disorders with the application of interventional techniques in managing subacute, chronic, persistent, and intractable pain. Interventional techniques include percutaneous (through the skin) needle placement to inject drugs in targeted areas. Interventional techniques also include nerve ablation (excision or amputation) and certain surgical procedures. Interventional techniques often involve injection of steroids, analgesics, and anesthetics and include: lumbar, thoracic, and cervical spine injections, intra-articular injections, intrathecal injections, epidural injections (both regular and transforaminal), facet injections, discography, nerve destruction, occipital nerve blocks, lumbar sympathetic blocks and vertebroplasty, and kyphoplasty. Interventional chronic pain management includes the use of fluoroscopy when it is used to assess the cause of a patient's chronic pain or when it is used to identify anatomic landmarks during interventional techniques. Specific interventional techniques include: SI joint injections; spinal punctures; epidural blood patches; epidural injections; epidural/spinal injections; lumbar injections; epidural/subarachnoid catheters; occipital nerve blocks; axillary nerve blocks; intercostals nerve blocks; multiple intercostals nerve blocks; ilioinguinal nerve blocks; peripheral nerve blocks; facet joint injections; cervical/thoracic facet joint injections; lumbar facet injections; multiple lumbar facet injections; transforaminal epidural steroid injections; transforaminal cervical steroid injections; sphenopalatine ganglion blocks; paravertebral sympathetic blocks; neurolysis of the lumbar facet nerve; neurolysis of the cervical facet nerve; and destruction of the peripheral nerve.

**13.9(2) Interventional chronic pain management.** The practice of interventional chronic pain management shall include the following:

- a.* Comprehensive assessment of the patient;
- b.* Diagnosis of the cause of the patient's pain;
- c.* Evaluation of alternative treatment options;
- d.* Selection of appropriate treatment options;
- e.* Termination of prescribed treatment options when appropriate;
- f.* Follow-up care; and
- g.* Collaboration with other health care providers.

**13.9(3) Practice of medicine.** Interventional chronic pain management is the practice of medicine.

[ARC 8918B, IAB 6/30/10, effective 8/4/10]

**653—13.10(147,148,272C) Standards of practice—physicians who prescribe or administer abortion-inducing drugs.**

**13.10(1) Definition.** As used in this rule:

“*Abortion-inducing drug*” means a drug, medicine, mixture, or preparation, when it is prescribed or administered with the intent to terminate the pregnancy of a woman known to be pregnant.

**13.10(2) Physical examination required.** A physician shall not induce an abortion by providing an abortion-inducing drug unless the physician has first performed a physical examination of the woman to determine, and document in the woman’s medical record, the gestational age and intrauterine location of the pregnancy.

**13.10(3) Physician’s physical presence required.** When inducing an abortion by providing an abortion-inducing drug, a physician must be physically present with the woman at the time the abortion-inducing drug is provided.

**13.10(4) Follow-up appointment required.** If an abortion is induced by an abortion-inducing drug, the physician inducing the abortion must schedule a follow-up appointment with the woman at the same facility where the abortion-inducing drug was provided, 12 to 18 days after the woman’s use of an abortion-inducing drug to confirm the termination of the pregnancy and evaluate the woman’s medical condition. The physician shall use all reasonable efforts to ensure that the woman is aware of the follow-up appointment and that she returns for the appointment.

**13.10(5) Parental notification regarding pregnant minors.** A physician shall not induce an abortion by providing an abortion-inducing drug to a pregnant minor prior to compliance with the requirements of Iowa Code chapter 135L and rules 641—89.12(135L) and 641—89.21(135L) adopted by the public health department.

[ARC 1034C, IAB 10/2/13, effective 11/6/13]

**653—13.11 to 13.19** Reserved.

**653—13.20(147,148) Principles of medical ethics.** The Code of Medical Ethics (2002-2003) prepared and approved by the American Medical Association and the Code of Ethics (2002-2003) prepared and approved by the American Osteopathic Association shall be utilized by the board as guiding principles in the practice of medicine and surgery and osteopathic medicine and surgery in this state.

**13.20(1) Conflict of interest.** A physician should not provide medical services under terms or conditions which tend to interfere with or impair the free and complete exercise of the physician’s medical judgment and skill or tend to cause a deterioration of the quality of medical care.

**13.20(2) Fees.** Any fee charged by a physician shall be reasonable.

**653—13.21(17A,147,148,272C) Waiver or variance prohibited.** Rules in this chapter are not subject to waiver or variance pursuant to 653—Chapter 3 or any other provision of law.

[Filed 2/5/79, Notice 11/29/78—published 2/21/79, effective 3/29/79]

[Filed 3/13/81, Notice 1/7/81—published 4/1/81, effective 5/6/81]

[Filed emergency 4/15/88—published 5/4/88, effective 4/15/88]

[Filed 5/11/90, Notice 3/7/90—published 5/30/90, effective 6/6/90]

[Filed 3/22/96, Notice 9/27/95—published 4/10/96, effective 6/15/96]

[Filed 11/22/96, Notice 8/28/96—published 12/18/96, effective 1/22/97]

[Filed 5/2/97, Notice 3/26/97—published 5/21/97, effective 6/25/97]

[Filed 11/7/00, Notice 4/19/00—published 11/29/00, effective 1/3/01]

[Filed 12/1/00, Notice 10/18/00—published 12/27/00, effective 1/31/01]

[Filed 2/16/01, Notice 12/27/00—published 3/7/01, effective 4/11/01]

[Filed emergency 8/31/01 after Notice 7/25/01—published 9/19/01, effective 8/31/01]

[Filed 2/14/02, Notice 1/9/02—published 3/6/02, effective 4/10/02]

[Filed 6/6/02, Notice 5/1/02—published 6/26/02, effective 7/31/02]

[Filed 1/3/03, Notice 11/27/02—published 1/22/03, effective 2/26/03]

[Filed 12/4/03, Notice 8/20/03—published 12/24/03, effective 1/28/04]

[Filed 5/20/04, Notice 4/14/04—published 6/9/04, effective 7/14/04]

[Filed 5/3/06, Notice 2/15/06—published 5/24/06, effective 10/1/06]

[Filed 6/28/07, Notice 5/9/07—published 8/1/07, effective 9/5/07]

[Filed 4/3/08, Notice 2/13/08—published 4/23/08, effective 5/28/08]

[Filed 9/18/08, Notice 8/13/08—published 10/8/08, effective 11/12/08]

[Filed ARC 8918B (Notice ARC 8579B, IAB 3/10/10), IAB 6/30/10, effective 8/4/10]

[Filed ARC 9088B (Notice ARC 8925B, IAB 6/30/10), IAB 9/22/10, effective 10/27/10]

[Filed ARC 9599B (Notice ARC 9414B, IAB 3/9/11), IAB 7/13/11, effective 8/17/11]

[Filed ARC 1033C (Notice ARC 0890C, IAB 7/24/13), IAB 10/2/13, effective 11/6/13]

[Filed ARC 1034C (Notice ARC 0891C, IAB 7/24/13), IAB 10/2/13, effective 11/6/13]

<sup>1</sup> Effective date of 13.2(148,272C) delayed 70 days by the Administrative Rules Review Committee at its meeting held May 14, 1996.

**REGENTS BOARD[681]**

[Prior to 4/20/88, Regents, Board of [720]]

## CHAPTER 1

## ADMISSION RULES COMMON TO THE THREE STATE UNIVERSITIES

- 1.1(262) Admission of undergraduate students directly from high school
- 1.2(262) Admission of undergraduate students by transfer from other colleges
- 1.3(262) Transfer credit practices
- 1.4(262) Classification of residents and nonresidents for admission, tuition, and fee purposes
- 1.5(262) Registration and transcripts—general
- 1.6(262) College-bound program
- 1.7(262) Application fees

## CHAPTER 2

## SUPPLEMENTAL SPECIFIC RULES FOR EACH INSTITUTION

## UNIVERSITY OF IOWA

- 2.1(262) Formal application for admission
- 2.2 Reserved
- 2.3(262) College of business administration
- 2.4(262) College of dentistry
- 2.5(262) College of engineering
- 2.6(262) Graduate college
- 2.7(262) College of law
- 2.8(262) College of medicine
- 2.9(262) College of nursing
- 2.10(262) College of pharmacy
- 2.11(262) College of liberal arts
- 2.12(262) College of education
- 2.13 to 2.24 Reserved

## IOWA STATE UNIVERSITY OF SCIENCE AND TECHNOLOGY

- 2.25(262) Undergraduate students
- 2.26(262) College of veterinary medicine
- 2.27(262) Graduate college
- 2.28 to 2.34 Reserved

## UNIVERSITY OF NORTHERN IOWA

- 2.35(262) Admission policies for undergraduate students
- 2.36 Reserved
- 2.37(262) Teaching curricula
- 2.38(262) Admission requirements for graduate students

## CHAPTER 3

## PERSONNEL ADMINISTRATION

## ORGANIZATION AND ADMINISTRATION

- 3.1(8A) Creation and purpose
- 3.2(8A) Covered employees
- 3.3(8A) Administration
- 3.4 to 3.13 Reserved

## DEFINITIONS

- 3.14(8A) Definitions
- 3.15 to 3.24 Reserved

## CLASSIFICATION

- 3.25(8A) Preparation and maintenance of the classification plan
- 3.26(8A) Administration of the classification plan
- 3.27 to 3.36 Reserved

## COMPENSATION PLAN

- 3.37(8A) Preparation, content and adoption of the pay plan
- 3.38(8A) Review and revision of the pay plan
- 3.39(8A) Administration of the pay plan
- 3.40 to 3.49 Reserved

## APPLICATION AND EXAMINATION

- 3.50(8A) Applications
- 3.51(8A) Examinations
- 3.52(8A) Character of examinations
- 3.53 and 3.54 Reserved
- 3.55(8A) Rejection or disqualification of applicants
- 3.56 to 3.66 Reserved

## CERTIFICATION AND SELECTION

- 3.67(8A) Eligibility lists
- 3.68(8A) Personnel requisitions
- 3.69(8A) Certification from eligibility lists
- 3.70(8A) Selection of employees
- 3.71 to 3.80 Reserved

## APPOINTMENTS AND PROBATION

- 3.81(8A) Appointments
- 3.82(8A) Temporary appointments
- 3.83 Reserved
- 3.84(8A) Trainee, apprentice, or career development appointment
- 3.85(8A) Project appointment
- 3.86 Reserved
- 3.87(8A) Permanent appointments
- 3.88 Reserved
- 3.89(8A) Reinstatement
- 3.90(8A) Probationary period
- 3.91 to 3.100 Reserved

## PROMOTIONS, DEMOTIONS, TRANSFERS AND TERMINATIONS

- 3.101(8A) Promotions
- 3.102(8A) Transfers
- 3.103(8A) Demotion (voluntary)
- 3.104(8A) Terminations
- 3.105 to 3.114 Reserved

## DISCIPLINARY ACTIONS

- 3.115(8A) Causes for disciplinary action
- 3.116(8A) Disciplinary actions
- 3.117 to 3.126 Reserved

## GRIEVANCES AND APPEALS

- 3.127(8A) Reviews of position classification
- 3.128(8A) Appeals on application, examination and certification procedures
- 3.129(8A) Grievances
- 3.130 to 3.139 Reserved

## VACATIONS AND LEAVES OF ABSENCE

3.140(8A)	Attendance
3.141(8A)	Vacations
3.142(8A)	Holidays
3.143(8A)	Sick leave
3.144(8A)	Military leave
3.145(8A)	Family leave
3.146(8A)	Court and jury service
3.147(8A)	Voting leave
3.148(8A)	Family care and funeral leave
3.149(8A)	Leave of absence without pay
3.150(8A)	Election leave
3.151(8A)	Disaster service volunteer leave

CHAPTER 4  
TRAFFIC AND PARKING AT UNIVERSITIES

## UNIVERSITY OF IOWA

4.1(262)	Purpose
4.2(262)	Definitions
4.3(262)	General traffic
4.4(262)	Registration
4.5(262)	Parking facilities
4.6(262)	Parking privileges
4.7(262)	Violations
4.8(262)	Administration of rules
4.9 to 4.24	Reserved

## IOWA STATE UNIVERSITY OF SCIENCE AND TECHNOLOGY

4.25(262)	Purpose
4.26(262)	Definitions
4.27(262)	General traffic
4.28(262)	Registration
4.29(262)	Parking facilities
4.30(262)	Parking privileges
4.31(262)	Violations
4.32(262)	Administration of rules
4.33 to 4.65	Reserved

## UNIVERSITY OF NORTHERN IOWA

4.66(262)	Purpose
4.67(262)	Definitions
4.68(262)	Registration
4.69(262)	Parking facilities
4.70(262)	Parking privileges
4.71(262)	Violations
4.72(262)	Effect of rules
4.73(262)	Administration of rules

CHAPTER 5  
STATE HYGIENIC LABORATORY

GENERAL REGULATIONS

- 5.1(263) Scope of services
- 5.2(263) Specimens examined
- 5.3(263) Charges

CHAPTER 6  
Reserved

CHAPTER 7  
EQUAL EMPLOYMENT OPPORTUNITY, AFFIRMATIVE ACTION, AND  
TARGETED SMALL BUSINESS

- 7.1(262) Equal opportunity policy
- 7.2(262) Equal employment opportunity
- 7.3(262) Employment services
- 7.4(262) State educational, counseling, and training programs
- 7.5(262) State services and facilities
- 7.6(262) Contract compliance
- 7.7(73GA,ch315) Targeted small business

CHAPTER 8  
PURCHASING

- 8.1(262) Procurement policy
- 8.2(262) Special considerations
- 8.3 Reserved
- 8.4(262) Insurance purchases
- 8.5 Reserved
- 8.6(262) Capital procedures
- 8.7(262) Insurance deductions
- 8.8(262) Selection of financial advisors
- 8.9(68B,262) Prohibited interest in public contracts

CHAPTER 9  
POLICIES, PRACTICES AND PROCEDURES

- 9.1(262) Uniform rules of personal conduct
- 9.2(262) Transfers
- 9.3(262) Alternate procedures when resources are not adequate
- 9.4(23A) Policy on competition with private enterprise
- 9.5(262) Telecommunications policies and procedures
- 9.6(262) Notification to students on increases in tuition, fees, or charges
- 9.7(262) Distribution of docket information

CHAPTER 10  
RECORDS MANAGEMENT

- 10.1(305) Records management
- 10.2(305) Records system
- 10.3(305) Public inspection

## CHAPTER 11

## BOARD OF REGENTS ORGANIZATION AND GENERAL RULES

11.1(262) Organization

## CHAPTER 12

## UNIVERSITY OF IOWA ORGANIZATION AND GENERAL RULES

12.1(262) Statement of university mission  
 12.2(262) Officers  
 12.3(262) Organization/administration  
 12.4(262) University operations manual  
 12.5(262) Contracting authority  
 12.6(262) No-smoking policy  
 12.7(262) Alcoholic beverage policy  
 12.8(262) Communication, marketing, and public relations  
 12.9(262) Merit system employee grievances  
 12.10(262) Grievance procedure  
 12.11(262) Appeals

## CHAPTER 13

IOWA STATE UNIVERSITY OF SCIENCE AND TECHNOLOGY  
ORGANIZATION AND GENERAL RULES

13.1(262) Organization  
 13.2 to 13.5 Reserved  
 13.6(262) Forms  
 13.7 Reserved  
 13.8(262) Contracting authority  
 13.9(262) Lost and found

## USE OF FACILITIES

13.10(262) General priority for facilities and grounds use  
 13.11(262) Access to facilities and grounds  
 13.12(262) When authorization is required for use of facilities and grounds open for general use  
 13.13(262) Display of noninstructional materials

## STANDARDS OF CONDUCT ON CAMPUS

13.14(262) General rules for facilities and grounds use  
 13.15(262) Commercial and charitable uses  
 13.16(262) Conduct at public events  
 13.17(262) Regulation of smoking, alcohol and food and beverages  
 13.18(262) Animals on campus  
 13.19(262) Authority to order persons off the campus

## CHAPTER 14

THE UNIVERSITY OF NORTHERN IOWA  
ORGANIZATION AND GENERAL RULES

14.1(262) Organization  
 14.2(262) General rules

## CHAPTER 15

IOWA BRAILLE AND SIGHT SAVING SCHOOL  
ORGANIZATION AND GENERAL RULES

15.1(262) Organization  
 15.2 to 15.5 Reserved

15.6(262)	Forms
15.7(262)	Contracting authority
15.8(262)	General rules
15.9(262)	Transportation reimbursement
15.10(262)	Admission requirements

CHAPTER 16  
IOWA SCHOOL FOR THE DEAF  
ORGANIZATION AND GENERAL RULES

16.1(262)	Organization
16.2 to 16.5	Reserved
16.6(262)	Forms
16.7(262)	Contracting authority
16.8(262)	Transportation
16.9(262)	General rules

CHAPTER 17  
PUBLIC RECORDS AND  
FAIR INFORMATION PRACTICES  
(Uniform Rules)

17.1(22)	Definitions
17.3(22)	Requests for access to records
17.6(22)	Procedure by which a subject may have additions, dissents, or objections entered into the record
17.7(22)	Consent to disclosure by the subject of a confidential record
17.9(22)	Disclosures without consent of the subject
17.10(22)	Routine use
17.11(22)	Consensual disclosure of confidential records
17.12(22)	Release to subject
17.13(22)	Availability of records
17.14(22)	Personally identifiable information
17.15(22)	Other groups of records
17.16(22)	Applicability

CHAPTER 18  
DECLARATORY ORDERS

18.1(17A)	Petition for declaratory order
18.2(17A)	Assignment to regent institution
18.3(17A)	Notice of petition
18.4(17A)	Intervention
18.5(17A)	Briefs
18.6(17A)	Inquiries
18.7(17A)	Service and filing of petitions and other papers
18.8(17A)	Action on petition
18.9(17A)	Refusal to issue order
18.10(17A)	Contents of declaratory order—effective date
18.11(17A)	Copies of orders
18.12(17A)	Effect of a declaratory order

CHAPTER 19  
PROCEDURE FOR RULE MAKING

19.1(17A)	Applicability
19.2(17A)	Advice on possible rules before notice of proposed rule adoption

19.3(17A)	Public rule-making docket
19.4(17A)	Notice of proposed rule making
19.5(17A)	Public participation
19.6(17A)	Regulatory analysis
19.7(17A,25B)	Fiscal impact statement
19.8(17A)	Time and manner of rule adoption
19.9(17A)	Variance between adopted rule and published notice of proposed rule adoption
19.10(17A)	Exemptions from public rule-making procedures
19.11(17A)	Concise statement of reasons
19.12(17A)	Contents, style, and form of rule
19.13(17A)	Board of regents rule-making record
19.14(17A)	Filing of rules
19.15(17A)	Effectiveness of rules prior to publication
19.16(17A)	General statements of policy
19.17(17A)	Review of rules by board of regents
19.18(17A)	Waiver or variance from rule

#### CHAPTER 20 CONTESTED CASES

20.1(17A)	Scope and applicability
20.2(17A)	Definitions
20.3(17A)	Time requirements
20.4(17A)	Requests for contested case proceeding
20.5(17A)	Notice of hearing
20.6(17A)	Presiding officer
20.7(17A)	Waiver of procedures
20.8(17A)	Telephone proceedings
20.9(17A)	Disqualification
20.10(17A)	Consolidation—severance
20.11(17A)	Pleadings
20.12(17A)	Service and filing of pleadings and other papers
20.13(17A)	Discovery
20.14(17A)	Subpoenas
20.15(17A)	Motions
20.16(17A)	Prehearing conference
20.17(17A)	Continuances
20.18(17A)	Withdrawals
20.19(17A)	Hearing procedures
20.20(17A)	Evidence
20.21(17A)	Default
20.22(17A)	Ex parte communication
20.23(17A)	Recording costs
20.24(17A)	Interlocutory appeals
20.25(17A)	Final decision
20.26(17A)	Appeals and review—actions by regent institution
20.27(17A)	Appeals to the board of regents
20.28(17A)	Applications for rehearing
20.29(17A)	Stays of board of regents actions
20.30(17A)	No factual dispute contested cases
20.31(17A)	Emergency adjudicative proceedings



CHAPTER 13  
IOWA STATE UNIVERSITY OF SCIENCE AND TECHNOLOGY  
ORGANIZATION AND GENERAL RULES  
[Prior to 4/20/88, Regents, Board of[720]]

**681—13.1(262) Organization.**

**13.1(1) *Statement of university mission.*** Iowa State University of science and technology is a public land-grant institution serving the people of Iowa, the nation, and the world through its interrelated programs of instruction, research, extension and professional service. With an institutional emphasis in areas related to science and technology, the university carries out its traditional mission of discovering, developing, disseminating and preserving knowledge. The university's mission and vision may be found in the strategic plan at [www.president.iastate.edu/planning/strategic/plan.php](http://www.president.iastate.edu/planning/strategic/plan.php).

**13.1(2) *Officers.*** The university has three statutory officers: president, secretary, and treasurer. The president is the chief administrative officer of the university and has authority and duties as have been delegated by the board of regents.

A detailed listing of the university units is shown on the organizational chart at the following Web site: [www.president.iastate.edu/org/univorg.pdf](http://www.president.iastate.edu/org/univorg.pdf).

**13.1(3) *Operations.***

*a.* The senior vice president and provost oversees the academic, research, and extension activities of the university.

*b.* The academic mission of the university is principally carried out through its eight colleges: graduate, agriculture and life sciences, engineering, human sciences, liberal arts and sciences, design, business and veterinary medicine. The dean of each college is its chief administrative officer.

*c.* Extension and outreach are integral parts of the land-grant university system and provide the link whereby the findings of research are taken to the people of Iowa. The chief administrative officer is the vice president for extension and outreach.

*d.* The vice president for research and economic development oversees the university's broad range of research, which contributes to economic development in the state and the nation.

*e.* The senior vice president for student affairs oversees the various services provided to students, including student activities, student health and student housing and dining.

*f.* The senior vice president for business and finance oversees the various business-related functions of the university, including physical plant, safety, accounting and purchasing.

**13.1(4) *Communications.*** Inquiries, submissions, and requests should be addressed to the Office of University Relations. Contact information for the Office of University Relations may be found online at the following address: [www.ur.iastate.edu](http://www.ur.iastate.edu). Communications may also be addressed to the office of the Board of Regents, 11260 Aurora Avenue, Urbandale, Iowa 50322-7905. Generally, inquiries, submissions, and requests by the public may be submitted by informal letter or e-mail. However, application for some purposes is to be made on a specified form. Rule 681—13.6(262) provides an address for obtaining forms.

**13.1(5) *Policy library.*** The university policy library contains the policies governing the internal administrative operation of the university. It is available online at the following address: [www.policy.iastate.edu/](http://www.policy.iastate.edu/). Copies of the policies may be obtained from the Iowa State University Policy Administrator, 3550 Beardshear Hall, telephone (515)294-1385.

[ARC 8070B, IAB 8/26/09, effective 9/30/09; ARC 1078C, IAB 10/2/13, effective 11/6/13]

**681—13.2 to 13.5 Reserved.**

**681—13.6(262) Forms.** The university uses a number of forms (primarily electronic) in dealing with the public. Forms may be found via the University Forms Web site at [www.policy.iastate.edu/forms.php](http://www.policy.iastate.edu/forms.php). [ARC 8070B, IAB 8/26/09, effective 9/30/09; ARC 1078C, IAB 10/2/13, effective 11/6/13]

**681—13.7(262) General rules.** Rescinded IAB 8/7/02, effective 9/11/02.

**681—13.8(262) Contracting authority.**

**13.8(1) General delegation.** Except for authority retained by the board of regents in the rules adopted under [681] of the Iowa Administrative Code or in the regents policy manual, the board of regents has delegated to the president authority to enter into contracts and agreements. The president has delegated authority for entering into such contracts and agreements to the senior vice president for business and finance in all cases except the following:

*a.* Employment contracts and agreements involving deans, directors, department chairs and faculty are signed by the senior vice president and provost.

*b.* Applications, proposals, grants, contracts and agreements relating to economic development, research and sponsored projects are signed by the senior vice president and provost, vice president for research and economic development or the director of the office of sponsored programs administration.

*c.* Contracts and agreements relating to educational consortia, joint educational projects, cooperative education, service-learning and internship opportunities, and academic instruction provided to others are signed by the senior vice president and provost.

**13.8(2) Specific delegations.** Within the limits prescribed by the board of regents, the president, the senior vice president for business and finance, the senior vice president and provost, the vice president for research and economic development, and the director of the office of sponsored programs administration may delegate the authority they have received as provided by the ISU contracting authority policy found in the policy library.

[ARC 8070B, IAB 8/26/09, effective 9/30/09; ARC 1078C, IAB 10/2/13, effective 11/6/13]

**681—13.9(262) Lost and found.** Inquiries about items lost or found may be made by contacting Central Stores at (515)294-5762. A listing of lost and found items may be found at [www.iastate.edu/found/](http://www.iastate.edu/found/).

[ARC 1078C, IAB 10/2/13, effective 11/6/13]

## USE OF FACILITIES

**681—13.10(262) General priority for facilities and grounds use.** University facilities and grounds are primarily dedicated to the university's missions of teaching, research and service. While facilities and grounds are generally open to noncommercial use by the public, students, student organizations and staff, use for other than university-related purposes must not substantially interfere with university activities and must be in conformity with the requirements of this chapter. University-related activities, including the activities of recognized campus and student organizations, will be given priority. (The ISU facilities and grounds use activities policy may be found in the policy library.)

**13.10(1)** Except as specifically indicated, the policies stipulated in rules 681—13.11(262) to 681—13.19(262) are applicable to noncommercial uses.

**13.10(2)** Commercial uses, including solicitation, advertising and sales, are subject to the university's rule on commercial and charitable uses in rule 681—13.15(262).

[ARC 8070B, IAB 8/26/09, effective 9/30/09; ARC 1078C, IAB 10/2/13, effective 11/6/13]

**681—13.11(262) Access to facilities and grounds.** University facilities and grounds are generally open to public access except as provided below:

**13.11(1)** Persons may not enter facilities or grounds without authorization when the facilities or grounds are locked, when signs indicate they are closed to the public or when they are closed to the public for specific events.

**13.11(2)** The following facilities and grounds are restricted areas. Access requires express permission of the relevant building supervisor, superintendent or other person in charge of the facility: individual residences or dwellings; research laboratories or facilities; farms and associated buildings; animal storage and confinement facilities; utility and maintenance closets; mechanical rooms; utility facilities; utility tunnels; storage areas; hazardous materials waste storage and handling areas; marked or fenced construction areas; institutional food preparation areas; private offices; workrooms; shops; areas where medical, psychological or other consultation takes place; radio and television studios; intercollegiate athletics competition facilities; or areas which bear signs indicating that access is

restricted. The university has leased some of its facilities and grounds to other parties for use related to university purposes (for example, the Ames Laboratory and the National Laboratory for Agriculture and the Environment). Such areas are not open to public use except as provided by the lessee of the property or facility. The buildings at the Iowa State Center (Scheman Continuing Education Building, Stephens Auditorium and Fisher Theater) and the Iowa State University Research Park are managed by separate organizations that regulate the use of these facilities and grounds.

**13.11(3)** Access to facilities and grounds may be denied when they are closed to the public for special university events or when access would conflict with an approved use of the facilities or grounds. The university may limit or control access to areas of the campus for ceremonial events and celebrations such as graduation and VEISHEA.

**13.11(4)** Unapproved uses of university facilities and grounds by the general public are subject to preemption for university activities, for use by recognized student and campus organizations and for use by students, faculty and staff for purposes related to the university's mission.

**13.11(5)** Access to performances, art exhibits, museums and other exhibitions may be regulated by requirement of payment of a fee for entry. Visitors are required to abide by policies established for the various facilities and grounds.

**13.11(6)** Access to campus roads and parking is governed by university parking and traffic regulations, as well as signage erected upon campus roadways and parking areas.

[ARC 8070B, IAB 8/26/09, effective 9/30/09; ARC 1078C, IAB 10/2/13, effective 11/6/13]

**681—13.12(262) When authorization is required for use of facilities and grounds open for general use.** To prevent conflicts in the use of facilities and grounds, groups or persons wishing to use facilities and grounds, whether indoors or outdoors, should schedule use of university facilities and grounds as provided in this rule. ISU has designated public forum areas with few restrictions. Public events require filing of a notice, or approval depending on the event. "Public events" are defined as outdoor events in which more than 50 persons are participating or at which the sponsor reasonably expects more than 50 persons to be involved, or indoor events in which more than 15 persons are participating or at which the sponsor reasonably expects more than 15 persons to be involved. Organizations and groups desiring to use university facilities and grounds should contact the offices listed in subrule 13.12(3) to determine availability and fees for use.

**13.12(1) Outdoor areas.**

*a. Designated public forums.* The Edward S. Allen Area of Free Debate, located west and south of the Hub, and the area south of the Campanile have been designated as public forums for noncommercial expression. If these areas have not been reserved for use for university purposes or by student, faculty or staff organizations, any member of the public or of the university community may use these areas for expressive activities on a first-come, first-served basis. Signs or placards, each of which is carried by one or two persons, are permitted. Freestanding displays are permitted as long as the display occupies a space of less than 200 cubic feet and has a footprint of not more than 100 square feet, weighs less than 300 pounds and is accompanied at all times by an individual responsible for the display. Leafleting may be conducted if done in a way that avoids substantial littering of the campus.

*b. Uses that require only notice.* Student organizations, university departments, and others wishing to use outdoor areas other than a designated public forum for a public event must notify the Memorial Union Event Management office. If possible, such notice should be submitted at least 24 hours in advance of the event but, in any case, must be submitted at least 3 hours prior to the event. No approval is necessary if the event meets the following criteria:

(1) On weekdays between the hours of 8 a.m. and 4 p.m., the event will be held at least 100 feet away from buildings that normally hold classes;

(2) No other person or group has been authorized to use the area or has filed a notice of intent to use that area or an adjacent area;

(3) The organizers do not intend to use amplification equipment or equipment requiring use of electrical power connections. Hand-held megaphones are permitted if used so as to direct the sound away from nearby buildings that normally hold classes;

(4) Participants will not use displays other than signs or banners carried at all times by one or two participants (unattended displays may not be used without permission);

(5) If the event is not held at one of the two public forum areas, the event will occur only between the hours of 8 a.m. and 10 p.m.; and

(6) The sponsor of the event indicates that the event will comply with the general restrictions indicated above.

*c. Uses that require approval.* A public event not at a designated public forum, and which does not meet the above criteria, requires prior approval by the filing of an Online Event Authorization Request Form with the Student Activities Center when recognized student organizations make the request and with Facilities Planning and Management when university departments and nonuniversity entities make the request. It is preferred that the online request be made at least ten business days and not less than four business days in advance of the proposed event. The Student Activities Center or Facilities Planning and Management will make every effort to provide approval or nonapproval, with a statement of the reasons for nonapproval, in a timely manner. The sponsors of the event may request a waiver of the four-day requirement. A waiver may be granted if the Student Activities Center or Facilities Planning and Management determines that there are good reasons for an exception.

(1) Approval of events will be based upon whether the event meets the general rules indicated in rule 681—13.14(262) and whether the event is appropriate for the location. Approval may be conditioned upon sponsors making reasonable assurances that the event will comply with the general rules. In addition, reasonable time, place and manner restrictions may be required. Unless the event will violate the law, events will not be disapproved based upon the content of proposed speaking or expressive activity. Persons denied authorization may appeal to the senior vice president for business and finance.

(2) Following approval of the event, the organization shall make particular arrangements regarding location, electrical power needs, custodial services, and provision for liability insurance as directed by the Student Activities Center or Facilities Planning and Management. If parking lots will be involved, the organization must receive clearance from the Parking Division, (515)294-3388. If streets will be involved, the organization must receive clearance from the office of the senior vice president for business and finance, (515)294-6162. Preferred locations for outdoor events covered under this subrule are the areas south or north of the Campanile, west of Curtiss Hall, south of MacKay Hall, south of the Hub, south of the Parks Library, and west of Marston Hall provided the events do not conflict with university classes or scheduled activities and provided the events conform to appropriate uses for the area.

### **13.12(2) Indoor areas.**

*a. General policy regarding use.* Any use of indoor areas must not conflict with university programs and events and must be compatible with the purpose of the facility or the particular area to be used.

(1) Members of the general public and campus community are free to enter university facilities, other than restricted areas, during business hours as necessary to transact business, seek information about the university or deliver petitions or correspondence.

(2) Organizations and groups desiring to use university buildings and facilities for meetings, events, and conferences should contact the offices listed in 13.12(3) to determine availability and fees for use.

(3) Organizations (other than recognized campus and student organizations) using classrooms, auditoriums, and meeting rooms will be charged the customary rental of those facilities. All users will be responsible for costs incurred for setup, equipment use, cleanup and use of services and materials of the university.

(4) To avoid disruption, the following kinds of indoor areas are not available for non-university-related assembly or solicitation: hallways, stairways, waiting rooms, residence halls and apartments, dining facilities, workrooms, common areas provided around service windows, the Lloyd Veterinary Medical Center and the Thielen Student Health Center. Atria and open areas in buildings are generally available for use except when they are used as waiting areas or common areas around service windows.

*b. Uses that require scheduling.* To avoid conflicts with university activities and permitted use by others, organized use of indoor areas by groups of 15 or fewer persons that will substantially exclude

others from using the same or adjacent areas, other than transitory passage through public areas and hallways, requires scheduling through the Memorial Union Event Management Office when recognized student organizations make the request and with Facilities Planning and Management or Conference Planning and Management when university departments or nonuniversity entities make the request.

*c. Uses that require approval.* Organized or concerted assembly in or solicitation at indoor areas by groups involving more than 15 persons for non-university-related purposes must be approved by the filing of an Online Event Authorization Request Form with the Student Activities Center when recognized student organizations make the request and with Facilities Planning and Management or Conference Planning and Management when university departments or nonuniversity entities make the request. It is preferred that the online request be made at least ten business days and not less than four business days in advance of the activity. The Student Activities Center and Facilities Planning and Management or Conference Planning and Management will make every effort to provide approval or nonapproval, with a statement of the reasons for nonapproval, in a timely manner. The sponsors of the event may request waiver of the four-day requirement. A waiver may be granted if the Student Activities Center or Facilities Planning and Management or Conference Planning and Management determines that there are good reasons for an exception.

(1) Approval of events will be based upon whether the event meets the general rules indicated in rule 681—13.14(262) and whether the event is appropriate for the facility.

(2) Approval may be conditioned upon sponsors making reasonable assurances that the event will comply with the general rules. In addition, reasonable time, place and manner restrictions may be required. Unless the event will violate the law, events will not be disapproved based upon the content of proposed speaking or expressive activity. Persons denied authorization may appeal to the senior vice president for business and finance.

**13.12(3) Facilities and grounds managed by separate university offices or organizations.**

*a.* The Student Activities Center and users must coordinate use of these facilities with the listed offices:

(1) Common areas in buildings—building supervisor for the building can be found at [www.fpm.iastate.edu/maps/buildings/](http://www.fpm.iastate.edu/maps/buildings/);

(2) Rooms in academic or administrative buildings—Room Scheduling, General Services Building, (515)294-4493. Room Reservation Request Forms are available at [www.fpm.iastate.edu/roomscheduling/department form/](http://www.fpm.iastate.edu/roomscheduling/department_form/);

(3) Memorial Union—Event Management Office, 3630 Memorial Union, (515)294-1437;

(4) Iowa State Center—Center Office, 4 Scheman Conference Center, (515)294-3347;

(5) Residence Halls—(515)294-2900 (general); (515)294-6428 (meeting rooms); (515)294-8384 (conferences);

(6) Schilleter and University Village (SUV) Office—(515)294-5360;

(7) Fredericksen Court Office—(515)294-2107;

(8) Recreation facilities and grounds—Recreation Services Administrative Office, 1180 State Gym, (515)294-4980. Recreation facilities and grounds are listed at [www.recservices.iastate.edu/facilities/](http://www.recservices.iastate.edu/facilities/);

(9) Howe Hall Auditorium—Engineering Distance Education, (515)294-7470;

(10) University Studios—(515)294-6014;

(11) Farm Bureau Pavilion—Animal Science, (515)294-5424;

(12) Athletics facilities and grounds—Athletic Department, Jacobson Athletic Building, (515)294-3662. Athletic facilities and grounds are listed at [www.cyclones.com](http://www.cyclones.com/);

(13) Alumni Center—Alumni Association, 420 Beach Avenue, (515)294-4625;

(14) Reiman Gardens—1407 University Boulevard, (515)294-8994.

*b.* Students and student organizations have priority for use of residence facilities and grounds, recreation facilities and grounds and the Memorial Union. Students and student organizations may directly contact the offices listed above to schedule use of meeting rooms and other facilities and grounds.

*c.* Organizations (other than recognized campus and student organizations) using facilities and grounds will be charged the customary rental of those facilities and grounds. All users will be responsible for costs incurred for setup, equipment use, cleanup and use of services and materials of the university.

*d.* As part of the university's comprehensive effort to conserve energy and save money, activities will generally be scheduled in buildings normally open and operational in the evenings. More information may be obtained through the Room Scheduling Office, (515)294-5338. The ISU policy on facilities and grounds use after hours may be found in the policy library.  
[ARC 8070B, IAB 8/26/09, effective 9/30/09; ARC 1078C, IAB 10/2/13, effective 11/6/13]

**681—13.13(262) Display of noninstructional materials.**

**13.13(1) *Displays within buildings.*** Posters, advertisements, or other visual display materials may be affixed only on permanent building bulletin boards. Such display materials may not have a surface area of greater than 300 square inches. Additional information regarding displays within buildings may be found in the ISU policy on facilities and grounds use activities in the policy library.

*a.* "General" bulletin boards may be used by Iowa State University students and organizations as well as the general public without approval for posting.

(1) Bulletin board notices must include the date they are posted or the date of the event and may be posted no more than one month in advance of the event.

(2) Undated and early notices will be removed.

(3) Properly posted notices will be removed after 30 days or, in the case of advertisements for an event, after the date of the event.

*b.* "Restricted" bulletin boards are limited to the use of designated departments or organizations. Use of these bulletin boards must be approved by the official representative of the respective department or organization.

**13.13(2) *Exterior displays.***

*a. Residence department buildings.* Signs, banners, and other display materials may be affixed to buildings only with the authorization of the coordinator of residence life in each residence complex.

*b. Academic buildings.* Signs, banners, and other display materials may not be affixed to buildings. Rare exceptions may be made in cases in which the display materials are clearly associated with an academic function. Prior approval must be obtained from the Student Activities Center and from Facilities Planning and Management by the submission of an Activity Authorization Form. Such forms are available at the Student Activities Center.

*c. Exterior display, not on buildings.* Signs, banners, and other display materials may not be affixed to sidewalks, trees, fences, shrubs, light poles, or any other fixture of the landscape, nor may freestanding displays be placed in any area other than those areas scheduled through the activity authorization process. Except for those displays indicated in 13.12(1)"a" and 13.12(1)"b"(4) at events for which approval is not required, prior approval of displays must be obtained from the Student Activities Center by the submission of an Online Event Authorization Request Form for recognized student organizations or from Facilities Planning and Management for university departments or nonuniversity entities.

*d. Cleanup and repair.* All visual displays should be removed as they become outdated or after authorization has expired. Cleanup and repair charges may be billed to the organization/department/individual for failure to clean up promptly. Organizations, departments, individuals, or nonuniversity entities may be billed for cleanup and repair expenses for illegally posted materials. Additional information regarding exterior displays may be found in the ISU policy on facilities and grounds use activities in the policy library.

[ARC 8070B, IAB 8/26/09, effective 9/30/09; ARC 1078C, IAB 10/2/13, effective 11/6/13]

STANDARDS OF CONDUCT ON CAMPUS

**681—13.14(262) General rules for facilities and grounds use.**

**13.14(1)** University facilities and grounds may not be used in a manner that:

- a.* Substantially disrupts university events or the lawful use by other persons;
- b.* Substantially interferes with the free flow of vehicle or pedestrian traffic;
- c.* Results in injury or creates the threat of injury to persons;
- d.* Involves commission of a crime or illegal behavior;

- e.* Damages or defaces university property or threatens to damage property; or
- f.* Results in significant littering, pollution or other nuisance.

**13.14(2)** No person shall engage in harassment or stalking as defined by Iowa criminal law or engage in sexual or racial harassment in violation of university policy.

**13.14(3)** No person may engage in public urination, defecation or other actions that create a sanitary hazard.

**13.14(4)** A person who enters specialized facilities, such as libraries, recreation facilities and grounds, clinics, research laboratories and other research facilities, and areas not open to the general public must comply with policies established by such facilities and grounds. Questions about applicable policies should be directed to the manager or supervisor of the facility or grounds.

**13.14(5)** Weapons are not permitted on the campus except for purposes of law enforcement and as specifically authorized for purposes of instruction, research or service. A weapon is any instrument or device which is designed primarily for use in inflicting death or injury upon a human being or animal and which is capable of inflicting death or injury when used in the manner for which it was designed. Weapons include any pistol, revolver, shotgun, machine gun, rifle or other firearm, BB or pellet gun, taser or stun gun, bomb, grenade, mine or other explosive or incendiary device, ammunition, archery equipment, dagger, stiletto, switchblade knife, or knife having a blade exceeding five inches in length. Residents of university housing may possess knives having a blade exceeding five inches for cooking purposes.

**13.14(6)** Consumption of alcohol is not permitted in outdoor areas of the campus. An exception is made for the consumption of alcoholic beverages served at approved events for which a valid liquor permit has been issued as provided by state law, and for private events or in designated areas at events. Unauthorized alcoholic beverages are subject to confiscation.

**13.14(7)** Vehicles are not permitted off roadways or parking areas without permission from Manager, Campus Services, 152 General Services Building, telephone (515)294-0692 or from the Manager of Parking Division, 27 Armory, telephone (515)294-1987.

**13.14(8)** For reasons of safety, sanitation, and preservation of campus property, camping is not permitted except for special events approved by the senior vice president for business and finance or senior vice president for student affairs.

[ARC 1078C, IAB 10/2/13, effective 11/6/13]

**681—13.15(262) Commercial and charitable uses.** This rule applies to commercial and charitable uses other than those of university units, of university-affiliated entities or of recognized campus organizations.

**13.15(1)** *Commercial solicitation, advertising and sales.* Commercial solicitation, advertising and sales are not permitted on the campus except as follows:

*a.* Newspapers and periodicals may be distributed in established locations in accordance with the university's periodical distribution policy, which is available from the senior vice president for business and finance.

*b.* Commercial advertising or displays on bulletin boards must conform to the provisions of subrule 13.13(1).

*c.* Commercial sales or solicitation may be approved by the senior vice president for business and finance. Such activity may be approved for academic areas of the campus if the activity directly relates to the academic program. Otherwise, such commercial activity may be approved only in the area directly to the north of the Memorial Union, with priority being given to all other campus-related uses.

**13.15(2)** *Charitable solicitation.* Use of university mail systems and related facilities may be approved by the senior vice president for business and finance for the solicitation of employees by charitable organizations when the following criteria are met.

*a.* The charitable organization presents documentation of its tax-exempt status as provided in Section 501(c)(3) of the Internal Revenue Code;

b. The solicitation is conducted once a year through an on-campus coordinated campaign of all eligible organizations meeting the conditions and giving written notice to the university of the desire to participate at least 120 days prior to the campaign period;

c. The organization may be expected to pay the administrative and out-of-pocket costs associated with using the university mail system or other university facilities and grounds;

d. The solicitation by any one charitable organization may occur once in any calendar year; and

e. Any eligible charitable organization acting pursuant to the authority of this rule may also make use of the payroll deduction system described in Iowa Code sections 70A.14 and 70A.15, if qualified under the terms of those provisions.

[ARC 1078C, IAB 10/2/13, effective 11/6/13]

**681—13.16(262) Conduct at public events.** The following rules are intended to ensure the safety of students, faculty, staff and visitors to the campus and to ensure widest enjoyment of the benefit of public events at Iowa State University.

**13.16(1)** No person may engage in behavior that causes or threatens injury or damage to property, that results in disruption of a public event or that causes unreasonable interference with others' enjoyment of a public event.

**13.16(2)** Special rules may be enforced with respect to events that are open to the public, based upon the nature of the event. For example, performers may require that no cameras or audio- or video-recording devices be permitted in the arena. Persons may be refused entry with items that may be used as projectiles. Umbrellas and other items that may obstruct the views of other attendees may be excluded from facilities and grounds.

**13.16(3)** Possession of, carrying in or consumption of alcohol is not permitted at public events. An exception may be made for the consumption of beer or wine served at approved events for which a valid liquor permit has been issued as provided by state law, and for designated events or designated areas at events. Unauthorized alcoholic beverages are subject to confiscation.

**13.16(4)** Aisles, walkways and stairs must be kept clear of hazards and obstacles. Knapsacks, duffel bags, backpacks, bags or other containers shall be small enough to fit completely on or under one seat, and shall be so kept at all times.

**13.16(5)** Laser pointers and similar devices are not permitted at athletic and performing events and are subject to confiscation. A person who uses any such device to interfere with athletes and performances is subject to immediate removal from the facility and grounds.

**13.16(6)** Iowa State University reserves the right to reassign parking and seating locations at public events for purposes of access, efficiency or to reduce the likelihood of disruption.

**13.16(7)** Any person carrying containers or bags which may contain materials not permitted at public events may be required either to open the container or bag to assure compliance, or to check the container or bag, if such facilities are available for storage of such items, or to dispose of such materials, or to return the materials to the person's automobile. In addition, a patron may be subject to search using a magnetometer to ensure the absence of weapons or other hazardous or banned materials.

**13.16(8)** Auditorium doors will be closed when performances begin. A latecomer may be required to wait to be seated until an appropriate program break. Standing in aisles during performances is not permitted, except by employees.

**13.16(9)** In order to ensure that a person attending events may enter facilities and grounds efficiently, a person leaving the facility or grounds early in the event may be denied the right to secure a pass to reenter.

[ARC 1078C, IAB 10/2/13, effective 11/6/13]

**681—13.17(262) Regulation of smoking, alcohol and food and beverages.**

**13.17(1)** Consistent with the Iowa smokefree air Act (Iowa Code chapter 142D), Iowa State University has adopted a smoke-free campus policy, which is incorporated by reference herein. The policy is available on the Internet at the following address: <http://policy.iastate.edu/policy/smoking/>.

**13.17(2)** Unless specifically authorized, the consumption of alcoholic beverages is not permitted on the campus, within university buildings, within university vehicles, or on other university property.

Alcohol may be consumed in residences or privately leased units on the campus as allowed by law and the rules or lease agreement applicable to the unit. Otherwise, the university will determine the time, place, and conditions under which alcoholic beverages are consumed on university property. Events at which alcoholic beverages are served require evidence of a properly issued state alcohol permit. Persons violating state law with respect to possession and consumption of alcohol are subject to citation, arrest or exclusion from the campus. The ISU policy on alcohol, drugs, and other intoxicants may be found in the policy library.

**13.17(3)** Food and beverages shall be consumed in academic buildings only in areas designated by the responsible departmental supervisor.

[ARC 8070B, IAB 8/26/09, effective 9/30/09]

**681—13.18(262) Animals on campus.**

**13.18(1)** All livestock and other domesticated animals, including but not limited to fowl, cats, dogs, cows, horses, mules, sheep, goats, swine, or reptiles, when on university property, must be kept confined or otherwise physically constrained. Any such animal found running at large on university grounds or found within university facilities and not part of a university-sponsored research program or project may be impounded. Consistent with the laws of the state of Iowa, such animals may be turned over to a city pound or other appropriate state or university agency.

**13.18(2)** For sanitation and safety reasons, except as provided below, animals are not permitted in university buildings. This prohibition shall not apply to animals that are:

- a. Specially trained for and under the control of an individual with disabilities.
- b. Used for teaching and research purposes.
- c. Receiving treatment at the Lloyd Veterinary Medical Center or other approved facility.

**13.18(3)** Pets are permitted on the campus in outdoor areas when properly controlled and confined and when their presence does not jeopardize the safety or sanitation of university facilities or grounds or the safety of individuals on the campus. In the case of pets such as dogs, proper confinement shall consist of a cage or a leash of sufficient strength to restrain the dog held by a person competent to govern the behavior of the dog.

a. Any pets brought on the campus must be properly licensed and vaccinated under the laws of Iowa, and tags indicating such license and vaccination shall at all times be attached to the collar of the pet.

b. In those cases in which impoundment is necessary, the owner of the animal or its claimant shall be personally responsible for all costs associated with reclaiming the animal.

c. Any person who walks an animal on public areas of the campus shall be responsible for the control and behavior of the animal, as well as the prompt collection and disposal of the solid waste excreted by that animal.

[ARC 1078C, IAB 10/2/13, effective 11/6/13]

**681—13.19(262) Authority to order persons off the campus.** Any person violating university regulations may have the person's permission to remain in or on university premises revoked. A person who does not voluntarily leave, or who immediately returns, is subject to arrest for trespassing under state law. A person who has engaged in serious or repeat violations of university regulations, who has committed crimes, or who has endangered other persons may be banned by the director of public safety or the director's designee from all or part of the campus. Such orders shall be issued in writing. Any person who is subject to such an order may appeal such action to the senior vice president for business and finance, who shall promptly handle the appeal. A person who violates such orders is subject to arrest and prosecution for trespassing.

[ARC 1078C, IAB 10/2/13, effective 11/6/13]

These rules are intended to implement Iowa Code sections 17A.3 and 262.9.

[Filed 6/30/75]

[Filed 12/22/76, Notice 11/17/76—published 1/12/77, effective 2/16/77]

[Filed emergency after Notice 10/17/78, Notice 8/23/78—published 11/1/78, effective 10/17/78]

[Filed emergency 8/13/80—published 9/3/80, effective 8/15/80]

[Filed 8/28/80, Notice 2/20/80—published 9/17/80, effective 10/22/80]  
[Filed 3/29/88, Notice 2/10/88—published 4/20/88, effective 5/25/88]  
[Filed 9/30/88, Notice 8/10/88—published 10/19/88, effective 1/18/89]  
[Filed 5/25/89, Notice 3/22/89—published 6/14/89, effective 7/19/89]  
[Filed 5/19/95, Notice 4/12/95—published 6/7/95, effective 7/12/95]  
[Filed 11/23/99, Notice 4/7/99—published 12/15/99, effective 1/19/00]  
[Filed 7/19/02, Notice 5/15/02—published 8/7/02, effective 9/11/02]  
[Filed ARC 8070B (Notice ARC 7905B, IAB 7/1/09), IAB 8/26/09, effective 9/30/09]  
[Filed ARC 1078C (Notice ARC 0818C, IAB 7/10/13), IAB 10/2/13, effective 11/6/13]

CHAPTER 601  
APPLICATION FOR LICENSE

**761—601.1(321) Application for license.**

**601.1(1) General.** In addition to the information required under Iowa Code sections 321.182 and 321.196, the information in this rule is required from an applicant for a driver's license. Additional requirements for a commercial driver's license are found in 761—Chapter 607.

**601.1(2) Name.** The applicant's full legal name shall be given on the application. Full legal name means an individual's first name, middle name(s), and last name, without use of initials or nicknames. Civilian and military titles, initials and nicknames shall not be given and shall not be used on the applicant's license or in the applicant's record. This prohibition on the use of initials does not apply where a portion of an individual's legal name, whether first, middle or last, consists of a single character, whether followed by a period or not.

**601.1(3) Out-of-state verification.** If a person is licensed in another licensing jurisdiction but does not have a current out-of-state license to surrender, the department may require an official letter from the out-of-state licensing agency before issuing a license. The official letter must verify the person's driving record to assist the department in determining whether it is safe to grant the person a license.

**601.1(4) Disabilities.** The applicant shall indicate and explain any mental or physical disabilities which might affect the applicant's ability to operate a motor vehicle safely.

**601.1(5) Physical description.** The applicant shall provide the applicant's physical description, which shall consist of the applicant's sex, height to the nearest inch, weight to the nearest pound, and eye color.

**601.1(6) Address.** The applicant shall provide the applicant's current residential address and the applicant's current mailing address, if different from the applicant's current residential address. The applicant shall not provide as a mailing address an address for which a forwarding order is in place.

**601.1(7) Signature.**

*a.* The applicant's signature shall be without qualification and shall contain only the applicant's usual signature without any other titles, characters or symbols.

*b.* The applicant's signature certifies, under penalty of perjury and pursuant to the laws of the state of Iowa, that the statements made and information provided in the applicant's application are true and correct.

*c.* The applicant's signature further certifies that the fee collected and the change returned, if any, is correct and acknowledges that the applicant is aware of the requirement to notify the department of a change in mailing address within 30 days of the change.

*d.* The applicant's signature will be captured electronically.

This rule is intended to implement Iowa Code sections 321.182, 321.196 and 321C.1, Article V, the REAL ID Act of 2005 (49 U.S.C. Section 30301 note), and 6 CFR Part 37.  
[ARC 0347C, IAB 10/3/12, effective 11/7/12]

**761—601.2(321) Surrender of license and nonoperator's identification card.** An applicant for a driver's license shall surrender all other driver's licenses and nonoperator's identification cards. This includes those issued by jurisdictions other than Iowa. An applicant who renews a driver's license electronically pursuant to 761—subrule 605.25(7) shall destroy the previous driver's license upon receipt of the renewed driver's license.

This rule is intended to implement Iowa Code section 321.182.  
[ARC 0895C, IAB 8/7/13, effective 7/9/13; ARC 1073C, IAB 10/2/13, effective 11/6/13]

**761—601.3 and 601.4** Reserved.

**761—601.5(321) Proofs submitted with application.** A person who applies for a new driver's license or nonoperator's identification card or a duplicate license or card to replace one that is lost, stolen or destroyed shall submit proof of identity, date of birth, social security number, Iowa residency and current residential address, and lawful status in the United States.

**601.5(1) Verification of identity and date of birth.** To establish identity and date of birth, an applicant must submit at least one of the following documents. The department may require additional documentation if the department believes that the documentation submitted is questionable or if the department has reason to believe that the person is not who the person claims to be.

- a. A valid, unexpired U.S. passport or U.S. passport card.
- b. A certified copy of a birth certificate and, if applicable, a certified amended birth certificate showing a change in name, date of birth, or sex, filed with a state office of vital statistics or equivalent agency in the applicant's state of birth. The birth certificate must be a certified copy and have the stamp or raised seal of the issuing authority. A hospital-issued certificate is not acceptable. As used herein, "state" means a state of the United States, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Commonwealth of the Northern Mariana Islands.
- c. A Consular Report of Birth Abroad issued by the U.S. Department of State (Form FS-240, DS-1350 or FS-545).
- d. A valid, unexpired Permanent Resident Card (Form I-551) issued by the U.S. Department of Homeland Security or U.S. Immigration and Naturalization Service.
- e. An unexpired employment authorization document issued by the U.S. Department of Homeland Security (Form I-766 or Form I-688B).
- f. An unexpired foreign passport with a U.S. visa affixed, accompanied by the approved I-94 form documenting the applicant's most recent admittance into the United States.
- g. A Certificate of Naturalization issued by the U.S. Department of Homeland Security (Form N-550 or Form N-570).
- h. A Certificate of Citizenship (Form N-560 or Form N-561) issued by the U.S. Department of Homeland Security.
- i. A REAL ID driver's license or identification card issued in compliance with the standards established by 6 CFR Part 37.
- j. Such other documents as the U.S. Department of Homeland Security may designate as acceptable proof of identity and date of birth for REAL ID purposes by notice published in the Federal Register.
- k. An Inmate Descriptor Inquiry, Client Information Inquiry or Offender Snapshot document issued by the Iowa department of corrections or the United States District Court, Northern and Southern Districts of Iowa. The document must contain the applicant's full legal name and date of birth and be notarized. An applicant who provides only a document listed in this paragraph shall not be eligible for a driver's license or nonoperator's identification card marked as acceptable for federal purposes under 6 CFR Part 37.

**601.5(2) Verification of social security number.**

a. Except as provided in paragraph 601.5(2) "b," an applicant must present the applicant's Social Security Administration's account number card; or if a social security account number card is not available, the applicant may present any of the following documents bearing the applicant's social security number:

- (1) A W-2 form.
- (2) A Social Security Administration-1099 form.
- (3) A non-Social Security Administration-1099 form.
- (4) A pay stub with the applicant's name and social security number on it.

b. An applicant who establishes identity by presenting the identity document listed in paragraph 601.5(1) "f" (unexpired foreign passport with a valid, unexpired U.S. visa affixed accompanied by the approved I-94 form documenting the applicant's most recent admittance into the United States) must document the applicant's social security number as set forth in paragraph 601.5(2) "a" or demonstrate non-work authorized status.

**601.5(3) Verification of Iowa residency and current residential address.**

a. To document Iowa residency and current residential address, an applicant must present two documents that include the applicant's name and current Iowa residential address and that demonstrate residency in the state of Iowa. Acceptable documents are documents issued by a person, organization, or

entity other than the applicant, that include the issuer's name and address, include the applicant's name and current residential address, and demonstrate residency in the state of Iowa. The documents must be reasonable, authentic documents capable of verification by the department.

*b.* The address must be a street or highway address, and may not be a post office box. In areas where a number and street name have not been assigned, an address convention used by the U.S. Postal Service is acceptable. The current residence of a person with more than one dwelling is the dwelling for which the person claims a homestead tax credit under Iowa Code chapter 425, if applicable.

*c.* An applicant who is a member of the armed forces and is an Iowa resident stationed in another state may use the applicant's address in the state of station as the applicant's current residential address if the applicant does not maintain an Iowa residence during the applicant's deployment outside the state of Iowa. The applicant must provide official documentation confirming the applicant's residential address in the state of station and that the applicant is stationed in that state. The applicant's mailing address may be the applicant's current residential address or another address at which the applicant receives mail.

*d.* An applicant who is a dependent family member of and resides with a member of the armed forces who is an Iowa resident stationed in another state may use the applicant's address in the state of station as the applicant's current residential address if the applicant does not maintain an Iowa residence during the applicant's deployment outside the state of Iowa. The applicant must provide official documentation confirming the applicant's residential address in the state of station and that the applicant is a dependent family member of a member of the armed forces stationed in that state. The applicant's mailing address may be the applicant's current residential address or another address at which the applicant receives mail.

**601.5(4) Verification of lawful status in the United States.**

*a.* If an applicant presents one of the identity documents listed under subrule 601.5(1), the department's verification of that identity document is satisfactory evidence of lawful status.

*b.* An applicant who presents only a document listed under subrule 601.5(1), paragraph "e," "f," or "i," is not eligible to receive a driver's license or nonoperator's identification card marked as REAL ID compliant unless the applicant also provides one of the other documents listed in subrule 601.5(1), or another United States Department of Homeland Security-approved document.

**601.5(5) Verification of name change.** The name listed on the driver's license or nonoperator's identification card that is issued shall be identical to the name listed on the identity document submitted unless the applicant submits an affidavit of name change on Form 430043. The affidavit must be accompanied by the chain of legal documents necessary to show the legal change of the applicant's name from the identity document submitted to the name listed on the affidavit. The following documents are acceptable:

*a.* Court-ordered name change. A court order must contain the applicant's prior full legal name, the applicant's court-ordered full legal name, the applicant's date of birth, and the official court seal. Acceptable court orders include orders under petition for name change, orders for name change set forth in a decree of dissolution, and orders for name change set forth in a decree of adoption.

*b.* Marriage certificate. The marriage certificate must be filed with a state office of vital statistics or equivalent agency in the person's state or country of marriage. The certificate must be a certified copy and have the stamp or raised seal of the issuing authority. A church, chapel or similarly issued certificate is not acceptable. As used herein, "state" means a state of the United States, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Commonwealth of the Northern Mariana Islands.

**601.5(6) Verification of change of date of birth.** The date of birth listed on the driver's license or nonoperator's identification card that is issued shall be identical to the date of birth listed on the identity document submitted unless the applicant submits a certified amended birth certificate that documents the change of date of birth and that meets the requirements of paragraph 601.5(1) "b," or submits a court-ordered date of birth change. The court order must contain the applicant's full legal name, the applicant's prior date of birth, the applicant's court-ordered date of birth, and official court seal.

**601.5(7) Verification of change of sex designation.** The sex designation listed on the driver's license or nonoperator's identification card that is issued shall be identical to the sex designation listed on

the identity document submitted unless the applicant submits a certified amended birth certificate that documents the change of sex designation and that meets the requirements of paragraph 601.5(1) “b,” or submits a court-ordered change of sex designation. The court order must contain the applicant’s full legal name, the applicant’s date of birth, the applicant’s prior sex designation, the applicant’s court-ordered sex designation, and official court seal.

This rule is intended to implement Iowa Code sections 321.182 and 321.189, the REAL ID Act of 2005 (49 U.S.C. Section 30301 note), and 6 CFR Part 37.

[ARC 7902B, IAB 7/1/09, effective 8/5/09; ARC 0347C, IAB 10/3/12, effective 11/7/12]

**761—601.6(321) Parental consent.** An unmarried person under the age of 18 who applies for an Iowa license shall submit parental consent and birth date confirmation on Form 430018, Parent’s Written Consent to Issue Privilege to Drive or Affidavit to Obtain Duplicate. The parent’s signature must be notarized; however, in lieu of notarization it may be witnessed by a driver’s license examiner or clerk. No exception shall be made for parental absence from Iowa. A married person under the age of 18 shall submit an original or certified copy of a marriage certificate to avoid submission of the consent form.

This rule is intended to implement Iowa Code section 321.184.

[ARC 7902B, IAB 7/1/09, effective 8/5/09]

**761—601.7(321) REAL ID driver’s license.** A person who seeks a driver’s license that is compliant with the REAL ID Act of 2005, 49 U.S.C. § 30301 note, as further defined in 6 CFR Part 37 (“REAL ID driver’s license”), must meet and comply with all lawful requirements for an Iowa driver’s license, and must also meet and comply with all application and documentation requirements set forth at 6 CFR Part 37, including but not limited to documentation of identity, date of birth, social security number, address of principal residence, and evidence of lawful status in the United States. Documents and information provided to fulfill REAL ID requirements must be verified as required in 6 CFR 37.13. An applicant for a REAL ID driver’s license is subject to a mandatory facial image capture that meets the requirements of 6 CFR 37.11(a). A REAL ID driver’s license may not be issued, reissued, or renewed except as permitted in 6 CFR Part 37 and may not be issued, reissued, or renewed by any procedure, in any circumstance, to any person, or for any term prohibited under 6 CFR Part 37. The information on the front of any REAL ID driver’s license must include all information and markings required by 6 CFR 37.17. Nothing in this rule requires a person to obtain a REAL ID driver’s license.

This rule is intended to implement Iowa Code chapter 321, the REAL ID Act of 2005 (49 U.S.C. Section 30301 note), and 6 CFR Part 37.

[ARC 8339B, IAB 12/2/09, effective 12/21/09; ARC 8514B, IAB 2/10/10, effective 3/17/10]

[Filed emergency 6/7/90—published 6/27/90, effective 7/1/90]

[Filed 12/18/91, Notice 11/13/91—published 1/8/92, effective 2/12/92]

[Filed 11/1/95, Notice 9/27/95—published 11/22/95, effective 12/27/95]

[Filed 10/30/96, Notice 9/25/96—published 11/20/96, effective 12/25/96]

[Filed emergency 4/3/97—published 4/23/97, effective 4/3/97]

[Filed 1/21/98, Notice 12/17/97—published 2/11/98, effective 3/18/98]

[Filed 10/28/98, Notice 9/23/98—published 11/18/98, effective 12/23/98]

[Filed 2/15/02, Notice 12/26/01—published 3/20/02, effective 4/24/02]

[Filed 6/19/02, Notice 4/17/02—published 7/10/02, effective 8/14/02]

[Filed ARC 7902B (Notice ARC 7721B, IAB 4/22/09), IAB 7/1/09, effective 8/5/09]

[Filed Emergency ARC 8339B, IAB 12/2/09, effective 12/21/09]

[Filed ARC 8514B (Notice ARC 8342B, IAB 12/2/09), IAB 2/10/10, effective 3/17/10]

[Filed ARC 0347C (Notice ARC 0201C, IAB 7/11/12), IAB 10/3/12, effective 11/7/12]

[Filed Emergency ARC 0895C, IAB 8/7/13, effective 7/9/13]

[Filed ARC 1073C (Notice ARC 0894C, IAB 8/7/13), IAB 10/2/13, effective 11/6/13]

CHAPTER 604  
LICENSE EXAMINATION

[Prior to 6/3/87, see Transportation Department[820]—(07,C)rules 13.3 and 13.17]

**761—604.1(321) Authority and scope.**

**604.1(1)** The department is authorized to determine by examination an applicant's ability to operate motor vehicles safely upon the highways and to issue all driver's licenses.

**604.1(2)** This chapter of rules shall apply to the examination for all driver's licenses. Information on the additional examination procedures and requirements for a commercial driver's license or commercial driver's instruction permit is given in 761—Chapter 607.

This rule is intended to implement Iowa Code sections 321.2, 321.3, 321.13, 321.177, and 321.186.

**761—604.2(321) Definitions.**

*"Binocular field of vision"* is the sum of the temporal measurements or the sum of the nasal measurements.

*"Monocular field of vision"* is the sum of the temporal measurement and the nasal measurement for one eye.

*"Representative vehicle"* is a vehicle which is characteristic of and requires operating skills comparable to those vehicles that may legally be operated under the class of license or endorsement desired.

This rule is intended to implement Iowa Code sections 321.174 and 321.186.  
[ARC 9991B, IAB 2/8/12, effective 3/14/12]

**761—604.3(17A) Information and forms.**

**604.3(1)** Applications, forms, and information about driver's license examinations are available at any driver's license examination station. Assistance is also available from the office of driver services at the address in 761—600.2(17A).

**604.3(2)** The "Iowa Driver Manual" and the "Iowa Motorcycle Operator Manual" are also available from the department.

This rule is intended to implement Iowa Code section 17A.3.

**761—604.4 to 604.6** Reserved.

**761—604.7(321) Examination.**

**604.7(1)** An examination shall include:

- a. A vision screening if the person has not filed a vision report.
- b. A knowledge test of Iowa traffic laws and highway signs.
- c. A driving test of the person's ability to operate a motor vehicle.

**604.7(2)** The examination required for a driver's license depends upon the class of license requested, applicable endorsements, and the qualifications of the applicant.

This rule is intended to implement Iowa Code sections 321.186 and 321.186A.

**761—604.8 and 604.9** Reserved.

**761—604.10(321) Vision screening.**

**604.10(1) Requirement.** Vision screening or a vision report is required of an applicant for a driver's license.

**604.10(2) Method.** At driver's license examination stations, a vision screening instrument shall be used to screen the applicant's vision. An applicant who has corrective lenses may be screened with or without the corrective lenses.

**604.10(3) Report.** A vision report shall be submitted on Form 430032 signed by a licensed vision specialist and shall report the person's visual acuity level and field of vision as measured within 30 days prior to the date of the application. In lieu of Form 430032, a vision report signed by a licensed vision

specialist on the specialist's letterhead may be accepted if it contains all the information specified on Form 430032.

**604.10(4) Exception for persons renewing electronically.** An applicant renewing a driver's license electronically pursuant to 761—subrule 605.25(7) is not required to complete a vision screen or submit a vision report to complete the renewal. This subrule does not preclude the department from requiring a vision screen or vision report of a person who has renewed a driver's license electronically when the department has reason to believe that the person is not capable of operating a motor vehicle safely.

This rule is intended to implement Iowa Code sections 321.186, 321.186A and 321.196 as amended by 2013 Iowa Acts, House File 355, section 1.

[ARC 9991B, IAB 2/8/12, effective 3/14/12; ARC 0895C, IAB 8/7/13, effective 7/9/13; ARC 1073C, IAB 10/2/13, effective 11/6/13]

**761—604.11(321) Vision standards.** The visual acuity and field of vision standards for licensing and the applicable restrictions are as follows.

**604.11(1) Visual acuity standards.**

*a. When the applicant is screened without corrective lenses.* If the visual acuity is 20/40 or better with both eyes or with the better eye, no restriction will be imposed. If the visual acuity is less than 20/40 but at least 20/70 with both eyes or with the better eye, the applicant shall be restricted from driving when headlights are required.

*b. When the applicant is screened with corrective lenses.* If the visual acuity is 20/40 or better with both eyes or with the better eye, the applicant shall be required to wear corrective lenses. If the visual acuity is less than 20/40 but at least 20/70 with both eyes or with the better eye, the applicant shall be required to wear corrective lenses and shall be restricted from driving when headlights are required.

*c. Other standards.* If the visual acuity in the left eye is less than 20/100, the applicant shall be restricted to driving a vehicle with both left and right outside rearview mirrors. However, if the applicant has a visual acuity of 20/40 in the right eye and less than 20/100 in the left eye without corrective lenses and has corrective lenses that improve the vision in the left eye to better than 20/100, the applicant shall have the option of being restricted to driving with corrective lenses or driving a vehicle with both left and right outside rearview mirrors.

**604.11(2) Field of vision standards.**

*a.* If the binocular field of vision is at least 140 degrees, no restriction will be imposed.

*b.* If the binocular field of vision is less than 140 degrees but at least 110 degrees, or one eye has a monocular field of vision of at least 100 degrees, the applicant shall be restricted to driving a vehicle with both left and right outside rearview mirrors.

This rule is intended to implement Iowa Code sections 321.186, 321.193, and 321.196.

[ARC 9991B, IAB 2/8/12, effective 3/14/12]

**761—604.12(321) Vision referrals.**

**604.12(1) Referral.**

*a.* If an applicant on first screening cannot attain 20/40 but can attain 20/70 with at least one eye, the department shall not issue a license to the applicant. Instead, the department shall advise the applicant to consult a licensed vision specialist.

*b.* A vision report, pursuant to subrule 604.10(3), shall be required before the department will reconsider licensing.

**604.12(2) License.**

*a.* The department shall affix a sticker to the applicant's license stating: "Renewal or license issuance denied due to vision."

*b.* If the applicant's license is valid for less than 30 days, the department may issue a temporary driving permit with restrictions appropriate to the applicant's visual acuity level and field of vision. The temporary driving permit is valid for not more than 30 days from the end of the current license validity.

**604.12(3) Report.** If the vision report recommends a restriction, the department shall issue a restricted license even though it would not be required by departmental standards.

**604.12(4) Applicant refusal.** If an applicant refuses to consult a licensed vision specialist, the department shall issue or deny the license based on the results achieved on the vision screening.

This rule is intended to implement Iowa Code sections 321.181, 321.186, 321.186A, 321.193 and 321.196.

**761—604.13(321) Vision screening results.**

**604.13(1) Two-year license.** An applicant who cannot attain a visual acuity of 20/40 with both eyes or with the better eye shall be issued a two-year license. This restriction may be waived by the department when a vision report pursuant to subrule 604.10(3) certifies that the vision has stabilized and is not expected to deteriorate.

**604.13(2) License denied.**

*a.* An applicant who cannot attain a visual acuity of 20/70 with both eyes or with the better eye shall not be licensed, subject to discretionary issuance under subrule 604.13(4).

*b.* If the applicant's binocular field of vision is less than 110 degrees, or the monocular field of vision is less than 100 degrees, the applicant shall not be licensed, subject to discretionary issuance under subrule 604.13(4).

**604.13(3) Reapplication.** An applicant who cannot meet the vision standards in subrule 604.13(2) may reapply when the vision improves and meets the vision standards. If a suspension or denial notice was served, reapplication must be made to the office of driver services at the address in 761—600.2(17A), and not at a driver's license examination station.

**604.13(4) Discretionary issuance.**

*a.* An applicant whose license is restricted under rule 761—604.11(321) or who cannot meet the vision standards in subrule 604.13(2) may submit a written request for review by an informal settlement officer.

*b.* Based upon consideration of the applicant's vision screening results or vision report, driving test and driving record, the written recommendation of the applicant's licensed vision specialist, and traffic conditions in the vicinity of the applicant's residence, the officer may recommend issuing a license with restrictions suitable to the applicant's capabilities. However:

(1) An applicant who cannot attain a visual acuity of 20/100 with both eyes or with the better eye may be considered for licensing only after recommendation by the medical advisory board.

(2) An applicant who cannot attain a visual acuity of 20/199 with both eyes or with the better eye shall not be licensed.

(3) If an applicant's binocular field of vision or monocular field of vision is less than 75 degrees, the applicant may be considered for licensing only after recommendation by the medical advisory board.

(4) An applicant who cannot attain a binocular or monocular field of vision of 21 degrees shall not be licensed.

*c.* The officer's recommendation denying discretionary issuance or regarding the extent and nature of restrictions is subject to reversal or modification upon review or appeal only if it is clearly characterized by an abuse of discretion.

This rule is intended to implement Iowa Code sections 321.186, 321.186A, 321.193 and 321.196.  
[ARC 9991B, IAB 2/8/12, effective 3/14/12]

**761—604.14 to 604.19** Reserved.

**761—604.20(321) Knowledge test.**

**604.20(1) Written test.** A knowledge test is a written test to determine an applicant's ability to read and understand Iowa traffic laws and the highway signs that regulate, warn, and direct traffic. A test may be revised at any time but each test states the minimum passing score.

**604.20(2) Three types of tests.** There are three types of knowledge tests: an operator's test, a chauffeur's test, and a motorcycle test. The requirement for a license depends upon the class of license desired, applicable endorsements, and the qualifications of the applicant.

**604.20(3) Oral test.** An applicant who is unable to read or understand a written test may request an oral test. The oral test may be administered by an examiner or by an automated testing device.

**604.20(4) Waiver.** Rescinded IAB 1/8/92, effective 2/12/92.

This rule is intended to implement Iowa Code section 321.186.

**761—604.21(321) Knowledge test requirements and waivers.**

**604.21(1) Knowledge test requirements.** The knowledge test requirements are as follows:

*a. Operator's test.* An operator's knowledge test is required for all classes of driver's licenses and all types of special driver's licenses and permits.

*b. Motorcycle test.* A motorcycle knowledge test is required for all:

- (1) Motorcycle instruction permits.
- (2) Class M driver's licenses.
- (3) Motorcycle endorsements.

*c. Chauffeur's test.* A chauffeur's knowledge test is required for all:

- (1) Chauffeur's instruction permits.
- (2) Class D driver's licenses except those with an endorsement for "passenger vehicle less than 16-passenger design."

**604.21(2) Knowledge test waivers.** The department may waive a knowledge test listed in subrule 604.21(1) if the applicant meets one of the following qualifications:

*a.* The applicant has passed the same type of test for another Iowa driver's license or an equivalent out-of-state license that is still valid.

*b.* The applicant has a valid, equivalent driver's license issued by a foreign jurisdiction with which Iowa has a nonbinding reciprocity agreement.

*c.* The applicant has a military extension and is renewing the applicant's Iowa driver's license within six months following separation from active duty.

This rule is intended to implement Iowa Code sections 321.180, 321.180A, 321.180B, 321.186, 321.189, 321.196 and 321.198.

**761—604.22(321) Knowledge test results.**

**604.22(1) Proof of Passing score.** When necessary, the department shall give the applicant a form, valid for 90 days, which certifies that the applicant has passed the knowledge test.

**604.22(2) Retesting.** An applicant who fails a knowledge test may repeat the test at the discretion of the examiner, but at least two hours shall elapse between tests.

This rule is intended to implement Iowa Code section 321.186.

**761—604.23 to 604.29** Reserved.

**761—604.30(321) Driving test.** A driving test is a demonstration of an applicant's ability to exercise ordinary and reasonable control in the operation of a motor vehicle under actual traffic conditions. The test is also called a road test, field test, or driving demonstration. A motorcycle skill test is an off-street demonstration of an applicant's ability to control the motorcycle in a set of standard maneuvers, and a motorcycle driving test is an on-street demonstration.

**604.30(1) Vehicle type and safety.**

*a.* For the driving test, the applicant shall provide a representative vehicle as defined in 761—604.2(321).

*b.* The examiner or other authorized personnel shall visually inspect the vehicle. If a vehicle is illegal or unsafe, or is not a representative vehicle, the examiner shall refuse to administer the test until corrections are made or an acceptable vehicle is provided.

**604.30(2) Criteria and route.** Form 430024, "Your Driving Test," explains the criteria for passing the test and shall be given to the applicant before any required test, except a motorcycle skill test. The applicant shall be directed over one of the routes which have been preselected by the examiner to test driving skills and maneuvers.

**604.30(3) Test score.** The examiner shall use the standard departmental score sheet and shall enter the test score and the licensing decision in the spaces provided. At the end of the test, the examiner shall explain the test score. The test score result is valid for 90 days.

**604.30(4) Retesting.** If an applicant fails a driving test, the test may be rescheduled at the discretion of the examiner.

This rule is intended to implement Iowa Code sections 321.174 and 321.186.  
[ARC 9991B, IAB 2/8/12, effective 3/14/12]

**761—604.31(321) Driving test requirements and waivers for noncommercial driver's licenses.**

**604.31(1) Driving test requirements.** The driving test requirements for noncommercial driver's licenses are as follows:

- a. *Instruction permits.* A driving test is not required to obtain an instruction permit.
- b. *Class C driver's licenses.* For a Class C driver's license other than an instruction permit or a motorized bicycle license, an operator's driving test in a representative vehicle is required.
- c. *Class D driver's licenses.* For a Class D driver's license, a driving test in a representative vehicle for the endorsement requested, as set out in 761—subrule 605.4(2), is required.
- d. *Class M driver's licenses and motorcycle endorsements.* The driving test for a Class M driver's license or motorcycle endorsement consists of two parts: an off-street motorcycle skill test and an on-street driving test.

(1) The off-street motorcycle skill test is required. The on-street motorcycle driving test is also required if the applicant does not have another driver's license that permits unaccompanied driving.

(2) A motorcycle shall be used for these tests. If a three-wheeled motorcycle is used, the driver's license shall be restricted: "Not valid for 2-wheel vehicle."

e. *Motorized bicycle licenses.* For a motorized bicycle license, an off-street or on-street driving test may be required. A motorized bicycle shall be used for the test.

**604.31(2) Driving test waivers.** The department may waive a required driving test listed in subrule 604.31(1) if the applicant meets one of the following qualifications:

a. The applicant is applying for the applicant's first Iowa driver's license that permits unaccompanied driving following successful completion of the appropriate Iowa-approved course or courses. The appropriate Iowa-approved courses are the following: driver education for a Class C driver's license other than motorized bicycle, driver education and motorcycle rider education for a Class M driver's license or motorcycle endorsement, and motorized bicycle education for a motorized bicycle license. However:

(1) The department may select dates and require a driving test of applicants whose birth dates fall on the selected dates. The department shall notify the Iowa department of education quarterly of the dates selected.

(2) If an applicant is under the age of 18, a driving test is required if so requested by the applicant's parent, guardian, or instructor.

b. The applicant is renewing a Class C, Class D or Class M Iowa driver's license or endorsement within 14 months after the expiration date.

c. The applicant has passed the same type of driving test for another Iowa driver's license or endorsement that is still valid or has expired within the past 14 months.

d. The applicant has a military extension and is renewing the applicant's Iowa driver's license within six months following separation from active duty.

e. The applicant is applying for a Class C Iowa driver's license that permits unaccompanied driving and has an equivalent out-of-state license that is valid or has expired within the past year.

f. The applicant is applying for a Class D Iowa driver's license and has an equivalent out-of-state license that is valid or has expired within the past year.

g. The applicant is applying for a Class M driver's license or a motorcycle endorsement and has an equivalent out-of-state Class M driver's license or motorcycle endorsement that is valid or has expired within the past year.

*h.* The applicant has a valid, equivalent driver's license issued by a foreign jurisdiction with which Iowa has a nonbinding reciprocity agreement.

This rule is intended to implement Iowa Code sections 321.174, 321.178, 321.180, 321.180A, 321.180B, 321.186, 321.189, 321.193, 321.196 and 321.198.  
[ARC 7902B, IAB 7/1/09, effective 8/5/09]

**761—604.32(321) Driving tests requirements.** Rescinded IAB 1/8/92, effective 2/12/92.

**761—604.33 and 604.34** Reserved.

**761—604.35(321) Determination of gross vehicle weight rating.** For a vehicle that has no legible manufacturer's certification label, the applicant may provide documentation of the gross vehicle weight rating, such as a manufacturer's certificate of origin, a title, a vehicle registration document, or the vehicle identification number information for the vehicle. In the absence of the above documentation, the registered weight of the vehicle shall be presumed to be the gross vehicle weight rating.

This rule is intended to implement Iowa Code section 321.1.

**761—604.36 to 604.39** Reserved.

**761—604.40(321) Failure to pass examination.**

**604.40(1)** An applicant who fails to pass a required examination or reexamination shall not be licensed.

*a.* If the applicant does not have a valid Iowa license, the department shall deny the applicant a license.

*b.* If the applicant has a valid Iowa license, the department shall suspend the license for incapability. However, if the applicant's license is valid for less than 30 days, the department shall deny further licensing. The department shall serve a notice of suspension or denial.

*c.* See 761—615.4(321) for further information on denials and 761—615.14(321) for further information on suspensions for incapability.

*d.* An applicant may contest a denial or suspension in accordance with 761—615.38(321).

**604.40(2) Limitations on the hearing and appeal process.**

*a.* After a suspension or denial for failure to pass a required knowledge or driving test, a person who contests the suspension or denial shall be deemed to have exhausted the person's administrative remedies after three unsuccessful attempts to pass the required test.

*b.* After the three unsuccessful attempts, no further testing shall be allowed until six months have elapsed from the date of the last test failure, and then only if the applicant demonstrates a significant change or improvement in those physical or mental factors that resulted in the original decision. A request for further testing must be submitted in writing to the office of driver services at the address in rule 761—600.2(17A).

*c.* Notwithstanding paragraphs "a" and "b" of this subrule, no testing shall occur if the director determines that it is unsafe to allow testing.

This rule is intended to implement Iowa Code chapter 17A and sections 321.177, 321.180A and 321.210.

**761—604.41 to 604.44** Reserved.

**761—604.45(321) Reinstatement.** A person whose license has been suspended or denied for failure to pass a required examination or reexamination shall meet the vision standards for licensing, pass the required knowledge examination(s), and pass the required driving test(s) before an Iowa license will be issued.

This rule is intended to implement Iowa Code sections 321.177 and 321.186.

**761—604.46 to 604.49** Reserved.

**761—604.50(321) Special reexaminations.** The department may require a special reexamination consisting of a vision screening, knowledge test and driving test of any licensee.

**604.50(1)** The department may require a special reexamination when a licensee has been involved in a fatal motor vehicle accident and the investigating officer's report of the accident indicates the licensee contributed to the accident.

**604.50(2)** The department may require a special reexamination when a licensee has been involved in two accidents within a three-year period and the investigating officer's report of each accident lists one of the following "Driver/Vehicle Related Contributing Circumstances" for the licensee:

- a. Ran traffic signal.
- b. Ran stop sign.
- c. Passing, interfered with other vehicle.
- d. Left of center, not passing.
- e. Failure to yield right-of-way at uncontrolled intersection.
- f. Failure to yield right-of-way from stop sign.
- g. Failure to yield right-of-way from yield sign.
- h. Failure to yield right-of-way making left turn.
- i. Failure to yield right-of-way to pedestrian.
- j. Failure to have control.

**604.50(3)** The department may require a special reexamination when a licensee has been involved in two accidents within a three-year period and the investigating officers' reports for both accidents list a driver condition for the licensee of "apparently asleep."

**604.50(4)** The department may require a special reexamination when a licensee who is 65 years of age or older has been involved in an accident and information in the investigating officer's or the person's own report of the accident indicates the need for reexamination. A circumstance that may indicate a need for reexamination includes, but is not limited to, any one of the following:

- a. The licensee made a left turn that resulted in the accident.
- b. The licensee failed to yield the right-of-way at a stop sign.
- c. The licensee failed to yield the right-of-way at a yield sign.
- d. The licensee failed to yield the right-of-way at an uncontrolled intersection.
- e. The licensee failed to yield the right-of-way at a traffic control signal.
- f. The licensee's vision may be a contributing factor to a nighttime accident.
- g. The licensee has a physical disability-related license restriction other than "corrective lenses" and the accident involved one of the circumstances listed in paragraphs "a" to "f" above.

**604.50(5)** The department may require a special reexamination when recommended by a peace officer, a court, or a properly documented citizen's request. A factor that may indicate a need for reexamination includes, but is not limited to, any one of the following:

- a. Loss of consciousness.
- b. Confusion, disorientation or dementia.
- c. Inability to maintain a vehicle in the proper lane.
- d. Repeatedly ignoring traffic control devices in a nonchase setting.
- e. Inability to interact safely with other vehicles.
- f. Inability to maintain consistent speed when no reaction to other vehicles or pedestrians is required.

This rule is intended to implement Iowa Code sections 321.177, 321.186 and 321.210.

[Filed 7/1/75]

[Filed 12/28/76, Notice 11/3/76—published 1/12/77, effective 2/16/77]

[Filed 8/25/80, Notice 7/9/80—published 9/17/80, effective 10/22/80]

[Filed 5/11/87, Notice 3/11/87—published 6/3/87, effective 7/8/87<sup>1</sup>]

[Filed 1/20/88, Notice 12/2/87—published 2/10/88, effective 3/16/88]

[Filed emergency 11/30/89—published 12/27/89, effective 12/1/89]

[Filed emergency 6/7/90—published 6/27/90, effective 7/1/90]

[Filed 12/18/91, Notice 11/13/91—published 1/8/92, effective 2/12/92]

[Filed 11/4/93, Notice 9/29/93—published 11/24/93, effective 12/29/93]  
[Filed 1/11/95, Notice 11/23/94—published 2/1/95, effective 3/8/95]  
[Filed 1/21/98, Notice 12/17/97—published 2/11/98, effective 3/18/98]  
[Filed 10/28/98, Notice 9/23/98—published 11/18/98, effective 12/23/98]  
[Filed emergency 4/12/00 after Notice 2/23/00—published 5/3/00, effective 4/14/00]  
[Filed 5/3/00, Notice 3/8/00—published 5/31/00, effective 7/5/00]  
[Filed 10/11/06, Notice 8/30/06—published 11/8/06, effective 12/13/06]  
[Filed ARC 7902B (Notice ARC 7721B, IAB 4/22/09), IAB 7/1/09, effective 8/5/09]  
[Filed ARC 9991B (Notice ARC 9874B, IAB 11/30/11), IAB 2/8/12, effective 3/14/12]  
[Filed Emergency ARC 0895C, IAB 8/7/13, effective 7/9/13]  
[Filed ARC 1073C (Notice ARC 0894C, IAB 8/7/13), IAB 10/2/13, effective 11/6/13]

<sup>1</sup> Effective date of 604.11(2) and 604.13(2) “b” delayed until adjournment of the 1988 Session of the General Assembly pursuant to Iowa Code section 17A.8(9) by the Administrative Rules Review Committee at its June 1987 meeting.

CHAPTER 605  
LICENSE ISSUANCE

**761—605.1(321) Scope.** This chapter of rules applies to the issuance of all Iowa driver's licenses. Additional information on the issuance of a commercial driver's license or a commercial driver's instruction permit is given in 761—Chapter 607.

This rule is intended to implement Iowa Code section 321.174.

**761—605.2(321) Contents of license.** In addition to the information specified in Iowa Code subsection 321.189(2), the following information shall be shown on a driver's license.

**605.2(1) Name.** The licensee's full legal name shall be listed as established according to 761—subrule 601.5(1) and 761—subrule 601.5(5) and shall conform to the requirements of 761—subrule 601.1(2).

**605.2(2) Current residential address.** The licensee's current residential address shall be listed as established according to the requirements of 761—subrule 601.5(3).

**605.2(3) Physical description.** The physical description of the licensee on the face of the driver's license shall include:

*a.* The licensee's eye color using these abbreviations: Blk-black, Blu-blue, Bro-brown, Gry-gray, Grn-green, Haz-hazel, and Pnk-pink.

*b.* The licensee's height in inches.

**605.2(4) Date of birth.** The licensee's date of birth shall be listed as established according to 761—subrule 601.5(1) and 761—subrule 601.5(6).

**605.2(5) Sex.** The licensee's sex designation shall be listed as established according to the requirements of 761—subrule 601.5(7).

**605.2(6) REAL ID markings.**

*a.* A driver's license that is issued as a REAL ID license as defined in 761—601.7(321) shall include a security marking as required by 6 CFR 37.17(n).

*b.* Beginning January 15, 2013, a driver's license that is not issued as a REAL ID license as defined in 761—601.7(321) may be marked as required by 6 CFR 37.71 and any subsequent guidance issued by the U.S. Department of Homeland Security.

*c.* A driver's license issued to a foreign national with temporary lawful status shall include the following statement on the face of the license: "limited term."

This rule is intended to implement Iowa Code section 321.189, the REAL ID Act of 2005 (49 U.S.C. Section 30301 note), and 6 CFR Part 37.

[ARC 0347C, IAB 10/3/12, effective 11/7/12]

**761—605.3(321) License class.** The driver's license class shall be coded on the face of the driver's license using these codes:

Class A—commercial driver's license

Class B—commercial driver's license

Class C—commercial driver's license

Class C—noncommercial driver's license

Class D—noncommercial driver's license, chauffeur

Class M—noncommercial driver's license, motorcycle only

This rule is intended to implement Iowa Code section 321.189.

**761—605.4(321) Endorsements.** The endorsements shall be coded on the face of the driver's license and explained in text on the back of the driver's license.

**605.4(1) For a commercial driver's license.** The following endorsements may be added to a Class A, B or C commercial driver's license using these letter codes:

H—Hazardous material

P—Passenger

N—Tank

X—Hazardous material and tank

T—Double/triple trailers

S—School bus

**605.4(2)** *For a Class D driver's license (chauffeur).* The following endorsements may be added to a Class D driver's license using these number codes:

1—Truck-tractor semitrailer combination

2—Vehicle with 16,001 pounds gross vehicle weight rating or more. Not valid for truck-tractor semitrailer combination

3—Passenger vehicle less than 16-passenger design

**605.4(3)** *Motorcycle endorsement.* A motorcycle endorsement may be added to any driver's license that permits unaccompanied driving, other than a Class M driver's license or a motorized bicycle license, using the following letter code:

L—Motorcycle

This rule is intended to implement Iowa Code section 321.189.

**761—605.5(321) Restrictions.** Restrictions shall be coded on the face of the driver's license and explained in text on the back of the driver's license.

**605.5(1)** *For all licenses.* The following restrictions may apply to any driver's license:

B—Corrective lenses required

C—Mechanical aid (as detailed in the restriction on the back of the card)

D—Prosthetic aid (as detailed in the restriction on the back of the card)

E—Automatic transmission

F—Left and right outside rearview mirrors

G—No driving when headlights required

H—Temporary restricted license or permit (work permit)

I—Ignition interlock required

J—Restrictions on the back of card

S—SR required (proof of financial responsibility for the future)

T—Medical report required at renewal

U—Not valid for 2-wheel vehicle

W—Restricted commercial driver's license (CDL)

Y—Intermediate license

**605.5(2)** *For a noncommercial driver's license.* The following restrictions apply only to a noncommercial driver's license:

P—Special instruction permit

Q—No interstate or freeway driving

**605.5(3)** *For a commercial driver's license.* The following restrictions apply only to a commercial driver's license:

K—Commercial driver's license intrastate only

L—Vehicle without air brakes

M—Except Class A bus

N—Except Class A and Class B bus

O—Except tractor-trailer

V—Medical Variance document required

**605.5(4)** *Special licenses.* A numbered restriction will designate a special driver's license using these codes:

1—Motorcycle instruction permit

2—Noncommercial instruction permit (vehicle less than 16,001 gross vehicle weight rating)

3—Commercial driver's instruction permit

4—Chauffeur's instruction permit

5—Motorized bicycle license

6—Minor's restricted license

7—Minor's school license

**605.5(5) Additional information.**

*a. Reexamination or report.* The department may issue a restriction requiring a person to reappear at a specified time for examination. The department may require a medical report to be submitted. The department shall send Form 430029 as a reminder to appear.

*b. Loss of consciousness or voluntary control.*

(1) If a person is licensed pursuant to 761—subrule 600.4(4), the department shall issue the first driver's license with a restriction stating: "Medical report to be furnished at the end of six months."

(2) If this medical report shows that the person has been free of an episode of loss of consciousness or voluntary control since the previous medical report and the report recommends licensing, the department shall issue a duplicate driver's license with a restriction stating: "Medical report required at renewal." At each renewal accompanied by a favorable medical report, the department shall issue a two-year driver's license with the same restriction.

(3) If the latest medical report indicates the person experienced only a single nonrecurring episode, the cause has been identified, and the qualified medical professional is not treating or has not treated the person for the episode and believes it is unlikely to recur, the department may waive the medical report requirement upon receipt of a favorable recommendation from a qualified medical professional.

(4) The department may remove the medical report requirement and issue a full-term driver's license if recommended by a qualified medical professional and if the latest medical information on file with the department indicates the person has not had an episode of loss of consciousness or voluntary control and has not been prescribed medications to control such episodes during the 24-month period immediately preceding application for a license.

(5) The department may remove the medical report requirement and issue a full-term driver's license if recommended by a qualified medical professional and if the latest medical information on file with the department indicates the person has not had an episode of loss of consciousness or voluntary control during the 10-year period immediately preceding application for a license.

*c. Financial responsibility.* When a person is required under Iowa Code chapter 321A to have future proof of financial responsibility on file, the license restriction will read: "SR required." The license shall be valid only for the operation of motor vehicles covered by the class of license issued and by the proof of financial responsibility filed.

*d. Vision restriction.* Restrictions relating to vision are addressed in 761—Chapter 604.

This rule is intended to implement Iowa Code chapter 321A and sections 321.178, 321.180, 321.180A, 321.180B, 321.189, 321.193, 321.194, 321.215, 321J.4, and 321J.20.

[ARC 9991B, IAB 2/8/12, effective 3/14/12; ARC 0661C, IAB 4/3/13, effective 5/8/13]

**761—605.6(321) License term for temporary foreign national.** A driver's license issued to a person who is a foreign national with temporary lawful status shall be issued only for the length of time the person is authorized to be present as verified by the department, not to exceed two years. However, if the person's lawful status as verified by the department has no expiration date, the driver's license shall be issued for a period of no longer than one year.

This rule is intended to implement Iowa Code section 321.196, the REAL ID Act of 2005 (49 U.S.C. Section 30301 note), and 6 CFR Part 37.

[ARC 0347C, IAB 10/3/12, effective 11/7/12]

**761—605.7(321L) Handicapped designation.** Rescinded IAB 2/11/98, effective 3/18/98.

**761—605.8** Reserved.

**761—605.9(321) Fees for driver's licenses.** Fees for driver's licenses are specified in Iowa Code section 321.191. A license fee may be paid by cash, check, credit card, debit card or money order. If payment is by check, the following requirements apply:

**605.9(1)** The check shall be for the exact amount of the fee and shall be payable to: Treasurer, State of Iowa. An exception may be made when a traveler's check is presented.

**605.9(2)** One check may be used to pay fees for several persons, such as members of a family or employees of a business firm. One check may pay all fees involved, such as the license fee and the reinstatement fee.

This rule is intended to implement Iowa Code section 321.191.  
[ARC 9991B, IAB 2/8/12, effective 3/14/12]

**761—605.10(321) Waiver or refund of license fees.** Rescinded IAB 2/8/12, effective 3/14/12.

**761—605.11(321) Duplicate license.**

**605.11(1) *Lost, stolen or destroyed license.*** To replace a valid license that is lost, stolen or destroyed, the licensee shall submit Form 430052 and shall comply with the requirements of 761—601.5(321). The replacement fee is \$3.

**605.11(2) *Voluntary replacement.*** The department shall issue a duplicate of a valid license to an eligible licensee if the license is surrendered to the department and the \$1 voluntary replacement fee is paid. Voluntary replacement includes but is not limited to:

- a. Replacement of a damaged license.
- b. Replacement to change the current residential address on a license. The licensee shall comply with the requirements of 761—subrule 601.5(3) to establish a change of current residential address.
- c. Replacement to change the name on a license. The licensee shall comply with the requirements of 761—subrule 601.5(5) to establish a name change.
- d. Replacement to change the date of birth on a license. The licensee shall comply with the requirements of 761—subrule 601.5(6) to establish a change of date of birth.
- e. Replacement to change the sex designation on a license. The licensee shall comply with the requirements of 761—subrule 601.5(7) to establish a change of sex designation.
- f. Issuance of a license without the words “under 21” to a licensee who is 21 years of age or older.
- g. Issuance of a license without the words “under 18” to a licensee who is 18 years of age or older. (If the licensee is under 21 years of age, the words “under 21” will replace the words “under 18.”)
- h. Issuance of a noncommercial driver’s license to an eligible person who has been disqualified from operating a commercial motor vehicle.
- i. Replacement of a valid license before its expiration date to obtain a license that may be accepted for federal identification purposes under 6 CFR Part 37 (a REAL ID license). The licensee shall comply with the requirements of 761—601.5(321) to obtain a REAL ID license.

This rule is intended to implement Iowa Code sections 321.189, 321.195 and 321.208, the REAL ID Act of 2005 (49 U.S.C. Section 30301 note), and 6 CFR Part 37.

[ARC 7902B, IAB 7/1/09, effective 8/5/09; ARC 0347C, IAB 10/3/12, effective 11/7/12]

**761—605.12(321) Address changes.**

**605.12(1)** A licensee shall notify the department of a change in the licensee’s mailing address within 30 days of the change. Notice shall be given by:

- a. Submitting the address change in writing to the office of driver services, or
- b. Appearing in person to change the mailing address at any driver’s license examination station.

**605.12(2)** Parents or legal guardians may provide written notice of a mailing address change on behalf of their minor children.

**605.12(3)** The department may use U.S. Postal Service address information to update its address records.

This rule is intended to implement Iowa Code sections 321.182 and 321.184.

**761—605.13 and 605.14** Reserved.

**761—605.15(321) License extension.**

**605.15(1) *Six-month extension.*** An Iowa resident may apply for a six-month extension of a license if the resident:

- a. Has a valid license,

- b. Is eligible for further licensing, and
- c. Is temporarily absent from Iowa or is temporarily incapacitated at the time for renewal.

**605.15(2) Procedure.** The licensee shall apply for an extension by submitting Form 430027 to the department. The form may be obtained from and submitted to a driver's license examination station. The licensee may also apply by letter to the address in 761—600.2(17A).

a. A six-month extension shall be added to the expiration date on the license. When the licensee appears to renew the license, the expiration date of the renewed license will be computed from the expiration date of the original license, notwithstanding the extension.

b. The department shall allow only two six-month extensions.

This rule is intended to implement Iowa Code section 321.196.

**761—605.16(321) Military extension.**

**605.16(1) Form 430028.** A person who qualifies for a military extension of a valid license should request Form 430028 from the department and carry it with the license for verification to peace officers. Form 430028 explains the provisions of Iowa Code section 321.198 regarding military extensions.

**605.16(2) Request for retention of record.** A person with a military extension may request that the department retain the record of license issuance for the duration of the extension or reenter the record if it has been removed from department records. The request may be made by letter or by using Form 430081. The letter or Form 430081 shall be signed by the person's commanding officer to verify the military service and shall be submitted to the department at the address in 761—600.2(17A).

**605.16(3) Renewal of license after military extension.** When an applicant renews a license after a military extension, the department may require the applicant to provide documentation of both the military service and the date of separation from military service.

**605.16(4) Reinstatement after sanction.** A person with a military extension whose license has been canceled, suspended or revoked shall comply with the requirements of 761—615.40(321) to reinstate the license.

This rule is intended to implement Iowa Code section 321.198.

**761—605.17 to 605.19** Reserved.

**761—605.20(321) Fee adjustment for upgrading license.** The fee for upgrading a driver's license shall be computed on a full-year basis. The fee is charged for each year or part of a year between the date of the change and the expiration date on the license.

**605.20(1)** The fee to upgrade a driver's license from one class to another is determined by computing the difference between the current license fee and the new license fee as follows:

- a. Converting noncommercial Class C to Class D—\$4 per year of new license validity.
- b. Converting Class M to Class D with a motorcycle endorsement—\$4 per year of new license validity.
- c. Converting Class M to noncommercial Class C with a motorcycle endorsement—\$1 one-time fee.

**605.20(2)** The fee to add a privilege to a driver's license is computed per year of new license validity as follows:

Noncommercial Class C (full privileges from a restricted Class C)	\$4 per year
Motorized bicycle	\$4 per year
Minor's restricted license	\$4 per year
Minor's school license	\$4 per year
Motorcycle instruction permit	\$1 per year
Motorcycle endorsement	\$1 per year

This rule is intended to implement Iowa Code sections 321.189 and 321.191.

**761—605.21 to 605.24** Reserved.

**761—605.25(321) License renewal.**

**605.25(1)** A licensee who wishes to renew a driver's license shall apply to the department and, if required, pass the appropriate examination.

**605.25(2)** A valid license may be renewed 30 days before the expiration date. If this is impractical, the department for good cause may renew a license earlier.

**605.25(3)** A valid license may be renewed within 60 days after the expiration date, unless otherwise specified.

**605.25(4)** If the licensee's current residential address, name, date of birth, or sex designation has changed since the previous license was issued, the licensee shall comply with the following:

*a. Current residential address.* The licensee shall comply with the requirements of 761—subrule 601.5(3) to establish a change of current residential address.

*b. Name.* The licensee shall comply with the requirements of 761—subrule 601.5(5) to establish a name change.

*c. Date of birth.* The licensee shall comply with the requirements of 761—subrule 601.5(6) to establish a change of date of birth.

*d. Sex designation.* The licensee shall comply with the requirements of 761—subrule 601.5(7) to establish a change of sex designation.

**605.25(5)** A licensee who has not previously been issued a license that may be accepted for federal identification purposes under 6 CFR Part 37 (a REAL ID license) and wishes to obtain a REAL ID license upon renewal must comply with the requirements of 761—601.5(321) to obtain a REAL ID license upon renewal.

**605.25(6)** A licensee who is a foreign national with temporary lawful status must provide documentation of lawful status as required by 761—subrule 601.5(4) at each renewal.

**605.25(7)** The department may determine means or methods for electronic renewal of a driver's license.

*a.* An applicant who meets the following criteria may apply for electronic renewal:

(1) The applicant must be at least 18 years of age but not yet 70 years of age.

(2) The applicant completed a satisfactory vision screen or submitted a satisfactory vision report under 761—subrules 604.10(1) to 604.10(3) and updated the applicant's photo at the applicant's last issuance or renewal.

(3) The applicant's driver's license has not been expired for more than one year.

(4) The department's records show the applicant is a U.S. citizen.

(5) The applicant's driver's license is not marked "valid without photo."

(6) The applicant is not seeking to change any of the following information as it appears on the applicant's driver's license:

1. Name.

2. Date of birth.

3. Sex.

(7) The applicant's driver's license is a Class C noncommercial driver's license, a Class D noncommercial driver's license (chauffeur), or Class M noncommercial driver's license (motorcycle) that is not a special license or permit, a temporary restricted license, or a two-year license.

(8) The applicant is not subject to a pending request for reexamination.

(9) The applicant does not wish to change any of the following:

1. Class of license.

2. License endorsements.

3. License restrictions.

(10) The applicant is not subject to any of the following restrictions:

G—No driving when headlights required

J—Restrictions on the back of card

T—Medical report required at renewal

- P—Special instruction permit
- Q—No interstate or freeway driving
- R—Maximum speed of 35 mph

*b.* The department reserves the right to deny electronic renewal and to require the applicant to personally apply for renewal at a driver's license examination station if it appears to the department that the applicant may have a physical or mental condition that may impair the applicant's ability to safely operate a motor vehicle, even if the applicant otherwise meets the criteria in 605.25(7) "a."

*c.* An applicant who has not previously been issued a driver's license that is compliant with the REAL ID Act of 2005, 49 U.S.C. Section 30301 note, as further defined in 6 CFR Part 37 (a REAL ID license) may not request a REAL ID driver's license by electronic renewal.

This rule is intended to implement Iowa Code sections 321.186 and 321.196 as amended by 2013 Iowa Acts, House File 355, section 1, the REAL ID Act of 2005 (49 U.S.C. Section 30301 note), and 6 CFR Part 37.

[ARC 0347C, IAB 10/3/12, effective 11/7/12; ARC 0895C, IAB 8/7/13, effective 7/9/13; ARC 1073C, IAB 10/2/13, effective 11/6/13]

**761—605.26(321) License renewal by mail.** Rescinded IAB 3/20/02, effective 4/24/02.

[Filed emergency 6/7/90—published 6/27/90, effective 7/1/90]

[Filed emergency 10/24/90—published 11/14/90, effective 10/24/90]

[Filed 5/9/91, Notices 11/14/90, 2/20/91—published 5/29/91, effective 7/3/91]

[Filed 12/18/91, Notice 11/13/91—published 1/8/92, effective 2/12/92]

[Filed 11/4/93, Notice 9/29/93—published 11/24/93, effective 12/29/93]

[Filed emergency 1/10/94—published 2/2/94, effective 1/10/94]

[Filed 10/30/96, Notice 9/25/96—published 11/20/96, effective 12/25/96]

[Filed 1/21/98, Notice 12/17/97—published 2/11/98, effective 3/18/98]

[Filed 10/28/98, Notice 9/23/98—published 11/18/98, effective 12/23/98]

[Filed emergency 7/20/00 after Notice 6/14/00—published 8/9/00, effective 7/24/00]

[Filed 2/15/02, Notice 12/26/01—published 3/20/02, effective 4/24/02]

[Filed 6/19/02, Notice 4/17/02—published 7/10/02, effective 8/14/02]

[Filed emergency 3/21/03—published 4/16/03, effective 3/21/03]

[Filed emergency 6/15/05 after Notice 5/11/05—published 7/6/05, effective 7/1/05]

[Filed 6/14/06, Notice 4/12/06—published 7/5/06, effective 8/9/06]

[Filed 10/11/06, Notice 8/30/06—published 11/8/06, effective 12/13/06]

[Filed ARC 7902B (Notice ARC 7721B, IAB 4/22/09), IAB 7/1/09, effective 8/5/09]

[Filed ARC 9991B (Notice ARC 9874B, IAB 11/30/11), IAB 2/8/12, effective 3/14/12]

[Filed ARC 0347C (Notice ARC 0201C, IAB 7/11/12), IAB 10/3/12, effective 11/7/12]

[Filed ARC 0661C (Notice ARC 0571C, IAB 1/23/13), IAB 4/3/13, effective 5/8/13]

[Filed Emergency ARC 0895C, IAB 8/7/13, effective 7/9/13]

[Filed ARC 1073C (Notice ARC 0894C, IAB 8/7/13), IAB 10/2/13, effective 11/6/13]

<sup>1</sup> Effective date of December 29, 1993, for 761—605.26(2) "a" and "d," delayed 70 days by the Administrative Rules Review Committee at its meeting held December 15, 1993; delay lifted by this Committee on January 5, 1994, effective January 6, 1994.



CHAPTER 630  
NONOPERATOR'S IDENTIFICATION  
[Prior to 6/3/87, see Transportation Department[820]—(07,C)Ch 12]

**761—630.1(321) General information.**

**630.1(1)** The department shall issue a nonoperator's identification card only to an Iowa resident who does not have a driver's license. However, a card may be issued to a person holding a temporary permit under Iowa Code section 321.181.

**630.1(2)** Information concerning the nonoperator's identification card is available at any driver's license examination station, or at the address in 761—600.2(17A).

**761—630.2(321) Application and issuance.**

**630.2(1)** An applicant for a nonoperator's identification card shall complete and sign an application form at a driver's license examination station. The signature shall be without qualification and shall contain only the applicant's usual signature without any other titles, characters or symbols.

**630.2(2)** The applicant shall present proof of identity, date of birth, social security number, Iowa residency, current residential address and lawful status as required by rule 761—601.5(321). Submission of parental consent is also required in accordance with rule 761—601.6(321).

**630.2(3)** The nonoperator's identification card shall be coded for identification only, as explained on the reverse side of the card. The county number shall indicate the county of residence. The card shall expire five years from the date of issue if the applicant is under the age of 70. A card issued to a person who is a foreign national with temporary lawful status shall be issued only for the length of time the person is authorized to be present in the United States as verified by the department, not to exceed two years. However, if the person's lawful status as verified by the department has no expiration date, the card shall be issued for a period of no longer than one year.

**630.2(4)** Upon the request of the cardholder, the department shall indicate on the nonoperator's identification card the presence of a medical condition, that the cardholder is a donor under the uniform anatomical gift law, or that the cardholder has in effect a medical advance directive.

**630.2(5)** The issuance fee is \$5. However, no issuance fee shall be charged for a person whose license has been suspended for incapability pursuant to rule 761—615.14(321) or who has been denied further licensing in lieu of a suspension for incapability pursuant to rule 761—615.4(321).

**630.2(6)** An applicant who is a foreign national with temporary lawful status must provide documentation of lawful status as required by 761—subrule 601.5(4) at each renewal.

**630.2(7)** A person who seeks a nonoperator's identification card that is compliant with the REAL ID Act of 2005, 49 U.S.C. § 30301 note, as further defined in 6 CFR Part 37 ("REAL ID nonoperator's identification card"), must meet and comply with all lawful requirements for an Iowa nonoperator's identification card, and must also meet and comply with all application and documentation requirements set forth at 6 CFR Part 37, including but not limited to documentation of identity, date of birth, social security number, address of principal residence, and evidence of lawful status in the United States. Documents and information provided to fulfill REAL ID requirements must be verified as required in 6 CFR 37.13. An applicant for a REAL ID nonoperator's identification card is subject to a mandatory facial image capture that meets the requirements of 6 CFR 37.11(a). A REAL ID nonoperator's identification card may not be issued, reissued, or renewed except as permitted in 6 CFR Part 37 and may not be issued, reissued, or renewed by any procedure, in any circumstance, to any person, or for any term prohibited under 6 CFR Part 37. The information on the front of any REAL ID nonoperator's identification card must include all information and markings required by 6 CFR 37.17. Nothing in this subrule requires a person to obtain a REAL ID nonoperator's identification card.

**630.2(8)** A nonoperator's identification card issued to a foreign national with temporary lawful status shall include the following statement on the face of the card: "limited term."

**630.2(9)** Beginning January 15, 2013, a nonoperator's identification card that is not issued as a REAL ID nonoperator's identification card as defined in subrule 630.2(7) may be marked as required by 6 CFR 37.71 and any subsequent guidance issued by the U.S. Department of Homeland Security.

**630.2(10)** The department may determine means or methods for electronic renewal of a nonoperator's identification card.

*a.* An applicant who meets the following criteria may apply for electronic renewal:

- (1) The applicant must be at least 18 years old.
- (2) The applicant updated the applicant's photo at the applicant's last issuance or renewal.
- (3) The applicant's nonoperator's identification card has not been expired for more than one year.
- (4) The department's records show the applicant is a U.S. citizen.
- (5) The applicant's nonoperator's identification card is not marked "valid without photo."
- (6) The applicant is not seeking to change any of the following as it appears on the applicant's nonoperator's identification card:

1. Name.
2. Date of birth.
3. Sex.

*b.* An applicant who has not previously been issued a REAL ID nonoperator's identification card may not request a REAL ID nonoperator's identification card by electronic renewal.

**630.2(11)** An applicant for a nonoperator's identification card shall surrender all other driver's licenses and nonoperator's identification cards, other than a temporary permit held under Iowa Code section 321.181. This includes any driver's licenses or nonoperator's identification cards issued by jurisdictions other than Iowa. An applicant who renews a nonoperator's identification card electronically pursuant to 630.2(10) shall destroy the previous nonoperator's identification card upon receipt of a renewed nonoperator's identification card.

[ARC 8339B, IAB 12/2/09, effective 12/21/09; ARC 8514B, IAB 2/10/10, effective 3/17/10; ARC 9991B, IAB 2/8/12, effective 3/14/12; ARC 0347C, IAB 10/3/12, effective 11/7/12; ARC 0895C, IAB 8/7/13, effective 7/9/13; ARC 1073C, IAB 10/2/13, effective 11/6/13]

**761—630.3(321) Duplicate card.**

**630.3(1)** *Lost, stolen or destroyed card.* To replace a nonoperator's identification card that is lost, stolen or destroyed, the cardholder shall submit Form 430052 and shall comply with the requirements of 761—601.5(321). The replacement fee is \$3.

**630.3(2)** *Voluntary replacement.* To voluntarily replace a nonoperator's identification card, the cardholder shall surrender to the department the card to be replaced. The reasons a card may be voluntarily replaced and any additional supporting documentation required are the same as those listed in 761—paragraphs 605.11(2) "a" to "i." The fee for voluntary replacement is \$1.

[ARC 0347C, IAB 10/3/12, effective 11/7/12]

**761—630.4(321) Cancellation.** The department shall cancel a nonoperator's identification card upon receipt of evidence that the person was not entitled or is no longer entitled to a card, failed to give correct information, committed fraud in applying or used the card unlawfully.

These rules are intended to implement Iowa Code sections 321.189, 321.190, 321.195, 321.216, 321.216A, 321.216B and 321.216C, the REAL ID Act of 2005 (49 U.S.C. Section 30301 note), and 6 CFR Part 37.

[Filed 12/28/76, Notice 11/3/76—published 1/12/77, effective 2/16/77]

[Filed emergency 6/20/84—published 7/18/84, effective 7/1/84]

[Filed 5/11/87, Notice 3/11/87—published 6/3/87, effective 7/8/87]

[Filed 1/20/88, Notice 12/2/87—published 2/10/88, effective 3/16/88]

[Filed 9/21/89, Notice 7/26/89—published 10/18/89, effective 11/22/89]

[Filed emergency 6/7/90—published 6/27/90, effective 7/1/90]

[Filed 12/18/91, Notice 11/13/91—published 1/8/92, effective 2/12/92]

[Filed 11/1/95, Notice 9/27/95—published 11/22/95, effective 12/27/95]

[Filed 10/30/96, Notice 9/25/96—published 11/20/96, effective 12/25/96]

[Filed 1/21/98, Notice 12/17/97—published 2/11/98, effective 3/18/98]

[Filed 10/28/98, Notice 9/23/98—published 11/18/98, effective 12/23/98]

[Filed emergency 7/20/00 after Notice 6/14/00—published 8/9/00, effective 7/24/00]

[Filed 6/19/02, Notice 4/17/02—published 7/10/02, effective 8/14/02]

[Filed 10/11/06, Notice 8/30/06—published 11/8/06, effective 12/13/06]

[Filed Emergency ARC 8339B, IAB 12/2/09, effective 12/21/09]

[Filed ARC 8514B (Notice ARC 8342B, IAB 12/2/09), IAB 2/10/10, effective 3/17/10]

[Filed ARC 9991B (Notice ARC 9874B, IAB 11/30/11), IAB 2/8/12, effective 3/14/12]

[Filed ARC 0347C (Notice ARC 0201C, IAB 7/11/12), IAB 10/3/12, effective 11/7/12]

[Filed Emergency ARC 0895C, IAB 8/7/13, effective 7/9/13]

[Filed ARC 1073C (Notice ARC 0894C, IAB 8/7/13), IAB 10/2/13, effective 11/6/13]



CHAPTER 26  
CONSTRUCTION SAFETY AND HEALTH RULES

[Prior to 9/24/86, Labor, Bureau of [530]]

[Prior to 10/7/98, see 347—Ch 26]

**875—26.1(88) Adoption by reference.** Federal Safety and Health Regulations for Construction beginning at 29 CFR 1926.16 and continuing through 29 CFR, Chapter XVII, Part 1926, are hereby adopted by reference for implementation of Iowa Code chapter 88. These federal rules shall apply and be interpreted to apply to the Iowa Occupational Safety and Health Act, Iowa Code chapter 88, not the Contract Work Hours and Safety Standards Act, and shall apply and be interpreted to apply to enforcement by the Iowa commissioner of labor, not the United States Secretary of Labor or the Federal Occupational Safety and Health Administration. The amendments to 29 CFR 1926 are adopted as published at:

38 Fed. Reg. 16856 (June 27, 1973)  
38 Fed. Reg. 27594 (October 5, 1973)  
38 Fed. Reg. 33397 (December 4, 1973)  
39 Fed. Reg. 19470 (June 3, 1974)  
39 Fed. Reg. 24361 (July 2, 1974)  
40 Fed. Reg. 23072 (May 28, 1975)  
41 Fed. Reg. 55703 (December 21, 1976)  
42 Fed. Reg. 2956 (January 14, 1977)  
42 Fed. Reg. 37668 (July 22, 1977)  
43 Fed. Reg. 56894 (December 5, 1978)  
45 Fed. Reg. 75626 (November 14, 1980)  
51 Fed. Reg. 22733 (June 20, 1986)  
51 Fed. Reg. 25318 (July 11, 1986)  
52 Fed. Reg. 17753 (May 12, 1987)  
52 Fed. Reg. 36381 (September 28, 1987)  
52 Fed. Reg. 46291 (December 4, 1987)  
53 Fed. Reg. 22643 (June 16, 1988)  
53 Fed. Reg. 27346 (July 20, 1988)  
53 Fed. Reg. 29139 (August 2, 1988)  
53 Fed. Reg. 35627 (September 14, 1988)  
53 Fed. Reg. 35953 (September 15, 1988)  
53 Fed. Reg. 36009 (September 16, 1988)  
53 Fed. Reg. 37080 (September 23, 1988)  
54 Fed. Reg. 15405 (April 18, 1989)  
54 Fed. Reg. 23850 (June 2, 1989)  
54 Fed. Reg. 30705 (July 21, 1989)  
54 Fed. Reg. 41088 (October 5, 1989)  
54 Fed. Reg. 45894 (October 31, 1989)  
54 Fed. Reg. 49279 (November 30, 1989)  
54 Fed. Reg. 52024 (December 20, 1989)  
54 Fed. Reg. 53055 (December 27, 1989)  
55 Fed. Reg. 3732 (February 5, 1990)  
55 Fed. Reg. 42328 (October 18, 1990)  
55 Fed. Reg. 47687 (November 14, 1990)  
55 Fed. Reg. 50687 (December 10, 1990)  
56 Fed. Reg. 2585 (January 23, 1991)  
56 Fed. Reg. 5061 (February 7, 1991)  
56 Fed. Reg. 41794 (August 23, 1991)  
56 Fed. Reg. 43700 (September 4, 1991)

57 Fed. Reg. 7878 (March 5, 1992)  
57 Fed. Reg. 24330 (June 8, 1992)  
57 Fed. Reg. 29119 (June 30, 1992)  
57 Fed. Reg. 35681 (August 10, 1992)  
57 Fed. Reg. 42452 (September 14, 1992)  
58 Fed. Reg. 21778 (April 23, 1993)  
58 Fed. Reg. 26627 (May 4, 1993)  
58 Fed. Reg. 35077 (June 30, 1993)  
58 Fed. Reg. 35310 (June 30, 1993)  
58 Fed. Reg. 40468 (July 28, 1993)  
59 Fed. Reg. 215 (January 3, 1994)  
59 Fed. Reg. 6170 (February 9, 1994)  
59 Fed. Reg. 36699 (July 19, 1994)  
59 Fed. Reg. 40729 (August 9, 1994)  
59 Fed. Reg. 41131 (August 10, 1994)  
59 Fed. Reg. 43275 (August 22, 1994)  
59 Fed. Reg. 65948 (December 22, 1994)  
60 Fed. Reg. 9625 (February 21, 1995)  
60 Fed. Reg. 11194 (March 1, 1995)  
60 Fed. Reg. 33345 (June 28, 1995)  
60 Fed. Reg. 34001 (June 29, 1995)  
60 Fed. Reg. 36044 (July 13, 1995)  
60 Fed. Reg. 39255 (August 2, 1995)  
60 Fed. Reg. 50412 (September 29, 1995)  
61 Fed. Reg. 5509 (February 13, 1996)  
61 Fed. Reg. 9248 (March 7, 1996)  
61 Fed. Reg. 31431 (June 20, 1996)  
61 Fed. Reg. 41738 (August 12, 1996)  
61 Fed. Reg. 43458 (August 23, 1996)  
61 Fed. Reg. 46104 (August 30, 1996)  
61 Fed. Reg. 56856 (November 4, 1996)  
61 Fed. Reg. 59831 (November 25, 1996)  
62 Fed. Reg. 1619 (January 10, 1997)  
63 Fed. Reg. 1295 (January 8, 1998)  
63 Fed. Reg. 1919 (January 13, 1998)  
63 Fed. Reg. 3814 (January 27, 1998)  
63 Fed. Reg. 13340 (March 19, 1998)  
63 Fed. Reg. 17094 (April 8, 1998)  
63 Fed. Reg. 20099 (April 23, 1998)  
63 Fed. Reg. 33468 (June 18, 1998)  
63 Fed. Reg. 35138 (June 29, 1998)  
63 Fed. Reg. 66274 (December 1, 1998)  
64 Fed. Reg. 22552 (April 27, 1999)  
66 Fed. Reg. 5265 (January 18, 2001)  
66 Fed. Reg. 37137 (July 17, 2001)  
67 Fed. Reg. 57736 (September 12, 2002)  
69 Fed. Reg. 31881 (June 8, 2004)  
70 Fed. Reg. 1143 (January 5, 2005)  
71 Fed. Reg. 2885 (January 18, 2006)  
70 Fed. Reg. 76985 (December 29, 2005)  
71 Fed. Reg. 10381 (February 28, 2006)  
71 Fed. Reg. 36008 (June 23, 2006)

71 Fed. Reg. 76985 (August 24, 2006)  
 72 Fed. Reg. 64428 (November 15, 2007)  
 73 Fed. Reg. 75583 (December 12, 2008)  
 75 Fed. Reg. 12685 (March 17, 2010)  
 75 Fed. Reg. 27429 (May 17, 2010)  
 75 Fed. Reg. 48130 (August 9, 2010)  
 76 Fed. Reg. 33606 (June 8, 2011)  
 77 Fed. Reg. 17764 (March 26, 2012)  
 76 Fed. Reg. 80738 (December 27, 2011)  
 77 Fed. Reg. 23118 (April 18, 2012)  
 77 Fed. Reg. 37598 (June 22, 2012)  
 77 Fed. Reg. 42988 (July 23, 2012)  
 77 Fed. Reg. 46949 (August 7, 2012)  
 78 Fed. Reg. 23841 (April 23, 2013)  
 78 Fed. Reg. 32116 (May 29, 2013)

This rule is intended to implement Iowa Code sections 84A.1, 84A.2, 88.2 and 88.5.  
 [ARC 7699B, IAB 4/8/09, effective 5/13/09; ARC 8997B, IAB 8/11/10, effective 9/15/10; ARC 9230B, IAB 11/17/10, effective 12/22/10; ARC 9755B, IAB 9/21/11, effective 10/26/11; ARC 0173C, IAB 6/13/12, effective 7/18/12; ARC 0282C, IAB 8/22/12, effective 9/26/12; ARC 0726C, IAB 5/1/13, effective 6/5/13; ARC 0898C, IAB 8/7/13, effective 9/11/13; ARC 1049C, IAB 10/2/13, effective 11/6/13]

[Filed 7/13/72; amended 8/29/72, 8/16/73, 10/11/73, 3/18/74, 12/3/74]  
 [Filed 2/20/76, Notice 12/29/75—published 3/8/76, effective 4/15/76]  
 [Filed 4/13/77, Notice 3/9/77—published 5/4/77, effective 6/9/77]  
 [Filed 11/3/78, Notice 9/20/78—published 11/29/78, effective 1/10/79]  
 [Filed 8/1/80, Notice 6/25/80—published 8/20/80, effective 9/25/80]  
 [Filed 8/12/81, Notice 7/8/81—published 9/2/81, effective 10/9/81]  
 [Filed emergency 9/5/86—published 9/24/86, effective 9/24/86]  
 [Filed emergency 10/1/86—published 10/22/86, effective 10/1/86]  
 [Filed 4/17/87, Notice 9/24/86—published 5/6/87, effective 6/10/87]  
 [Filed 4/17/87, Notice 10/22/86—published 5/6/87, effective 6/10/87]  
 [Filed emergency 6/15/87—published 7/1/87, effective 6/15/87]  
 [Filed 8/6/87, Notice 7/1/87—published 8/26/87, effective 9/30/87]  
 [Filed 7/8/88, Notice 5/18/88—published 7/27/88, effective 9/1/88]  
 [Filed 3/17/89, Notices 9/21/88, 10/19/88—published 4/5/89, effective 5/10/89]  
 [Filed 8/18/89, Notices 6/14/89, 6/28/89—published 9/6/89, effective 10/11/89]  
 [Filed 10/26/89, Notice 9/6/89—published 11/15/89, effective 12/20/89]  
 [Filed 1/19/90, Notice 11/15/89—published 2/7/90, effective 3/14/90]  
 [Filed 3/16/90, Notice 2/7/90—published 4/4/90, effective 5/9/90]  
 [Filed 6/8/90, Notice 4/4/90—published 6/27/90, effective 8/1/90]  
 [Filed 2/15/91, Notice 11/28/90—published 3/6/91, effective 4/10/91]  
 [Filed 4/23/91, Notice 3/6/91—published 5/15/91, effective 6/19/91]  
 [Filed 12/20/91, Notice 10/30/91—published 1/8/92, effective 2/12/92]  
 [Filed emergency 2/12/92 after Notice 1/8/92—published 3/4/92, effective 3/4/92]  
 [Filed emergency 5/6/92 after Notice 4/1/92—published 5/27/92, effective 5/27/92]  
 [Filed emergency 7/17/92—published 8/5/92, effective 8/5/92]  
 [Filed emergency 8/14/92 after Notice 7/8/92—published 9/2/92, effective 9/2/92]  
 [Filed emergency 9/11/92 after Notice 8/5/92—published 9/30/92, effective 9/30/92]  
 [Filed emergency 10/7/92 after Notice 9/2/92—published 10/28/92, effective 10/28/92]  
 [Filed emergency 12/4/92 after Notice 10/28/92—published 12/23/92, effective 12/23/92]  
 [Filed emergency 7/29/93 after Notices 5/26/93, 6/9/93—published 8/18/93, effective 8/18/93]  
 [Filed emergency 9/22/93 after Notice 8/18/93—published 10/13/93, effective 10/13/93]  
 [Filed emergency 10/7/93 after Notice 9/1/93—published 10/27/93, effective 10/27/93]  
 [Filed emergency 4/21/94 after Notice 3/16/94—published 5/11/94, effective 5/11/94]

- [Filed emergency 9/23/94 after Notice 8/17/94—published 10/12/94, effective 10/12/94]
- [Filed emergency 10/21/94 after Notice 9/14/94—published 11/9/94, effective 11/9/94]
- [Filed emergency 11/2/94 after Notice 9/28/94—published 11/23/94, effective 11/23/94]
- [Filed emergency 4/21/95 after Notice 3/15/95—published 5/10/95, effective 5/10/95]
- [Filed emergency 7/14/95 after Notice 5/10/95—published 8/2/95, effective 8/2/95]
- [Filed emergency 9/22/95 after Notice 8/16/95—published 10/11/95, effective 10/11/95]
- [Filed emergency 12/1/95 after Notice 10/11/95—published 12/20/95, effective 12/20/95]
- [Filed emergency 1/26/96 after Notice 12/20/95—published 2/14/96, effective 2/14/96]
- [Filed emergency 7/12/96 after Notice 5/22/96—published 7/31/96, effective 7/31/96]
- [Filed emergency 10/3/96 after Notice 7/31/96—published 10/23/96, effective 10/23/96]
- [Filed emergency 11/27/96 after Notice 10/23/96—published 12/18/96, effective 12/18/96]
- [Filed emergency 2/7/97 after Notice 12/18/96—published 2/26/97, effective 2/26/97]
- [Filed emergency 4/4/97 after Notice 2/26/97—published 4/23/97, effective 4/23/97]
- [Filed emergency 3/19/98 after Notice 2/11/98—published 4/8/98, effective 4/8/98]
- [Filed emergency 7/10/98 after Notice 4/8/98—published 7/29/98, effective 7/29/98]
- [Filed emergency 9/4/98 after Notice 7/29/98—published 9/23/98, effective 9/23/98]
- [Filed emergency 10/30/98 after Notice 9/23/98—published 11/18/98, effective 11/18/98]
- [Filed emergency 3/5/99 after Notice 1/27/99—published 3/24/99, effective 3/24/99]
- [Filed emergency 1/5/00 after Notice 8/25/99—published 1/26/00, effective 1/26/00]
- [Filed 11/20/01, Notice 6/13/01—published 12/12/01, effective 1/16/02]
- [Filed 11/21/01, Notice 10/17/01—published 12/12/01, effective 1/16/02]
- [Filed 1/17/03, Notice 12/11/02—published 2/5/03, effective 3/12/03]
- [Filed 10/28/04, Notice 7/21/04—published 11/24/04, effective 12/29/04]
- [Filed 3/9/06, Notice 1/18/06—published 3/29/06, effective 5/3/06]
- [Filed 4/18/06, Notice 3/1/06—published 5/10/06, effective 6/14/06]
- [Filed 6/14/06, Notice 5/10/06—published 7/5/06, effective 8/9/06]
- [Filed emergency 7/28/06—published 8/16/06, effective 8/28/06]
- [Filed 1/10/07, Notice 12/6/06—published 1/31/07, effective 3/7/07]
- [Filed 2/8/08, Notice 1/2/08—published 2/27/08, effective 5/15/08]
- [Filed ARC 7699B (Notice ARC 7541B, IAB 2/11/09), IAB 4/8/09, effective 5/13/09]
- [Filed ARC 8997B (Notice ARC 8862B, IAB 6/16/10), IAB 8/11/10, effective 9/15/10]
- [Filed ARC 9230B (Notice ARC 9090B, IAB 9/22/10), IAB 11/17/10, effective 12/22/10]
- [Filed ARC 9755B (Notice ARC 9640B, IAB 7/27/11), IAB 9/21/11, effective 10/26/11]
- [Filed ARC 0173C (Notice ARC 0105C, IAB 4/18/12), IAB 6/13/12, effective 7/18/12]
- [Filed ARC 0282C (Notice ARC 0175C, IAB 6/27/12), IAB 8/22/12, effective 9/26/12]
- [Filed ARC 0726C (Notice ARC 0587C, IAB 2/6/13), IAB 5/1/13, effective 6/5/13]
- [Filed ARC 0898C (Notice ARC 0752C, IAB 5/29/13), IAB 8/7/13, effective 9/11/13]
- [Filed ARC 1049C (Notice ARC 0905C, IAB 8/7/13), IAB 10/2/13, effective 11/6/13]