State of Iowa

Iowa Administrative Code Supplement

Biweekly
October 6, 2010

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Acting 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

Accountancy Examining Board[193A]

Replace Chapter 12

Utilities Division[199]

Replace Chapters 35 and 36

School Budget Review Committee[289]

Replace Chapters 2 to 5

Human Services Department[441]

Replace Analysis
Replace Chapter 36
Replace Chapter 58
Replace Chapters 78 and 79
Replace Chapter 92

Natural Resource Commission[571]

Replace Analysis
Replace Chapter 44

Homeland Security and Emergency Management Division[605]

Replace Chapter 9

Public Health Department[641]

Replace Analysis
Replace Chapter 91

Professional Licensure Division[645]

Replace Chapter 41
Replace Chapters 43 to 45

Pharmacy Board[657]

Replace Chapter 3

Public Safety Department[661]

Replace Chapter 276

Secretary of State[721]

Replace Chapter 21

Telecommunications and Technology Commission, Iowa[751]

Replace Chapter 1

CHAPTER 12
FEES

[Prior to 7/13/88, see Accountancy, Board of[10]]
[Prior to 5/1/02, see 193A—Chapter 14]

193A—12.1(542) Required fees. The following is a schedule of the fees for examinations, certificates, licenses, permits and renewals adopted by the board:

Initial CPA examination application:	
Paid directly to CPA examination services	not to exceed $1500
Reexamination:	
Paid directly to CPA examination services	not to exceed $1500
Original issuance of CPA certificate or LPA license by examination (fee includes wall certificate)	$100
Original issuance of CPA certificate by reciprocity or substantial equivalency	$100
CPA wall certificate or LPA license issued by reciprocity or substantial equivalency	$50
Replacement of lost or destroyed wall CPA certificate or LPA license	$50
Original issuance of attest qualification	$100
Biennial renewal of CPA certificate or LPA license—active status	$100
Late renewal of CPA certificate or LPA license within 30-day grace period (July 1 to July 30)—active status	$25
Biennial renewal of CPA certificate or LPA license—inactive status	$50
Late renewal of CPA certificate or LPA license within 30-day grace period (July 1 to July 30)—inactive status	$10
Penalty for failure to comply with continuing education requirements	$50 to $250
Original issuance of firm permit to practice	$100
Annual renewal of firm permit to practice	$100
Reinstatement of lapsed CPA certificate or LPA license	$100 + renewal fee + $25 per month of expired registration
Reinstatement of lapsed firm permit to practice	$100 + renewal fee + $25 per month of expired registration
Interstate Transfer Form	$25

[**ARC 7715B**, IAB 4/22/09, effective 7/1/09; **ARC 8866B**, IAB 6/30/10, effective 8/4/10; **ARC 8867B**, IAB 6/30/10, effective 8/4/10; **ARC 9040B**, IAB 9/8/10, effective 10/13/10]

193A—12.2(542) Reinstatement.

12.2(1) *Reinstatement of a lapsed CPA certificate or LPA license.* The fee for the reinstatement of a lapsed CPA certificate or LPA license for applications filed on or after July 1, 2009, is $100 plus the renewal fee plus $25 per month of expired registration up to a maximum of $1,000.

12.2(2) *Reinstatement of lapsed firm permit to practice.* The fee for the reinstatement of a lapsed CPA or LPA firm permit to practice for applications filed on or after July 1, 2009, is $100 plus the renewal fee plus $25 per month of expired registration up to a maximum of $1,000.

12.2(3) *Applicants for reinstatement.* All applicants for reinstatement shall be assessed the $100 reinstatement fee. The $25 per month penalty fee described in subrules 12.2(1) and 12.2(2) shall not be assessed if the applicant for reinstatement did not, during the period of lapse, engage in any acts or practices for which an active CPA certificate, LPA license, or firm permit to practice as a CPA or LPA firm is required in Iowa. Falsely claiming an exemption from the monthly penalty fee is a ground for

discipline; in addition, other grounds for discipline may arise from practicing on a lapsed certificate, license or permit to practice.
[**ARC 7715B**, IAB 4/22/09, effective 7/1/09; **ARC 8867B**, IAB 6/30/10, effective 8/4/10; **ARC 9123B**, IAB 10/6/10, effective 11/10/10]

193A—12.3(542) Prorating of certain fees.

12.3(1) Fees for issuance of an original certificate or license for less than one year to the biennial renewal date as provided in rule 193A—5.1(542) may be prorated on an annual basis for the remainder of time covered by the certificate or license. For example, if a CPA certificate or LPA license holder applies for the original certificate or license and is required to renew the certificate or license in 12 months or less, the fee would be $50. If the original certificate or license is not scheduled to be renewed for more than 12 months, the fee would be $100.

12.3(2) Fees for the issuance of an original CPA certificate or LPA license, pursuant to rule 193A—5.3(542), or the issuance of an initial permit to practice to a CPA or LPA firm, pursuant to rule 193A—7.1(542), will not be prorated.
[**ARC 7715B**, IAB 4/22/09, effective 7/1/09]

These rules are intended to implement Iowa Code chapter 542.

[Filed and effective September 22, 1975 under ch 17A, C ’73]
[Filed 2/2/79, Notice 12/27/78—published 2/21/79, effective 3/28/79]
[Filed emergency 3/9/79—published 4/4/79, effective 3/9/79]
[Filed 2/12/81, Notice 10/29/80—published 3/4/81, effective 4/8/81]
[Filed 2/8/82, Notice 12/9/81—published 3/3/82, effective 4/7/82]
[Filed 6/22/88, Notice 3/9/88—published 7/13/88, effective 8/17/88]
[Filed 3/30/89, Notice 2/8/89—published 4/19/89, effective 5/24/89]
[Filed 8/1/91, Notice 5/15/91—published 8/21/91, effective 9/25/91]
[Filed 12/30/92, Notice 10/28/92—published 1/20/93, effective 2/24/93]
[Filed 12/17/93, Notice 10/13/93—published 1/5/94, effective 2/9/94]
[Filed 4/12/02, Notice 3/6/02—published 5/1/02, effective 7/1/02]
[Filed 7/18/02, Notice 6/12/02—published 8/7/02, effective 9/11/02]
[Filed 1/30/04, Notice 12/24/03—published 2/18/04, effective 3/24/04]
[Filed ARC 7715B (Notice ARC 7484B, IAB 1/14/09), IAB 4/22/09, effective 7/1/09]
[Filed ARC 8866B (Notice ARC 8616B, IAB 3/24/10), IAB 6/30/10, effective 8/4/10]
[Filed ARC 8867B (Notice ARC 8617B, IAB 3/24/10), IAB 6/30/10, effective 8/4/10]
[Filed ARC 9040B (Notice ARC 8868B, IAB 6/30/10), IAB 9/8/10, effective 10/13/10]
[Filed ARC 9123B (Notice ARC 8988B, IAB 8/11/10), IAB 10/6/10, effective 11/10/10]

CHAPTER 35
ENERGY EFFICIENCY PLANNING AND COST REVIEW

199—35.1(476) Policy and purpose. The board deems the implementation of effective energy efficiency plans by utilities and the opportunity of the utilities' customers to participate in and benefit from the energy efficiency plans to be of the highest priority.

These rules are intended to implement Iowa Code sections 476.1, 476.6(17, 19-21), and 476.10A, for gas and electric utilities required by statute to be rate-regulated and to provide the board the necessary information to review each utility's assessment of potential, to develop specific capacity and energy savings performance standards for each utility and to evaluate the appropriateness of each utility's energy efficiency plan.

199—35.2(476) Definitions. The following words and terms, when used in this chapter, shall have the meanings shown below:

"After-tax discount rate" means the utility's weighted cost of capital reduced by the utility's composite federal and state income tax rate multiplied by the utility's weighted cost of debt.

"Assessment of potential" means development of energy and capacity savings available from actual and projected customer usage by cost-effectively applying commercially available technology and improved operating practices to energy-using equipment and buildings and considering market factors including, but not limited to, the effects of rate impacts, the need to capture lost opportunities, the nonenergy benefits of measures, uncertainty associated with industry restructuring, the strategic value of energy efficiency to the utility, and other market factors.

"Avoided cost" means the cost the utility would have to pay to provide energy and capacity from alternative sources of supply available to utilities as calculated pursuant to the formulas in subrules 35.9(7) and 35.10(4).

"Benefit/cost ratio" means the ratio of the present value of benefits to the present value of costs.

"Benefit/cost tests" means one of the four acceptable economic tests used to compare the present value of applicable benefits to the present value of applicable costs of an energy efficiency program or plan. The tests are the participant test, the ratepayer impact test, the societal test, and the utility cost test. A program or plan passes a benefit/cost test if the benefit/cost ratio is equal to or greater than one.

"Capacity purchase" or *"sale commitment"* means electric generating capacity which a utility has committed to purchase or sell by means of contracts or other enforceable agreements.

"Contract deliverability" means the maximum firm capacity which a utility has under contract with its suppliers.

"Customer incentive" means an amount or amounts provided to or on behalf of customers for the purpose of having customers participate in energy efficiency programs. Incentives include, but are not limited to, rebates, loan subsidies, payments to dealers, rate credits, bill credits, the cost of energy audits, the cost of equipment given to customers, and the cost of installing such equipment. Customer incentives do not include the cost of information provided by the utility, nor do they include customers' bill reductions associated with reduced energy usage due to the implementation of energy efficiency programs. For the purposes of energy efficiency pricing strategies, incentive means the difference between a customer's bill on an energy efficiency customized rate and the customer's bill on a traditional rate considering factors such as the elasticity of demand.

"Customer persistence" means a customer's consistent use of energy efficient equipment or operating practices over time. For example, a nonpersistent customer may initially adopt the use of compact fluorescent lights, but replace efficient lights with incandescent lights when the former wear out. By contrast, a persistent customer will replace burned out efficient lamps with energy saving lamps after the initial trial.

"Customer's side of the meter" means point of delivery. For reference, the utility's side of the meter refers to activities from and including generation or energy supply up to the point where the customer takes delivery, which may be the customer's billing meter or an unmetered fixture.

"Economic potential" means the energy and capacity savings that result in future years when measures are adopted or applied by customers at the time it is economical to do so. For purposes of this chapter, economic potential may be determined by comparing the utility's avoided cost savings to the incremental cost of the measure.

"Energy efficiency measures" means activities on the customers' side of the meter which reduce customers' energy use or demand including, but not limited to, end-use efficiency improvements; load control or load management; thermal energy storage; or pricing strategies.

"Energy savings performance standards" means those standards which shall be cost-effectively achieved, with the exception of low-income weatherization and tree planting programs, and includes the annual capacity savings stated in either kW or dth/day or Mcf/day and the annual energy savings stated in either kWh or dth or Mcf.

"Firm throughput" means firm sales of gas and gas transported over the utility's distribution facilities under firm transportation arrangements.

"Fixed operations and maintenance costs" means operations and maintenance costs which do not vary with changes in energy generation or supply.

"Free riders" means those program participants who would have done what an energy efficiency program intends to promote even without the program.

"Gross operating revenues" means all revenues from intrastate operations includable in the operating revenue accounts of the prescribed uniform system of accounts except:

1. Provisions for uncollectible revenues;
2. Amounts included in the accounts for interdepartmental sales and rents;
3. Wholesale revenue;
4. Revenues from the sale of natural gas used as a feedstock by customers; and
5. Revenues from the sale of transportation service.

"Incremental cost" means the difference in the customer's cost between a less energy efficient measure and a more energy efficient measure.

"Marginal energy cost" for a gas utility means the cost associated with supplying the next thousand cubic feet (Mcf) or dekatherm (dth) of gas.

"Marginal energy cost" for an electric utility means the energy or fuel cost associated with generating or purchasing the next kWh of electricity.

"Market barrier" means a real or perceived impediment to the adoption of energy efficient technologies or energy efficient behavior by consumers.

"Net societal benefits" means the present value of benefits less the present value of costs as defined in the societal test.

"Off-peak period" means the days and weeks not included in the gas utility's peak period.

"Participant test" means an economic test used to compare the present value of benefits to the present value of costs over the useful life of an energy efficiency measure or program from the participant's perspective. Present values are calculated using a discount rate appropriate to the class of customers to which the energy efficiency measure or program is targeted. Benefits are the sum of the present values of the customers' bill reductions, tax credits, and customer incentives for each year of the useful life of an energy efficient measure or program. Costs are the sum of present values of the customer participation costs (including initial capital costs, ongoing operations and maintenance costs, removal costs less a salvage value of existing equipment, and the value of the customer's time in arranging installation, if significant) and any resulting bill increases for each year of the useful life of the measure or program. The calculation of bill increases and decreases must account for any time-differentiated rates to the customer or class of customers being analyzed.

"Peak day demand" means the amount of natural gas required to meet firm customers' maximum daily consumption.

"Peak period" for a gas utility means the days and weeks when the gas utility's highest firm throughput is likely to occur.

"Phase-in technical potential" means the technical potential for energy and capacity savings from the adoption of commercially available technology and operating practices when existing equipment is

replaced or new equipment is installed. For example, if an energy-using unit of equipment has a ten-year lifetime, the phase-in technical potential in any one year might be one-tenth of the total number of such units in existence plus units projected to be installed.

"Process-oriented industrial assessment" means an analysis which promotes the adoption of energy efficiency measures by examining the facilities, operations and equipment of an industrial customer in which energy efficiency opportunities may be embedded and which includes:

1. The identification of opportunities which may provide increased energy efficiency in an industrial customer's production process from the introduction of materials to the final packaging of the product for shipping by:
   - Directly improving the efficiency or scheduling of energy use;
   - Reducing environmental waste; and
   - Technological improvements designed to increase competitiveness and to achieve cost-effective product quality enhancement;
2. The identification of opportunities for an industrial customer to improve the energy efficiency of lighting, heating, ventilation, air conditioning, and the associated building envelope;
3. The identification of cost-effective opportunities for using renewable energy technology in "1" and "2" above.

"Program delivery and support mechanisms" means methods used by the utility to promote the adoption of energy efficiency options by customers. Program delivery and support mechanisms may include but are not limited to informational, educational, or demonstration techniques, technical assistance, or energy audits. Program delivery and support mechanisms may target specific options and markets, or address a variety of options across any number of energy efficiency programs.

"Purchased gas adjustment (PGA) year" means the 12-month period beginning September 1 and ending August 31.

"Ratepayer impact measure test" means an economic test used to compare the present value of the benefits to the present value of the costs over the useful life of an energy efficiency measure or program from a rate level or utility bill perspective. Present values are calculated using the utility's discount rate. Benefits are the sum of the present values of utility avoided capacity and energy costs (excluding the externality factor) and any revenue gains due to the energy efficiency measures for each year of the useful life of the measure or program. Costs are the sum of the present values of utility increased supply costs, revenue losses due to the energy efficiency measures, utility program costs, and customer incentives for each year of the useful life of the measure or program. The calculation of utility avoided capacity and energy, increased utility supply costs, and revenue gains and losses must use the utility costing periods.

"Revenue requirement per net kW per year" for an electric utility means an annual cost amount calculated by the economic carrying charge for each year of the supply option's life such that when each annual amount is discounted by the utility's after-tax discount rate the sum of the discounted amounts equals the supply option's capital cost inclusive of income taxes on the return.

"Saturation" or *"market saturation"* means a comparison (using fractions or percentages) of the number of units of a particular type of equipment or building component to the total number of units in use which perform the particular function under study.

"Seasonal peak demand" for an electric utility means the maximum hourly demand that occurred during that season.

"Sensitivity analysis" means a set of evaluation methods or procedures which provides an estimation of the sensitivity of final results to changes in particular input data or assumptions.

"Societal test" means an economic test used to compare the present value of the benefits to the present value of the costs over the useful life of an energy efficiency measure or program from a societal perspective. Present values are calculated using a 12-month average of the 10-year and 30-year Treasury Bond rate as the discount rate. The average shall be calculated using the most recent 12 months at the time the utility calculates its benefit/cost tests for its energy efficiency plan in subrule 35.8(6). Benefits are the sum of the present values of the utility avoided supply and energy costs including the effects of externalities. Costs are the sum of the present values of utility program costs (excluding customer

incentives), participant costs, and any increased utility supply costs for each year of the useful life of the measure or program. The calculation of utility avoided capacity and energy and increased utility supply costs must use the utility costing periods.

"System energy losses" for an electric utility means net energy which is generated, purchased, or interchanged by a utility but which is not delivered either to ultimate customers or used for interdepartmental sales expressed as a percentage of net energy.

"Take-back effect" means a tendency to increase energy use in a facility, or for an appliance, as a result of increased efficiency of energy use. For example, a customer's installation of high efficiency light bulbs and then operating the lights longer, constitutes "taking-back" some of the energy otherwise saved by the efficient lighting.

"Target market" means a group of energy users who are the intended participants in an energy efficiency program.

"Technical potential" means the demand and energy savings which could occur if every existing piece of equipment or operating practice were changed to a technically feasible level of energy efficiency.

"Technically viable" means that a measure is appropriate for customers' equipment and buildings and Iowa's climatic conditions.

"Total throughput" means all volumes of natural gas flowing through the utility's distribution system.

"Transportation volume" means the volume of natural gas flowing through the utility's distribution system which is not owned or sold by the utility.

"Useful life" means the number of years an energy efficiency measure will produce benefits.

"Utility cost test" means an economic test used to compare the present value of the benefits to the present value of the costs over the useful life of an energy efficiency measure or program from the utility revenue requirement perspective. Present values are calculated using the utility's discount rate. Benefits are the sum of the present values of each year's utility avoided capacity and energy costs (excluding the externality factor) over the useful life of the measure or program. Costs are the sum of the present values of the utility's program costs, customer incentives, and any increased utility supply costs for each year of the useful life of the measure or program. The calculation of utility avoided capacity and energy and increased utility supply costs must use the utility costing periods.

"Variable operations and maintenance costs" means operations and maintenance costs which vary with the amount of energy generated or supplied.

199—35.3(476) Applicability. Each gas or electric utility required by statute to be rate-regulated shall file an assessment of potential energy and capacity savings and an energy efficiency plan which shall include economically achievable programs designed to attain the performance standards developed by the board. Combination electric and gas utilities may file combined assessments of potential and energy efficiency plans. Combined plans shall specify which energy efficiency programs are attributable to the electric operation, which are attributable to the natural gas operation, and which are attributable to both. If a combination utility files separate plans, the board may consolidate the plans for purposes of review and hearing. The board will conduct a contested case proceeding for the purpose of (1) developing specific capacity and energy savings performance standards for each utility and (2) reviewing energy efficiency plans and budgets designed to achieve those savings.

199—35.4(476) Schedule of filings.

35.4(1) The board will schedule each utility's filing of an assessment of potential and energy efficiency plan and each utility's prudence review proceeding by order.

35.4(2) Initial cost recovery proceedings. Rescinded IAB 4/28/93, effective 6/2/93.

35.4(3) Subsequent biennial filings. Rescinded IAB 4/28/93, effective 6/2/93.

35.4(4) Written notice of assessment of potential and energy efficiency plan. No more than 62 days prior to and prior to filing its assessment of potential and energy efficiency plan, a utility shall mail or deliver a written notice of its filing to all affected customers. The notice shall be submitted to the board

for approval not less than 30 days prior to proposed notification of customers. The notice shall, at a minimum, include the following elements:

a. A statement that the utility will be filing an assessment of potential and energy efficiency plan with the board;

b. A brief identification of the proposed energy efficiency programs and the estimated annual cost of the proposed energy efficiency programs during the five-year budget time frame;

c. The estimated annual rate and bills impacts of the proposed energy efficiency programs on each class of customer; and the estimated annual jurisdictional rate impact for each major customer grouping in dollars and as a percent, with the proposed actual increases to be filed at the time of notice to customers;

d. A statement that the board will be conducting a contested case proceeding to review the application and that a customer may file a written objection and request a consumer comment hearing; and

e. The telephone numbers and addresses of utility personnel, the board and the consumer advocate, for the customer to contact with questions.

199—35.5(476) Required programs. Rescinded IAB 1/13/99, effective 2/17/99.

199—35.6(476) Procedures. The following procedures shall govern the board's determination of performance standards and review of energy efficiency plans:

35.6(1) *Collaboration.* A utility shall offer interested persons the opportunity to participate in the development of its energy efficiency plan. At a minimum, a utility shall provide the opportunity to offer suggestions for programs and for the assessment of potential and to review and comment on a draft of the assessment of potential and energy efficiency plan proposed to be submitted by the utility. The utility may analyze proposals from participants to help determine the effects of the proposals on its plan. A participant shall have the responsibility to provide sufficient data to enable the utility to analyze the participant's proposal. The opportunity to participate shall commence at least 180 days prior to the date the utility submits its assessment of potential and plan to the board.

35.6(2) *Contested case proceeding.* Within 30 days after filing, each application for approval of an assessment of potential and accompanying energy efficiency plan which meets the requirements of this chapter shall be docketed as a contested case proceeding. All testimony, exhibits, and work papers shall be filed with each application for approval of an assessment of potential and energy efficiency plan. The energy bureau of the division of energy and geological resources of the Iowa department of natural resources shall be considered a party to the proceeding. Any portion of any plan, application, testimony, exhibit, or work paper which is based upon or derived from a computer program shall include as a filing requirement the name and description of the computer program, and a disk and a hard copy of all reasonably necessary data inputs and all reasonably necessary program outputs associated with each such portion. One copy of the computer information will be filed with the board, one copy of this information will be provided to the energy bureau of the division of energy and geological resources of the Iowa department of natural resources, and one copy of this information will be provided to the consumer advocate. Further copies shall be provided by the utility upon request by the board or the consumer advocate. The proceeding shall follow the applicable provisions of 199 IAC Chapter 7.

35.6(3) *Review of proposals offered by third parties.* The consumer advocate or a third-party intervenor may propose approval, modification, or rejection of a utility's assessment of potential and accompanying energy efficiency plan. All testimony, exhibits, and work papers shall be filed with any proposal. The testimony, exhibits, and work papers of the consumer advocate or a third-party intervenor shall include, if applicable:

a. An analysis showing why rejection of the proposed utility assessment of potential and plan is appropriate;

b. A statement of any proposed modification or alternate plan and why approval is appropriate;

c. An estimated implementation schedule for any modification or alternate plan; and

d. A statement of the projected costs and benefits and benefit/cost test results as a result of any modification or alternate plan and the amount of difference from the utility's projected costs and benefits.

35.6(4) *Modification after implementation.* An approved energy efficiency plan and budget may be modified during implementation if the modification is approved by the board. The consumer advocate or the utility may file either a separate or joint application for modification. The board, on its own motion, may consider modification of the energy efficiency plan and budget.

a. The utility shall file an application to modify if any one of the following conditions occurs or is projected to occur during the current or subsequent calendar year of implementation of its plan:

(1) The total annual plan budget has changed or will change by a factor of at least plus or minus 5 percent;

(2) The budget per customer class or grouping has changed or will change by a factor of at least plus or minus 10 percent;

(3) An approved program is eliminated or a new program is added.

b. All applications to modify shall be filed in the same docket in which the energy efficiency plan was approved. All parties to the docket in which the energy efficiency plan was approved shall be served copies of the application to modify and shall have 14 days to file their objection or agreement. Failure to file timely objection shall be deemed agreement.

c. Each application to modify an approved energy efficiency plan shall include:

(1) A statement of the proposed modification and the party's interest in the modification;

(2) An analysis supporting the requested modification;

(3) An estimated implementation schedule for the modification; and

(4) A statement of the effect of the modification on attainment of the utility's performance standards and on projected results of the utility's implementation of its plan.

d. If the board finds that reasonable grounds exist to investigate the proposed modification, a procedural schedule shall be set within 30 days after the application is filed.

e. If an application to modify is filed and the board finds that there is no reason to investigate, then the board shall issue an order stating the reasons for the board's decision relating to the application.

f. If the board rejects or modifies a utility's plan, the board may require the utility to file a modified plan and may specify the minimum acceptable contents of the modified plan.

199—35.7(476) Waivers. Upon request and for good cause shown, the board may waive any energy efficiency plan requirement. If the waiver request is granted, a copy of the board order shall be filed with the energy efficiency plan.

199—35.8(476) Assessment of potential and energy efficiency plan requirements. A utility's plan shall include a range of programs which address all customer classes across its Iowa jurisdictional territory. At a minimum, the plan shall include a program for qualified lower-income residential customers, including a cooperative program with any community action agency within the utility's service area. The utility shall consider including in its plan a program for tree planting. Advertising which is part of an approved energy efficiency program is deemed to be advertising required by the board for purposes of Iowa Code section 476.18(3). The utility's assessment of potential and energy efficiency plan shall include a summary not to exceed five pages in length written in a nontechnical style for the benefit of the general public. Each utility's assessment of potential and accompanying energy efficiency plan shall include the following:

35.8(1) *Assessment of potential and determination of performance standards.* The utility shall file with the board an assessment of the potential for energy and capacity savings available from actual and projected customer usage by applying commercially available technology and improved operating practices to energy-using equipment and buildings. The utility's assessment shall address the potential energy and capacity savings in each of ten years subsequent to the year the assessment is filed. Economic and impact analyses of measures shall address benefits and costs over the entire estimated lives of energy efficiency measures. At a minimum, each utility's assessment of potential shall include data and analyses as follows:

a. A base case survey projecting annual peak demand and energy use of customers' existing and estimated new energy-using buildings and equipment. The base case survey shall identify the annual

peak demand and energy savings projected to occur from customers' adoption of measures in the absence of new or continued demand-side management programs by the utility.

b. A survey to identify and describe all commercially available energy efficiency measures and their attributes needed to perform an assessment of potential energy and capacity savings, including but not limited to all relevant costs of the measures, utility bill savings, utility avoided cost savings, peak demand and energy savings, measures' lifetimes, current market saturation of the measures, market availability of the measures, and non-energy-related features, costs and benefits.

c. A description of the methods and results for any screening or selection process used to identify technically viable energy efficiency measures. The utility shall explain its elimination of measures from further consideration. The utility shall provide an assessment of either annual economic potential or annual phase-in technical potential for peak demand and energy savings from projected adoption of technically viable measures, describing its methods and assumptions.

d. An assessment of the annual potential for utility implementation of the following special programs:

(1) Peak demand and energy savings from programs targeted at qualified low-income customers, including cooperative programs with community action agencies;

(2) Implementation of tree-planting programs; and

(3) Peak demand and energy savings from cost-effective assistance to homebuilders and homebuyers in meeting the requirements of the Iowa model energy code.

e. An identification of the utility's proposed performance goals for peak demand and energy savings from utility implementation of cost-effective energy efficiency programs and special programs. The utility shall identify annual goals, by energy efficiency program and total plan, for five years subsequent to the year of the filing. The utility may constrain or accelerate projected utility implementation of programs from estimates of economic or phase-in potential, based on its assessment of market potential. The utility may consider market factors including, but not limited to, market barriers to implementation of programs, the effects of rate impacts, lost opportunities which decrease future implementation of measures or programs, the nonenergy benefits and detriments of programs, uncertainty associated with industry restructuring, the strategic value of energy efficiency to the utility and other market factors it deems relevant. The utility shall fully describe its data and assumptions. In lieu of the data required in (1) through (5) below, the utility may reference relevant data and analyses filed in its energy efficiency plan, pursuant to subrule 35.8(2). The utility shall describe its analyses and results for factors relevant to the development of performance goals, including:

(1) Cost-effectiveness tests. The utility shall analyze for cost-effectiveness proposed programs, using the societal, utility, ratepayer impact and participant tests. The utility's analyses shall use inputs or factors realistically expected to influence cost-effective implementation of programs, including the avoided costs filed pursuant to rules 35.9(476) and 35.10(476) or avoided costs determined by the utility's alternative method. If the utility uses a test other than the societal test as the criterion for determining the cost-effectiveness of utility implementation of energy efficiency programs and plans, the utility shall describe and justify its use of the alternative test or combination of tests and compare the resulting impacts with the impacts resulting from the societal test.

(2) Cost-effectiveness threshold(s). The utility shall describe and justify the level or levels of cost-effectiveness, if greater or less than a benefit/cost ratio of 1.0, to be used as a threshold for cost-effective utility implementation of programs. The utility's threshold of cost-effectiveness for its plan as a whole shall be a benefit/cost ratio of 1.0 or greater.

(3) A description of the proposed programs to be implemented, proposed utility implementation techniques, the number of eligible participants and proposed rates of participation per year, and the estimated annual peak demand and energy savings.

(4) The budgets or levels of spending for utility implementation of programs, including proposed special programs addressing low-income, tree-planting and home-building assistance measures.

(5) The rate impacts and average bill impacts, by customer class, resulting from utility implementation of programs.

f. An optional sensitivity analysis. If the utility's proposed standards differ from the level of energy and capacity savings resulting from the utility's current plan by more than 25 percent, the utility shall provide a sensitivity analysis identifying key variables, including levels of spending, and showing their impact on cost-effectiveness, energy savings, and capacity savings. The purpose of the sensitivity analysis shall be to explore the range of potential for utility implementation of programs.

35.8(2) *Proposed energy efficiency plan, programs, and budget and cost allocation.* The utility shall file with the board an energy efficiency plan listing all proposed new, modified, and existing energy efficiency programs. The following information shall be provided:

a. The analyses and results of cost-effectiveness tests for the plan as a whole and for each program. Low-income and tree-planting programs shall not be tested for cost-effectiveness, unless the utility wishes to present the results of cost-effectiveness tests for informational purposes. The utility shall analyze proposed programs and the plan as a whole for cost-effectiveness, using the societal, utility, ratepayer impact and participant tests. If the utility uses a test other than the societal test as the criterion for determining the cost-effectiveness of utility implementation of energy efficiency measures, the utility shall describe and justify its use of the alternative test or combination of tests and compare the resulting impacts with the impacts resulting from the societal test. The utility shall describe and justify the level or levels of cost-effectiveness, if greater or less than a benefit/cost ratio of 1.0, to be used as a threshold for determining cost-effectiveness of programs. The utility's threshold of cost-effectiveness for its plan as a whole shall be a benefit/cost ratio of 1.0 or greater.

The utility shall provide an explanation of its sensitivity analysis identifying key variables showing the impact on cost-effectiveness. If appropriate and calculable, the utility shall adjust the energy and demand savings for the interactive effects of various measures contained within each program and shall adjust energy and demand savings of the plan as a whole for the interactive effects of programs. For the plan as a whole and for each program, the utility shall provide:

(1) Cost escalation rates for each cost component of the benefit/cost test that reflect changes over the lives of the options in the potential program and benefit escalation rates for benefit components that reflect changes over the lives of the options;

(2) Societal, utility cost, ratepayer impact measure, and participant test benefit/cost ratios; and

(3) Net societal benefits.

b. Descriptions of each program. If a proposed program is identical to an existing program, the utility may reference the program description currently in effect. A description of each proposed program shall include:

(1) The name of each program;

(2) The customers each program targets;

(3) The energy efficiency measures promoted by each program;

(4) The proposed utility promotional techniques, including the rebates or incentives offered through each program; and

(5) The proposed rates of program participation or implementation of measures, including both eligible and estimated actual participants.

c. The estimated annual energy and demand savings for the plan and each program for each year the measures promoted by the plan and program will produce benefits. The utility shall estimate gross and net capacity and energy savings, accounting for free riders, take-back effects, and measure degradation.

d. The budget for the plan and for each program for each year of implementation or for each of the next five years of implementation, whichever is less, itemized by proposed costs. The budget shall be consistent with the accounting plan required pursuant to subrule 35.12(1). The budget may include the amount of the remittance to the Iowa energy center and the center for global and regional environmental research and the alternative energy revolving loan fund. The plan and program budgets shall be categorized into:

(1) Planning and design costs;

(2) Administrative costs;

(3) Advertising and promotional costs;

(4) Customer incentive costs;

(5) Equipment costs;
(6) Installation costs;
(7) Monitoring and evaluation costs; and
(8) Miscellaneous costs.

Cost categories shall be further described by the following subcategories:

Classifications of persons to be working on energy efficiency programs, full-time equivalents, dollar amounts of labor costs, and purpose of work;

Type and use of equipment and other assets, including types of assets required and use of asset; and the name of outside firm(s) employed and a description of service(s) to be provided.

e. The rate impacts and average bill impacts, by customer class, resulting from the plan and each program.

f. A monitoring and evaluation plan. The utility shall describe in complete detail how it proposes to monitor and evaluate the implementation of its proposed programs and plan and shall show how it will accumulate and validate the information needed to measure the plan's performance against the standards. The utility shall propose a format for monitoring reports and describe how annual results will be reported to the board on a detailed, accurate and timely basis.

35.8(3) to **35.8(8)** Rescinded IAB 1/13/99, effective 2/17/99.

35.8(9) *Coordination with other utilities and participation in plan preparation.* The utility shall provide the following reports:

a. A report which explains the results of attempts to coordinate energy efficiency programs with other gas or electric utilities sharing its service territory within the boundaries of incorporated municipalities having a population of 1000 or more individuals.

b. A report on the participation of interested persons in the preparation of the assessment of potential and energy efficiency plan pursuant to subrules 35.8(1) and 35.8(2). The report shall identify the persons with whom the utility consulted, the date and type of meetings held or other contacts made, and the results of the meetings and contacts.

35.8(10) *Pilot projects.* Pilot projects may be included as a program, if justified by the utility. Pilot projects shall explore areas of innovative or unproven approaches, as provided in Iowa Code section 476.1. The proposed evaluation procedures for the pilot project shall be included.

35.8(11) to **35.8(13)** Rescinded IAB 1/13/99, effective 2/17/99.

199—35.9(476) Additional requirements for electric utilities. In addition to the requirements in rule 35.8(476), a plan for an electric utility shall include the following information:

35.9(1) *Load forecast.* Information specifying forecasted demand and energy use on a calendar year basis which shall include:

a. A statement, in numerical terms, of the utility's current 20-year forecasts including reserve margin for summer and winter peak demand and for annual energy requirements. The forecast shall not include the effects of the proposed programs in subrule 35.8(8), but shall include the effects to date of current ongoing utility energy efficiency programs.

b. The date and amount of the utility's highest peak demand within the past five years, stated on both an actual and weather-normalized basis. The utility shall include an explanation of the weather-normalization procedure.

c. A comparison of the forecasts made for each of the previous five years to the actual and weather-normalized demand in each of the previous five years.

d. An explanation of all significant methods and data used, as well as assumptions made, in the current 20-year forecast. The utility shall file all forecasts of variables used in its demand and energy forecasts and shall separately identify all sources of variables used, such as implicit price deflator, electricity prices by customer class, gross domestic product, sales by customer class, number of customers by class, fuel price forecasts for each fuel type, and other inputs.

e. A statement of the margins of error for each assumption or forecast.

f. An explanation of the results of sensitivity analyses performed, including a specific statement of the degree of sensitivity of estimated need for capacity to potential errors in assumptions, forecasts

and data. The utility may present the results and an explanation of other methods of assessing forecast uncertainty.

35.9(2) *Class load data.* Load data for each class of customer that is served under a separate rate schedule or is identified as a separate customer class and accounts for 10 percent or more of the utility's demand in kilowatts at the time of the monthly system peak for every month in the year. If those figures are not available, the data shall be provided for each class of customer that accounts for 10 percent of the utility's electric sales in kilowatt hours for any month in the reporting period. The data shall be based on a sample metering of customers designed to achieve a statistically expected accuracy of plus or minus 10 percent at the 90 percent confidence level for loads during the yearly system peak hour(s). These data must appear in the 1992 and all subsequent filings, except as provided for in paragraph 35.9(2)*"c."*

a. The following information shall be provided for each month of the previous year:

(1) Total system class maximum demand (in kilowatts), number of customers in the class, and system class sales (in kilowatt-hours);

(2) Jurisdictional class contribution (in kilowatts) to the monthly maximum system coincident demand as allocated to jurisdiction;

(3) Total class contribution (in kilowatts) to the monthly maximum system coincident demand, if not previously reported;

(4) Total system class maximum demand (in kilowatts) allocated to jurisdiction, if not previously reported; and

(5) Hourly total system class loads for a typical weekday, a typical weekend day, the day of the class maximum demand, and the day of the system peak.

b. The company shall file an explanation, with all supporting work papers and source documents, as to how class maximum demand and class contribution to the maximum system coincident demand were allocated to jurisdiction.

c. The load data for each class of customer described above may be gathered by a multijurisdictional utility on a uniform integrated system basis rather than on a jurisdictional basis. Adjustments for substantive and unique jurisdictional characteristics, if any, may be proposed. The load data for each class of customer shall be collected continuously and filed annually, except for the period associated with necessary interruptions during any year to modify existing or implement new data collection methods. Data filed for the period of interruption shall be estimated. An explanation of the estimation technique shall be filed with the data. To the extent consistent with sound sampling and the required accuracy standards, an electric public utility is not required to annually change the customers being sampled.

35.9(3) *Existing capacity and firm commitments.* Information specifying the existing generating capacity and firm commitments to provide service. The utility shall include in its filing a copy of its most recent Load and Capability Report submitted to the Mid-continent Area Power Pool (MAPP).

a. For each generating unit owned or leased by the utility, in whole or in part, the plan shall include the following information:

(1) Both summer and winter net generating capability ratings as reported to the National Electric Reliability Council (NERC).

(2) The estimated remaining time before the unit will be retired or require life extension.

b. For each commitment to own or lease future generating firm capacity, the plan shall include the following information:

(1) The type of generating capacity.

(2) The anticipated in-service year of the capacity.

(3) The anticipated life of the generating capacity.

(4) Both summer and winter net generating capability ratings as reported to the NERC.

c. For each capacity purchase commitment which is for a period of six months or longer the plan shall include the following information:

(1) The entity with whom commitments have been made and the time periods for each commitment.

(2) The capacity levels in each year for the commitment.

d. For each capacity sale commitment which is for a period of six months or longer the following information:

(1) The entity with whom a commitment has been made and the time periods for the commitment.

(2) The capacity levels in each year.

(3) The capacity payments to be received per kW per year in each year.

(4) The energy payments to be received per kWh per year.

(5) Any other payments the utility receives in each year.

35.9(4) *Capacity surpluses and shortfalls.* Information identifying projected capacity surpluses and shortfalls over the 20-year planning horizon which shall include:

a. A numerical and graphical representation of the utility's 20-year planning horizon comparing forecasted demand in each year from subrule 35.9(1) to committed capacity in each year from paragraphs 35.9(3)*"a"* to 35.9(3)*"d."* Forecasted peak demand shall include reserve requirements.

b. For each year of the 20-year planning horizon, the plan shall list in MW the amount that committed capacity either exceeds or falls below the forecasted demand.

35.9(5) *Capacity outside the utility's system.* Information about capacity outside of the utility's system that could meet its future needs including, but not limited to, cogeneration and independent power producers, expected to be available to the utility during each of the 20 years in the planning horizon. The utility shall include in its filing a copy of its most recent Load and Capability Report submitted to the Mid-continent Area Power Pool (MAPP).

35.9(6) *Future supply options and costs.* Information about the new supply options and their costs identified by the utility as the most effective means of satisfying all projected capacity shortfalls in the 20-year planning horizon in subrule 35.9(4) which shall include:

a. The following information which describes each future supply option as applicable:

(1) The anticipated year the supply option would be needed.

(2) The anticipated type of supply option, by fuel.

(3) The anticipated net capacity of the supply option.

b. The utility shall use the actual capacity cost of any capacity purchase identified in paragraph 35.9(6)*"a"* and shall provide the anticipated annual cost per net kW per year.

c. The utility shall use the installed cost of a combustion turbine as a proxy for the capacity cost of any power plant identified in paragraph 35.9(6)*"a."* For the first power plant option specified in paragraph 35.9(6)*"a,"* the following information shall be provided:

(1) The anticipated life.

(2) The anticipated total capital costs per net kW, including AFUDC if applicable.

(3) The anticipated revenue requirement of the capital costs per net kW per year.

(4) The anticipated revenue requirement of the annual fixed operations and maintenance costs, including property taxes, per net kW for each year of the planning horizon.

(5) The anticipated net present value of the revenue requirements per net kW.

(6) The anticipated revenue requirement per net kW per year calculated by utilization of an economic carrying charge.

(7) The after tax discount rate used to calculate the revenue requirement per net kW per year over the life of the supply option.

(8) Adjustment rates (for example, inflation or escalation rates) used to derive each future cost in paragraph 35.9(6)*"c."*

d. The capacity costs of the new supply options allocated to costing periods. The utility shall describe its method of allocating capacity costs to costing periods. The utility shall specify the hours, days, and weeks which constitute its costing periods. For each supply option identified in paragraph 35.9(6)*"a,"* the plan shall include:

(1) The anticipated annual cost per net kW per year of capacity purchases from subparagraph 35.9(6)*"b"*(6) allocated to each costing period if it is the highest cost supply option in that year.

(2) The anticipated total revenue requirement per net kW per year from subparagraph 35.9(6)*"c"*(6) allocated to each costing period if it is the highest cost supply option in that year.

35.9(7) *Avoided capacity and energy costs.* Avoided capacity costs shall be based on the future supply option with the highest value for each year in the 20-year planning horizon identified in subrule 35.9(6). Avoided energy costs shall be based on the marginal costs of the utility's generating units or purchases. The utility shall use the same costing periods identified in 35.9(6)*"b"* when calculating avoided capacity and energy costs. A party may submit, and the board shall consider, alternative avoided capacity and energy costs derived by an alternative method. A party submitting alternative avoided costs shall also submit an explanation of the alternative method.

a. Avoided capacity costs. Calculations of avoided capacity costs in each costing period shall be based on the following formula:

AVOIDED CAPACITY COST = C x (1 + RM) x (1 + DLF) x (1 + EF)

C (capacity) is the greater of NC or RC.

NC (new capacity) is the value of future capacity purchase costs or future capacity costs expressed in dollars per net kW per year of the utility's new supply options from paragraphs 35.9(6)*"b"* and *"c"* in each costing period.

RC (resalable capacity) is the value of existing capacity expressed in dollars per net kW per year that could be sold to other parties in each costing period.

RM (reserve margin) is the generation reserve margin criterion adopted by the utility.

DLF (demand loss factor) is the system demand loss factor, expressed as a fraction of the net power generated, purchased, or interchanged in each costing period. For example, the peak system demand loss factor would be equal to peak system power loss (MW) divided by the net system peak load (MW) for each costing period.

EF (externality factor) is a 10 percent factor applied to avoided capacity costs in each costing period to account for societal costs of supplying energy. In addition, the utility may propose a different externality factor, but must document its accuracy.

b. Avoided energy costs. Calculations of avoided energy costs in each costing period shall be based on the following formula:

AVOIDED ENERGY COSTS = MEC x (1 + ELF) x (1 + EF)

MEC (marginal energy cost) is the marginal energy cost expressed in dollars per kWh, inclusive of variable operations and maintenance costs, for electricity in each costing period.

ELF (system energy loss factor) is the system energy loss factor, expressed as a fraction of net energy generated, purchased, or interchanged in each costing period.

EF (externality factor) is a 10 percent factor applied to avoided energy costs in each costing period to account for societal costs of supplying energy. In addition, the utility may propose a different externality factor, but must submit documentation of its accuracy.

199—35.10(476) Additional requirements for gas utilities. In addition to the requirements of rule 35.8(476), a plan for a gas utility shall include the following information:

35.10(1) *Forecast of demand and transportation volumes.* Information specifying its demand and transportation volume forecasts which includes:

a. A statement in numerical terms of the utility's current 12-month and 5-year forecasts of total annual throughput and peak day demand, including reserve margin, based on the PGA year by customer class. The forecasts shall not include the effects of the proposed energy efficiency programs in subrule 35.8(8), but shall include the effects to date of current ongoing utility energy efficiency programs.

b. A statement in numerical terms of the utility's highest peak day demand and annual throughput for the past five years by customer class.

c. A comparison of the forecasts made for the preceding five years to the actual and weather-normalized peak day demand and annual throughput by customer class including an explanation of the weather-normalization procedure.

d. A forecast of the utility's demand for transportation volume for both peak day demand and annual throughput for each of the next five years.

e. The existing contract deliverability by supplier, contract and rate schedule for the length of each contract.

f. An explanation of all significant methods and data used, as well as assumptions made, in the current five-year forecast(s). The utility shall file all forecasts of variables used in its demand and energy forecasts. If variables are not forecasted, the utility shall indicate all sources of variable inputs.

g. A statement of the margins of error for each assumption or forecast.

h. An explanation of the results of the sensitivity analysis performed by the utility, including a specific statement of the degree of sensitivity of estimated need for capacity to potential errors in assumptions, forecasts, and data.

35.10(2) *Capacity surpluses and shortfalls.* Information identifying projected capacity surpluses and shortfalls over the five-year planning horizon which includes a numerical and graphical representation of the utility's five-year planning horizon comparing forecasted peak day demand in each year from paragraph 35.10(1)*"a,"* to the total of existing contract deliverability, from paragraph 35.10(1)*"e."* The comparison shall list in dth or Mcf any amount for any year that contract deliverability falls below the forecast of peak day demand. Forecasted peak day demand shall include reserve margin.

35.10(3) *Supply options.* Information about new supply options identified by the utility as the most effective means of satisfying all projected capacity shortfall in the 12-month and 5-year planning horizons in subrule 35.10(2). For each supply option identified, the plan shall include:

a. The year the option would be needed.

b. The type of option.

c. The net peak day capacity.

d. The estimated future capacity costs per dth or Mcf of peak day demand of the options.

e. The estimated future energy costs per dth or Mcf of each option in current dollars.

f. A description of the method used to estimate future costs.

35.10(4) *Avoided capacity and energy costs.* Information regarding avoided costs, specifying the days and weeks which constitute the utility's peak and off-peak periods. Avoided costs shall be calculated for the peak and off-peak periods and adjusted for inflation to derive an annual avoided cost over a 20-year period. In addition, all parties may submit information specifying the hours, days, and weeks which constitute alternative costing periods. A party may submit, and the board shall consider, alternative avoided capacity and energy costs derived by an alternative method. A party submitting alternative avoided costs shall also submit an explanation of the alternative method.

a. Avoided capacity costs. Calculations of avoided capacity costs in the peak and off-peak periods shall be based on the following formula:

AVOIDED CAPACITY COSTS = [(D + OC) x (1 + RM)] x (1 + EF)

D (demand) is the greater of CD or FD.

CD (current demand cost) is the utility's average demand cost expressed in dollars per dth or Mcf during peak and off-peak periods.

FD (future demand costs) is the utility's average future demand cost over the 20-year period expressed in dollars per dth or Mcf when supplying gas during peak and off-peak periods.

RM (reserve margin) is the reserve margin adopted by the utility.

OC (other cost) is the value of any other costs per dth or Mcf related to the acquisition of gas supply or transportation by the utility over the 20-year period in the peak and off-peak periods.

EF (externality factor) is a 7.5 percent factor applied to avoided capacity costs in the peak and off-peak periods to account for societal costs of supplying energy. In addition, the utility may propose a different externality factor, but must submit documentation of its accuracy.

b. Avoided energy costs. Calculations of avoided energy costs in the peak and off-peak periods on a seasonal basis shall be based on the following formula:

AVOIDED ENERGY COSTS = (E + VOM) x (1 + EF)

E (energy costs) is the greater of ME or FE.

ME (current marginal energy costs) is the utility's current marginal energy costs expressed in dollars per dth or Mcf during peak and off-peak periods.

FE (future energy costs) is the utility's average future energy costs over the 20-year period expressed in dollars per dth or Mcf during peak and off-peak periods.

VOM (variable operations and maintenance costs) is the utility's average variable operations and maintenance costs over the 20-year period expressed in dollars per dth or Mcf during peak and off-peak periods.

EF (externality factor) is a 7.5 percent factor applied to avoided energy costs in the peak and off-peak periods to account for societal costs of supplying energy. In addition, the utility may propose a different externality factor, but must submit documentation of its accuracy.

199—35.11(476) Additional filing requirements. In those years an electric utility does not file an energy efficiency plan, the utility shall file by May 15 the information required in subrules 35.9(1) and 35.9(2). If there has been no change in the utility's forecast procedure in regard to information required in paragraphs 35.9(1)*"d"* through *"f,"* the utility may state "no change from previous forecast" for each paragraph. In those years a gas utility does not file an energy efficiency plan, the utility shall file by November 1 the information required in subrule 35.10(1). If there has been no change in the information required in paragraphs 35.10(1)*"f"* through *"h,"* the utility shall identify the portions of the previous docket where the information is located.

199—35.12(476) Energy efficiency cost recovery. A utility shall be allowed to recover the previously approved costs, deferred past costs, and estimated contemporaneous expenditures of its approved energy efficiency plans through an automatic adjustment mechanism. The utility may propose to recover the portion of the costs of process-oriented industrial assessments related to energy efficiency. Only unrecovered costs may be recovered through the automatic adjustment mechanism, and costs may be recovered only once.

For purposes of this rule, "previously approved costs" are defined as expenditures and related costs approved for recovery in previous energy efficiency cost recovery contested cases.

"Deferred past costs" are defined as funds actually spent by the utility on energy efficiency programs in its approved plan including the carrying charges associated with the deferred recovery of those costs, as defined in paragraph 35.12(1)*"b."* Deferred past costs shall be amortized and recovered over a period not to exceed the term of the plan.

"Estimated contemporaneous expenditures" are defined as costs to be incurred during the current 12-month recovery period pursuant to an approved energy efficiency plan.

35.12(1) *Accounting for costs.* Each utility shall maintain accounting plans and procedures to account for all energy efficiency costs incurred on or after July 1, 1990.

a. Deferred past costs incurred on or after July 1, 1990, up to a date terminating the accumulation of deferred costs set by a board order, shall be charged to account 186, "Miscellaneous Deferred Debits," as defined in the uniform system of accounts for utilities as provided in 199 IAC 16.

b. A carrying charge determined using the current monthly AFUDC rate from the formula prescribed in the uniform system of accounts for utilities, as provided in 199 IAC 16, shall accrue on costs in the account described in paragraph 35.12(1)*"a."* A utility shall continue to accrue a carrying charge on the account's costs, compounded semiannually, until the date terminating accumulation of deferred costs set by a board order.

c. Estimated contemporaneous expenditures proposed for concurrent recovery through an automatic adjustment mechanism shall be charged, after the date set by a board order, to the current accounts prescribed by the uniform system of accounts, as provided in 199 IAC 16, and shall be further identified using the accounts described in paragraph 35.12(1)*"d."*

d. Each utility shall maintain a subaccount system, a work order system, or an accounting system which identifies individual costs by each program. Examples of individual items include, but are not limited to, the costs for planning and design, labor, advertising and promotion, rebates, customer incentives, equipment, installation, funding of the Iowa energy center and the center for global and regional environmental research, funding of the alternate energy revolving loan program, and consultant fees. Each utility shall maintain accurate employee, equipment, materials, and other records which identify all amounts related to each individual energy efficiency program.

35.12(2) *Automatic adjustment mechanism.* Each utility required to be rate-regulated shall file by March 1 of each year, subject to the board's approval, energy efficiency costs proposed to be recovered in rates for the 12-month recovery period beginning at the start of the first utility billing month at least 30 days following board approval. Each utility may elect to file its first energy efficiency automatic adjustment up to 120 days after the effective date of these rules.

35.12(3) *Energy efficiency cost recovery (ECR) factors.* The utility shall calculate ECR factors separately for each customer classification or grouping previously approved by the board. For all plans current at the time this rule becomes effective and for all future plans, if a utility desires to use customer classifications or allocations of indirect or other related costs other than those previously approved, such customer classifications or allocations of indirect or other related costs must be approved as part of a plan filing or of a modification thereof. ECR factors shall use the same unit of measurement as the utility's tariffed rates. ECR factors shall be calculated according to the following formula:

$$\text{ECR factor} = \frac{(\text{PAC}) + (\text{ADPC} \times 12) + (\text{ECE}) + \text{A}}{\text{ASU}}$$

ECR factor is the energy efficiency recovery amount per unit of sales over the 12-month recovery period.

PAC is the annual amount of previously approved costs from earlier ECR proceedings, until the previously approved costs are fully extinguished.

ADPC is amortized deferred past cost. It is calculated as the levelized monthly payment needed to provide a return of and a return on the utility's deferred past costs (DPC). ADPC is calculated as:

$$\text{ADPC} = \text{DPC}\ [r(1+r)^n] / [(1+r)^n - 1]$$

DPC is deferred past costs including carrying charges which have not previously been approved for recovery, until the deferred past costs are fully recovered.

n is the length of the utility's plan in months.

r is the applicable monthly rate of return calculated as:

$$r = (1+R)^{1/12} - 1 \text{ or}$$

$$r = R \div 12 \text{ if previously approved}$$

R is the pretax overall rate of return the board held just and reasonable in the utility's most recent general rate case involving the same type of utility service. If the board has not rendered a decision in an applicable rate case for a utility, the average of the weighted average cost rates for each of the capital structure components allowed in general rate cases within the preceding 24 months for Iowa utilities providing the same type of utility service will be used to determine the applicable pretax overall rate of return.

ECE is the estimated contemporaneous expenditures to be incurred during the 12-month recovery period.

A is the adjustment factor equal to overcollections or undercollections determined in the annual reconciliation and for adjustments ordered by the board in prudence reviews.

ASU is the annual sales units estimated for the 12-month recovery period.

35.12(4) *Filing requirements.* Each utility proposing automatic recovery for its energy efficiency costs shall provide the following information:

a. The filing shall restate the derivation of each ECR factor previously approved by the board.

b. The filing shall include new ECR factors based on allocation methods and customer classifications and groupings approved by the board in previous proceedings.

c. The filing shall include all worksheets and detailed supporting data used to determine new ECR factors. Information already on file with the board may be incorporated by reference in the filing.

d. The filing shall include a reconciliation comparing the amounts actually collected by the previous ECR factors to the amounts expended. Overcollections or undercollections shall be used to compute adjustment factors.

e. If in a prudence review, the board has determined that previously recovered energy efficiency costs were imprudently incurred, adjustment factors shall include reductions for these amounts.

35.12(5) *Tariff sheets.* Upon approval of the new ECR factors, the utility shall file separate tariff sheets for board approval to implement the ECR factors in its rates.

199—35.13(476) Prudence review. The board shall periodically conduct a contested case to evaluate the reasonableness and prudence of the utility's implementation of energy efficiency plans and budgets. The burden shall be on the utility to prove it has taken all reasonable actions to cost-effectively implement an energy efficiency plan as it was approved.

35.13(1) *Information to be filed.* The parties to the prudence review shall provide the following information:

a. The utility shall file prepared direct testimony and exhibits in support of its past implementation results including information regarding: implementation issues; monitoring and evaluation issues; program costs; program benefits; energy and demand savings; and participation rates.

b. The Consumer Advocate Division of the Department of Justice and other intervenors to the contested case shall be allowed at least seven weeks to file rebuttal testimony and exhibits to the utility's direct testimony.

35.13(2) *Disallowance of past costs.* If the board finds the utility did not take all reasonable and prudent actions to cost-effectively implement its energy efficiency programs, the board shall determine the amount in excess of those costs that would have been incurred under reasonable and prudent implementation. That amount shall be deducted from the next ECR factors calculated pursuant to 199 IAC 35.12(3) until satisfied.

199—35.14(476) New structure energy conservation standards. A utility providing gas or electric service shall not provide service to any structure completed after April 1, 1984, unless the owner or builder of the structure has certified to the utility that the building conforms to the energy conservation requirements adopted under 661—16.801(103A) and 661—16.802(103A). If this compliance is already being certified to a state or local agency, a copy of that certification shall be provided to the utility. If no state or local agency is monitoring compliance with these energy conservation standards, the owner or builder shall certify that the structure complies with the standards by signing a form provided by the utility. No certification will be required for structures that are not heated or cooled by electric service, or are not intended primarily for human occupancy.

199—35.15(476) Exterior flood lighting.

35.15(1) *Newly installed lighting.* All newly installed public utility-owned exterior flood lighting shall be high-pressure sodium lighting or lighting with equivalent or better energy efficiency.

35.15(2) *In-service lighting replacement schedule.* In-service lighting shall be replaced with high-pressure sodium lighting or lighting with equivalent or better energy efficiency when worn out due to ballast or fixture failure for any other reason, such as vandalism or storm damage. A utility shall file with the board as part of its annual report required in 199—Chapter 23 a report stating progress to date in converting to high-pressure sodium lighting or lighting with equivalent or higher energy efficiency.

35.15(3) *Efficiency standards.* Lighting other than high-pressure sodium has equivalent or better energy efficiency if one or more of the following can be established:

a. For lamps less than 120 watts, the lumens-per-watt lamp rating is greater than 77.1, or

b. For lamps between 120 and 500 watts, the lumens-per-watt lamp rating is greater than 96, or

c. For lamps greater than 500 watts, the lumens-per-watt lamp rating is greater than 126, or

d. The new lighting uses no more energy per installation than comparable, suitably sized high-pressure sodium lighting, or

e. The new lighting consists of solid-state lighting (SSL) luminaries that have an efficacy rating equal to or greater than 66 lumens per watt according to a Department of Energy (DOE) Lighting Facts label, testing under the DOE Commercially Available LED Product Evaluation and Reporting Program

(CALiPER), or any other test that follows Illuminating Engineering Society of North America LM-79-08 test procedures.

[**ARC 9136B**, IAB 10/6/10, effective 11/10/10]

These rules are intended to implement Iowa Code sections 476.2(7), 476.6(19-21) and 476.10A.

[Filed emergency 3/15/91 after Notice 1/23/91—published 4/3/91, effective 3/15/91]
[Filed emergency 4/12/91 after Notice 11/14/90—published 5/1/91, effective 4/12/91]
[Filed 12/6/91, Notice 8/21/91—published 12/25/91, effective 1/29/92]
[Filed 4/9/93, Notice 10/28/92—published 4/28/93, effective 6/2/93]
[Filed 10/8/93, Notice 8/18/93—published 10/27/93, effective 12/1/93]
[Filed 2/25/94, Notice 11/24/93—published 3/16/94, effective 4/20/94]◊
[Filed emergency 10/25/96—published 11/20/96, effective 10/25/96]
[Filed 5/2/97, Notice 1/29/97—published 5/21/97, effective 6/25/97]
[Filed 12/15/98, Notice 5/6/98—published 1/13/99, effective 2/17/99]
[Filed 10/24/03, Notices 2/5/03, 4/2/03—published 11/12/03, effective 12/17/03]
[Filed ARC 9136B (Notice ARC 8931B, IAB 7/14/10), IAB 10/6/10, effective 11/10/10]

◊ Two or more ARCs

CHAPTER 36
ENERGY EFFICIENCY PLANNING AND REPORTING FOR NON-RATE-REGULATED GAS AND ELECTRIC UTILITIES

199—36.1(476) Non-rate-regulated utilities. Each non-rate-regulated gas and electric utility shall file energy efficiency plans as provided in this chapter.

199—36.2(476) Definitions. The following words and terms, when used in this chapter, shall have the following meanings:

"Annual" means during each calendar year.

"Demand savings" means the change in the rate of energy usage measured over a period, which period shall be specified.

"Dollar savings" means the reduction in the dollars spent on natural gas or electricity service by customers and by the utility system as the result of the energy efficiency programs.

"Energy efficiency programs" means activities conducted by a utility intended to enable or encourage customers to increase the amount of heat, light, cooling, motive power, or other forms of work performed per unit of energy used. Energy efficiency programs also means activities which lessen the amount of heating, cooling, or other forms of work which must be performed, or activities which decrease the cost of providing energy. Examples include, but are not limited to: energy studies or audits, general information, financial assistance, direct rebates to customers or vendors of energy-efficient products, research projects, direct installation by the utility of energy-efficient equipment, direct or indirect load control, and time-of-use rates, tree planting programs, and hot water insulation distribution programs.

"Energy savings" means the amount of energy not used because of an energy efficiency program, measured in kilowatt-hours (kWh) of electricity, thousands of cubic feet (Mcf) of natural gas, or dekatherms (dth) of natural gas.

"Filing year" means the calendar year during which an energy efficiency plan is filed.

"Peak demand savings" means the change in the rate of energy use at the time of the utility's highest annual use, measured in kilowatts (kW), thousands of cubic feet per day (Mcf/day) of natural gas, or dekatherms per day (dth/day) of natural gas.

"Year" means calendar year.

199—36.3(476) Schedule of filings. On or before July 1, 1992, each non-rate-regulated utility shall file its initial biennial energy efficiency plan with the board for the period January 1, 1992, through December 31, 1993. Each non-rate-regulated utility shall file subsequent biennial energy efficiency plans on or before July 1, 1994, and succeeding even-numbered years.

199—36.4(476) Joint filing of plans. A utility may file its plan jointly with other non-rate-regulated utilities or their agents. A joint plan shall contain the information required by rules 36.5(476) and 36.6(476) for each utility participating in the joint plan, whether jointly filed or individually filed. This information for each utility shall be separately identified, if a plan is filed jointly for several utilities by person(s) acting as an agent for the utilities. Those person(s) shall state to the board their authority to act on behalf of the utilities. The description of a utility's programs as required in paragraph *"a"* of subrules 36.5(1) and 36.5(2) may be provided by reference to an attached document or a section of a joint plan.

199—36.5(476) Energy efficiency plan requirements. Each utility's energy efficiency plan shall include the following:

36.5(1) A report on the results of all energy efficiency programs the utility has implemented and completed during each of the two calendar years immediately preceding the filing year. Summary information for energy efficiency programs implemented in earlier years and completed prior to the filing year may also be included in the original plan. For each program implemented during the past two calendar years and completed, the following information shall be provided:

a. A description of the program, including the purpose or goal of the program, and the energy-using facilities, equipment, or customer behavior that the program was designed to change;

b. Annual energy and peak demand savings, annual dollar savings, and, if available, nonpeak demand savings from the program;

c. A description of the method(s) for determining the annual energy savings, peak demand savings, nonpeak demand savings, and annual dollar savings, whether engineering estimates, surveys, metering, or other methods;

d. Annual number of program participants;

e. Annual and total costs of the program;

f. Date the program was initiated, terminated, and the reason for termination; and

g. Other relevant information.

36.5(2) A report on the results and projected results of all energy efficiency programs the utility is continuing or commencing in the filing year or the year following. For those programs continuing, the report shall describe the program results from the two calendar years immediately preceding the filing year and projected results for the filing year and the year following. Summary information for energy efficiency programs implemented in earlier years but still underway may also be included in the original plan. For those programs commencing in the filing year or the year following, the report shall describe projected implementation and results of programs for each of the two years, as well as an optional description of program results beyond the two years. For each program under this subrule, the following information shall be provided:

a. A description of the program, including the purpose or goal of the program and the energy-using facilities, equipment, or customer behavior that the program is designed to change;

b. Annual energy and peak demand savings, annual dollar savings, and, if available, nonpeak demand savings from the program;

c. Projected annual energy and peak demand savings, annual dollar savings, and, if available, nonpeak demand savings from the program;

d. A description of the method(s) for determining the annual energy savings, peak demand savings, nonpeak demand savings, and annual dollar savings, whether engineering estimates, surveys, metering, or other methods;

e. A description of the method(s) for projecting the annual energy savings, peak demand savings, nonpeak demand savings, annual dollar savings, whether engineering estimates, surveys, metering, or other methods;

f. Annual number of program participants and annual estimated number of program participants;

g. Annual and total costs of the program;

h. Estimated annual and total cost of program;

i. Date the program was initiated and planned termination dates; and

j. Other relevant information.

199—36.6(476) Program selection criteria. Each utility's plan shall include a description of the procedures or criteria used to continue current and to select future energy efficiency programs for implementation.

199—36.7(476) New Structure energy conservation standards. A utility providing gas or electric service shall not provide such service to any structure completed after April 1, 1984, unless the owner or builder of the structure has certified to the utility that the building conforms to the energy conservation requirements adopted under 661—16.801(103A) and 661—16.802(103A). If this compliance is already being certified to a state or local agency, a copy of that certification shall be provided to the utility. If no state or local agency is monitoring compliance with these energy conservation standards, the owner or builder shall certify that the structure complies with the standards by signing a form provided by the utility. No certification will be required for structures that are not heated or cooled by electric service, or are not intended primarily for human occupancy.

199—36.8(476) Exterior flood lighting.

36.8(1) *Newly installed lighting.* All newly installed public utility-owned exterior flood lighting shall be high-pressure sodium lighting or lighting with equivalent or better energy efficiency.

36.8(2) *In-service lighting replacement schedule.* In-service lighting shall be replaced with high-pressure sodium lighting or lighting with equivalent or better energy efficiency when worn out due to ballast or fixture failure for any other reason, such as vandalism or storm damage. Each utility shall file with the board as part of its annual report required in 199—Chapter 23 a report stating progress to date in converting to high-pressure sodium lighting or lighting with equivalent or higher energy efficiency.

36.8(3) *Efficiency standards.* Lighting other than high-pressure sodium has equivalent or better energy efficiency if one or more of the following can be established:

a. For lamps less than 120 watts, the lumens-per-watt lamp rating is greater than 77.1, or

b. For lamps between 120 and 500 watts, the lumens-per-watt lamp rating is greater than 96, or

c. For lamps greater than 500 watts, the lumens-per-watt lamp rating is greater than 126, or

d. The new lighting uses no more energy per installation than comparable, suitably sized high-pressure sodium lighting, or

e. The new lighting consists of solid-state lighting (SSL) luminaries that have an efficacy rating equal to or greater than 66 lumens per watt according to a Department of Energy (DOE) Lighting Facts label, testing under the DOE Commercially Available LED Product Evaluation and Reporting Program (CALiPER), or any other test that follows Illuminating Engineering Society of North America LM-79-08 test procedures.

[**ARC 9136B**, IAB 10/6/10, effective 11/10/10]

These rules are intended to implement Iowa Code sections 476.1A(6), 476.1B(1)*"l,"* and 476.2(5) to 476.2(7).

[Filed 1/29/92, Notice 10/30/91—published 2/19/92, effective 3/25/92]
[Filed 10/24/03, Notices 2/5/03, 4/2/03—published 11/12/03, effective 12/17/03]
[Filed ARC 9136B (Notice ARC 8931B, IAB 7/14/10), IAB 10/6/10, effective 11/10/10]

CHAPTER 2
PETITIONS FOR RULE MAKING

[Prior to 10/17/90, see School Budget Review, 289—1.4(442)]

The school budget review committee hereby adopts the petitions for rule making segment of the Uniform Administrative Rules which is printed in the first Volume of the Iowa Administrative Code with the following amendments:

289—2.1(17A) Petition for rule making. In lieu of the words "(designated office)", insert "the School Budget Review Committee, Grimes State Office Building, 400 E. 14th Street, Des Moines, Iowa 50319-0146". In lieu of the words "(AGENCY NAME)", the heading on the petition form should read:

"SCHOOL BUDGET REVIEW COMMITTEE"

[Editorial change: IAC Supplement 10/6/10]

289—2.3(17A) Inquiries. In lieu of the words "(designate official by full title and address)", insert, "Chairperson, School Budget Review Committee, Grimes State Office Building, 400 E. 14th Street, Des Moines, Iowa 50319-0146".

[Editorial change: IAC Supplement 10/6/10]

These rules are intended to implement Iowa Code section 17A.7.

[Filed 11/23/88, Notice 6/1/88—published 12/14/88, effective 1/18/89]
[Filed emergency 9/28/90—published 10/17/90, effective 9/28/90]
[Filed 12/21/90, Notice 10/17/90—published 1/9/91, effective 2/13/91]
[Editorial change: IAC Supplement 10/6/10]

CHAPTER 3
DECLARATORY RULINGS

[Prior to 10/17/90, see School Budget Review, 289—1.5(442)]

The school budget review committee hereby adopts the declaratory rulings segment of the Uniform Administrative Rules which is printed in the first Volume of the Iowa Administrative Code with the following amendments:

289—3.1(17A) Petition for declaratory ruling. In lieu of the words "(designate office)", insert "the School Budget Review Committee, Grimes State Office Building, 400 E. 14th Street, Des Moines, Iowa 50319-0146". In lieu of the words "(AGENCY NAME)", the heading on the petition should read:

"SCHOOL BUDGET REVIEW COMMITTEE"

[Editorial change: IAC Supplement 10/6/10]

289—3.3(17A) Inquiries. In lieu of the words "(designate official by full title and address)", insert "Chairperson, School Budget Review Committee, Grimes State Office Building, 400 E. 14th Street, Des Moines, Iowa 50319-0146".

[Editorial change: IAC Supplement 10/6/10]

These rules are intended to implement Iowa Code section 17A.9.

[Filed 3/17/78, Notice 9/21/77—published 4/5/78, effective 5/10/78]
[Filed 11/23/88, Notice 6/1/88—published 12/14/88, effective 1/18/89]
[Filed emergency 9/28/90—published 10/17/90, effective 9/28/90]
[Filed 12/21/90, Notice 10/17/90—published 1/9/91, effective 2/13/91]
[Editorial change: IAC Supplement 10/6/10]

CHAPTER 4
AGENCY PROCEDURE FOR RULE MAKING

[Prior to 10/17/90, see School Budget Review, 289—1.6(442)]

The school budget review committee hereby adopts the agency procedure for rule making segment of the Uniform Administrative Rules which is printed in the front of Volume I of the Iowa Administrative Code with the following amendments:

289—4.3(17A) Public rule-making docket.

4.3(2) *Anticipated rule making.* In lieu of the words "(commission, board, council, director)", insert "school budget review committee".

289—4.4(17A) Notice of proposed rule making.

4.4(3) *Notices mailed.* In lieu of the words "(specific time period)", insert "three years".

289—4.5(17A) Public participation.

4.5(1) *Written comments.* In lieu of the words "(identify office and address)", insert "the School Budget Review Committee, Grimes State Office Building, 400 E. 14th Street, Des Moines, Iowa 50319-0146".

[Editorial change: IAC Supplement 10/6/10]

289—4.6(17A) Regulatory flexibility analysis.

4.6(3) *Mailing list.* In lieu of the words "(designate office)" insert "the School Budget Review Committee, Grimes State Office Building, 400 E. 14th Street, Des Moines, Iowa 50319-0146".

[Editorial change: IAC Supplement 10/6/10]

289—4.10(17A) Exemptions from public rule-making procedures. Delete subrule 4.10(2) entitled "Categories exempt".

289—4.11(17A) Concise statement of reasons.

4.11(1) *General.* In lieu of the words "(specify the office and address)", insert "the School Budget Review Committee, Grimes State Office Building, 400 E. 14th Street, Des Moines, Iowa 50319-0146".

[Editorial change: IAC Supplement 10/6/10]

289—4.13(17A) Agency rule-making record.

4.13(2) *Contents.*

c. In lieu of the words "(agency head)", insert "chairperson".

These rules are intended to implement Iowa Code section 17A.4.

[Filed 11/23/88, Notice 6/1/88—published 12/14/88, effective 1/18/89]
[Filed emergency 9/28/90—published 10/17/90, effective 9/28/90]
[Filed 12/21/90, Notice 10/17/90—published 1/9/91, effective 2/13/91]
[Editorial change: IAC Supplement 10/6/10]

CHAPTER 5
PUBLIC RECORDS AND FAIR INFORMATION PRACTICES

[Prior to 10/17/90, see School Budget Review, 289—1.7(442, 22)]

The school budget review committee hereby adopts, with the following exceptions and amendments, the Uniform Administrative Rules relating to public records and fair information practices which are printed in the first Volume of the Iowa Administrative Code.

289—5.1(17A) Definitions. As used in this chapter:

"Agency." In lieu of the words "(official or body issuing these rules)", insert "school budget review committee".

289—5.3(17A) Requests for access to records.

5.3(1) *Location of record.* In lieu of the words "(insert agency head)", insert "chairperson of the committee". In lieu of the words "(insert agency name and address)", insert "School Budget Review Committee, Grimes State Office Building, 400 E. 14th Street, Des Moines, Iowa 50319-0146".

5.3(2) *Office hours.* In lieu of the words "(insert customary hours and, if agency does not have customary office hours of at least thirty hours per week, insert hours specified in Iowa Code section 22.4)", insert "8 a.m. to 4:30 p.m. daily, excluding Saturdays, Sundays, and legal holidays".

5.3(7) *Fees.*

c. *Supervisory fee.* In lieu of the words "(specify time period)", insert "one-half hour". In lieu of the words "An agency wishing to deal with search fees authorized by law should do so here", insert "The committee will give advance notice to the requester if it will be necessary to use an employee with a higher hourly wage in order to find or supervise the particular records in question, and shall indicate the amount of that higher hourly wage to the requester."

[Editorial change: IAC Supplement 10/6/10]

289—5.6(17A) Procedure by which additions, dissents, or objections may be entered into certain records. In lieu of the words "(designate office)", insert "the office of the chairperson of this committee".

289—5.9(17A) Disclosures without the consent of the subject. Open records are routinely disclosed without the consent of the subject.

289—5.10(17A) Routine use.

5.10(1) "Routine use" means the disclosure of a record without the consent of the subject or subjects, for a purpose for which the record was collected. It includes disclosures required to be made by statute other than public records law, Iowa Code chapter 22.

5.10(2) To the extent allowed by law, the following uses are considered routine uses of all committee records:

a. Disclosure to those members of the committee who have a need for the record in the performance of their duties.

b. Information released to staff of federal and state entities for audit purposes or to determine whether the agency is operating a program lawfully.

289—5.11(17A) Availability of records. Agency records are open for public inspection and copying unless otherwise provided by rule or law.

289—5.12(17A) Rule-making records. These records are routinely available to the public and may contain information about individuals making written or oral comments on proposed rules or proposing rules or rule amendments. This information is collected pursuant to Iowa Code sections 17A.3, 17A.4 and 17A.7. These records are stored on paper and not in an automated data processing system.

289—5.13(17A) Applicability. This chapter does not require the agency to index or retrieve records which contain information about individuals by that person's name or other personal identifier.

These rules are intended to implement Iowa Code section 17A.22.

[Filed emergency 9/16/88—published 10/5/88, effective 9/16/88]
[Filed 12/9/88, Notice 10/5/88—published 12/28/88, effective 2/1/89]
[Filed emergency 9/28/90—published 10/17/90, effective 9/28/90]
[Filed 12/21/90, Notice 10/17/90—published 1/9/91, effective 2/13/91]
[Editorial change: IAC Supplement 10/6/10]

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

CHAPTER 2
CONTRACTING OUT DEPARTMENT OF HUMAN SERVICES EMPLOYEES AND PROPERTY

CHAPTER 3
DEPARTMENT PROCEDURE FOR RULE MAKING

CHAPTER 4
PETITIONS FOR RULE MAKING

CHAPTER 8
PAYMENT OF SMALL CLAIMS

CHAPTER 9
PUBLIC RECORDS AND FAIR
INFORMATION PRACTICES

CHAPTER 10
Reserved

CHAPTER 11
COLLECTION OF PUBLIC ASSISTANCE DEBTS

CHAPTER 12
VOLUNTEER SERVICES

CHAPTER 13
PROGRAM EVALUATION

CHAPTER 25
DISABILITY SERVICES MANAGEMENT

DIVISION I
DETERMINATION OF STATE PAYMENT AMOUNT

DIVISION II
COUNTY MANAGEMENT PLAN

DIVISION III
MINIMUM DATA SET

DIVISION IV
INCENTIVE AND EFFICIENCY POOL FUNDING

DIVISION V
RISK POOL FUNDING

DIVISION VI
TOBACCO SETTLEMENT FUND RISK POOL FUNDING

DIVISION VII
COMMUNITY MENTAL HEALTH CENTER WAIVER REQUEST

CHAPTERS 26 and 27
Reserved

CHAPTER 28
POLICIES FOR ALL INSTITUTIONS

CHAPTER 29
MENTAL HEALTH INSTITUTES

CHAPTER 30
STATE RESOURCE CENTERS

CHAPTERS 31 to 33
Reserved

CHAPTER 34
ALTERNATIVE DIAGNOSTIC FACILITIES

CHAPTER 35
Reserved

CHAPTER 36
FACILITY ASSESSMENTS

DIVISION I
ASSESSMENT FEE FOR INTERMEDIATE CARE FACILITIES FOR THE MENTALLY RETARDED

DIVISION II
QUALITY ASSURANCE ASSESSMENT FOR NURSING FACILITIES

DIVISION III
HEALTH CARE ACCESS ASSESSMENT FOR HOSPITALS

CHAPTER 37
Reserved

CHAPTER 38
DEVELOPMENTAL DISABILITIES BASIC STATE GRANT

CHAPTER 39
Reserved

TITLE IV
FAMILY INVESTMENT PROGRAM

CHAPTER 40
APPLICATION FOR AID

DIVISION I
FAMILY INVESTMENT PROGRAM—CONTROL GROUP

DIVISION II
FAMILY INVESTMENT PROGRAM—TREATMENT GROUP

CHAPTER 41
GRANTING ASSISTANCE

DIVISION I
FAMILY INVESTMENT PROGRAM—
CONTROL GROUP

DIVISION II
FAMILY INVESTMENT PROGRAM—TREATMENT GROUP

CHAPTER 42
Reserved

CHAPTER 43
ALTERNATE PAYEES

DIVISION I
FAMILY INVESTMENT PROGRAM—CONTROL GROUP

DIVISION II
FAMILY INVESTMENT PROGRAM—TREATMENT GROUP

CHAPTER 44
Reserved

CHAPTER 45
PAYMENT

DIVISION I
FAMILY INVESTMENT PROGRAM—CONTROL GROUP

DIVISION II
FAMILY INVESTMENT PROGRAM—TREATMENT GROUP

CHAPTER 46
OVERPAYMENT RECOVERY

DIVISION I
FAMILY INVESTMENT PROGRAM—CONTROL GROUP

DIVISION II
FAMILY INVESTMENT PROGRAM—TREATMENT GROUP

CHAPTER 47
DIVERSION INITIATIVES

CHAPTERS 48 and 49
Reserved

TITLE V
STATE SUPPLEMENTARY ASSISTANCE

CHAPTER 50
APPLICATION FOR ASSISTANCE

CHAPTER 51
ELIGIBILITY

CHAPTER 52
PAYMENT

CHAPTER 53
Reserved

CHAPTER 54
FACILITY PARTICIPATION

TITLE VI
GENERAL PUBLIC ASSISTANCE PROVISIONS

CHAPTERS 55 and 56
Reserved

CHAPTER 57
INTERIM ASSISTANCE REIMBURSEMENT

CHAPTER 58
EMERGENCY ASSISTANCE

DIVISION I
IOWA DISASTER AID INDIVIDUAL ASSISTANCE GRANT PROGRAM

CHAPTER 61
REFUGEE SERVICES PROGRAM

CHAPTERS 62 to 64
Reserved

TITLE VII
FOOD PROGRAMS

CHAPTER 65
FOOD ASSISTANCE PROGRAM ADMINISTRATION

DIVISION I

CHAPTER 77
CONDITIONS OF PARTICIPATION FOR PROVIDERS
OF MEDICAL AND REMEDIAL CARE

CHAPTER 78
AMOUNT, DURATION AND SCOPE OF
MEDICAL AND REMEDIAL SERVICES

CHAPTER 83
MEDICAID WAIVER SERVICES

DIVISION I—HCBS ILL AND HANDICAPPED WAIVER SERVICES

DIVISION II—HCBS ELDERLY WAIVER SERVICES

DIVISION III—HCBS AIDS/HIV WAIVER SERVICES

CHAPTER 84
EARLY AND PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT

CHAPTER 85
SERVICES IN PSYCHIATRIC INSTITUTIONS

DIVISION I
PSYCHIATRIC HOSPITALS

DIVISION II
PSYCHIATRIC MEDICAL INSTITUTIONS FOR CHILDREN

DIVISION III
NURSING FACILITIES FOR PERSONS WITH MENTAL ILLNESS

CHAPTER 86
HEALTHY AND WELL KIDS IN IOWA (HAWK-I) PROGRAM

CHAPTER 87
STATE-FUNDED FAMILY PLANNING PROGRAM

CHAPTER 88
MANAGED HEALTH CARE PROVIDERS

DIVISION I
HEALTH MAINTENANCE ORGANIZATION

DIVISION II
PREPAID HEALTH PLANS

CHAPTER 89
DEBTS DUE FROM TRANSFERS OF ASSETS

CHAPTER 90
TARGETED CASE MANAGEMENT

CHAPTER 91
MEDICARE DRUG SUBSIDY

CHAPTER 92
IOWACARE

TITLE IX
WORK INCENTIVE DEMONSTRATION

CHAPTER 93
PROMISE JOBS PROGRAM

CHAPTER 94
Reserved

TITLE X
SUPPORT RECOVERY

CHAPTER 95
COLLECTIONS

PART C
INCOME WITHHOLDING—GENERAL PROVISIONS

DIVISION III
REVIEW AND ADJUSTMENT OF CHILD SUPPORT OBLIGATIONS

DIVISION IV
PUBLICATION OF NAMES

DIVISION V
ADMINISTRATIVE SEEK EMPLOYMENT ORDERS

DIVISION VI
DEBTOR OFFSET

DIVISION VII
ADMINISTRATIVE LEVY

DIVISION VIII
LICENSE SANCTION

TITLE XI
CHILDREN'S INSTITUTIONS

CHAPTER 101
IOWA STATE JUVENILE HOME

CHAPTER 102
Reserved

CHAPTER 103
ELDORA TRAINING SCHOOL

DIVISION I
GENERAL POLICIES AND PROCEDURES

CHAPTER 114
LICENSING AND REGULATION OF ALL
GROUP LIVING FOSTER CARE FACILITIES FOR CHILDREN

CHAPTER 115
LICENSING AND REGULATION OF
COMPREHENSIVE RESIDENTIAL FACILITIES FOR CHILDREN

CHAPTER 116
LICENSING AND REGULATION OF RESIDENTIAL FACILITIES
FOR MENTALLY RETARDED CHILDREN

CHAPTER 117
FOSTER PARENT TRAINING

CHAPTER 118
CHILD CARE QUALITY RATING SYSTEM

CHAPTER 119
RECORD CHECK EVALUATIONS FOR HEALTH CARE PROGRAMS

CHAPTERS 120 to 129
Reserved

TITLE XIII
SERVICE ADMINISTRATION

CHAPTER 130
GENERAL PROVISIONS

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

CHAPTER 151
JUVENILE COURT SERVICES DIRECTED PROGRAMS

DIVISION I
GENERAL PROVISIONS

DIVISION II
COURT-ORDERED SERVICES

DIVISION III
GRADUATED SANCTION SERVICES

CHAPTER 152
FOSTER GROUP CARE CONTRACTING

CHAPTER 153
FUNDING FOR LOCAL SERVICES

DIVISION I
SOCIAL SERVICES BLOCK GRANT

DIVISION II
DECATEGORIZATION OF CHILD WELFARE AND JUVENILE JUSTICE FUNDING

DIVISION III
MENTAL ILLNESS, MENTAL RETARDATION, AND DEVELOPMENTAL DISABILITIES—LOCAL SERVICES

DIVISION IV
STATE PAYMENT PROGRAM FOR LOCAL MENTAL HEALTH, MENTAL RETARDATION, AND DEVELOPMENTAL DISABILITIES SERVICES TO ADULTS WITHOUT LEGAL SETTLEMENT

CHAPTER 154
Reserved

CHAPTER 155
CHILD ABUSE PREVENTION PROGRAM

CHAPTER 156
PAYMENTS FOR FOSTER CARE

CHAPTER 157
Reserved

CHAPTER 158
FOSTER HOME INSURANCE FUND

CHAPTER 159
CHILD CARE RESOURCE AND REFERRAL SERVICES

CHAPTER 160
ADOPTION OPPORTUNITY GRANT PROGRAM

CHAPTER 161
IOWA SENIOR LIVING TRUST FUND

CHAPTER 162
NURSING FACILITY CONVERSION
AND LONG-TERM CARE SERVICES
DEVELOPMENT GRANTS

CHAPTER 163
ADOLESCENT PREGNANCY PREVENTION AND SERVICES
TO PREGNANT AND PARENTING ADOLESCENTS
PROGRAMS

CHAPTER 164
IOWA HOSPITAL TRUST FUND

CHAPTER 171
Reserved

CHAPTER 172
FAMILY-CENTERED CHILD WELFARE SERVICES

DIVISION I
GENERAL PROVISIONS

DIVISION II
SAFETY PLAN SERVICES

DIVISION III
FAMILY SAFETY, RISK, AND PERMANENCY SERVICES

DIVISION IV
FAMILY-CENTERED SUPPORTIVE SERVICES

CHAPTERS 173 and 174
Reserved

CHAPTER 175
ABUSE OF CHILDREN

DIVISION I
CHILD ABUSE

DIVISION II
CHILD ABUSE ASSESSMENT

CHAPTER 176
DEPENDENT ADULT ABUSE

CHAPTER 177
IN-HOME HEALTH RELATED CARE

CHAPTERS 178 to 183
Reserved

CHAPTER 184
INDIVIDUAL AND FAMILY DIRECT SUPPORT

DIVISION I
FAMILY SUPPORT SUBSIDY PROGRAM

DIVISION II
COMPREHENSIVE FAMILY SUPPORT PROGRAM

CHAPTER 185
Reserved

CHAPTER 186
COMMUNITY CARE

CHAPTER 187
AFTERCARE SERVICES AND SUPPORTS

DIVISION I
AFTERCARE SERVICES

CHAPTER 36
FACILITY ASSESSMENTS

DIVISION I
ASSESSMENT FEE FOR INTERMEDIATE CARE FACILITIES FOR THE MENTALLY RETARDED

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

441—36.1(249A) Assessment of fee. Intermediate care facilities for the mentally retarded (ICFs/MR) licensed in Iowa under 481—Chapter 64 shall pay a monthly fee to the department. Effective January 1, 2008, the fee shall equal 5.5 percent of the total revenue of the facility for the facility's preceding fiscal year divided by the number of months of facility operation during the preceding fiscal year.

441—36.2(249A) Determination and payment of fee for facilities certified to participate in the Medicaid program. For facilities certified to participate in the Medicaid program, the fee shall be determined and paid as follows:

36.2(1) The assessment for each facility fiscal year shall be based on the financial and statistical report for the facility's preceding fiscal year submitted pursuant to rule 441—82.5(249A), as adjusted pursuant to 441—subrules 82.5(10) and 82.17(1).

36.2(2) The department shall notify each facility of the amount of the fee assessed for each fiscal year following submission of the financial and statistical report for the facility's preceding fiscal year. The fee is subject to adjustment based on adjustments to the financial and statistical report.

36.2(3) The department shall deduct the monthly amount due from medical assistance payments to the facility. The department shall also deduct from medical assistance payments any additional amount due for past months as a result of an adjustment to the assessment.

36.2(4) Rescinded IAB 6/4/08, effective 5/15/08.

441—36.3(249A) Determination and payment of fee for facilities not certified to participate in the Medicaid program. For facilities not certified to participate in the Medicaid program, the fee shall be determined and paid as follows:

36.3(1) Any licensed ICF/MR in Iowa that is not certified to participate in the Medicaid program shall submit Form 470-0030, Financial and Statistical Report, as required for participating facilities by rule 441—82.5(249A), for purposes of determining the amount of the assessment. The department may audit and adjust the reports submitted, as provided for participating facilities in 441—subrules 82.5(10) and 82.17(1).

36.3(2) The assessment for each facility fiscal year shall be based on the financial and statistical report for the facility's preceding fiscal year as submitted and audited pursuant to subrule 36.3(1).

36.3(3) The department shall notify each facility of the amount of the fee assessed for each fiscal year following submission of the financial and statistical report for the facility's preceding fiscal year. The fee is subject to adjustment based on adjustments to the financial and statistical report.

36.3(4) The facility shall pay the assessed fee to the department on or before the fifteenth day of each month. Any additional amount due for past months as the result of an adjustment to the initial assessment is due 30 days after the department notifies the facility of the additional amount.

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

441—36.5 Reserved.

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

DIVISION II
QUALITY ASSURANCE ASSESSMENT FOR NURSING FACILITIES

These rules describe the nursing facility quality assurance assessment authorized by 2009 Iowa Code Supplement chapter 249L. The rules explain how the assessment is determined and paid.
[**ARC 8894B**, IAB 6/30/10, effective 7/1/10; **ARC 9127B**, IAB 10/6/10, effective 11/10/10]

441—36.6(249L) Assessment.

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

a. Nursing facilities operated by the state.

b. Non-state government-owned or government-operated nursing facilities.

c. Distinct-part skilled nursing units and swing-bed units operated by a hospital.

36.6(2) *Assessment level.*

a. Nursing facilities with 50 or fewer licensed beds are required to pay a quality assurance assessment of $1 per non-Medicare patient day.

b. Nursing facilities designated as continuing care retirement centers (CCRCs) by the insurance division of the Iowa department of commerce are required to pay a quality assurance assessment of $1 per non-Medicare patient day.

c. Nursing facilities with annual Iowa Medicaid patient days of 26,500 or more are required to pay a quality assurance assessment of $1 per non-Medicare patient day.

d. All other nursing facilities are required to pay a quality assurance assessment of $5.26 per non-Medicare patient day.
[**ARC 8258B**, IAB 11/4/09, effective 1/1/10; **ARC 8894B**, IAB 6/30/10, effective 7/1/10; **ARC 9127B**, IAB 10/6/10, effective 11/10/10]

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

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

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

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

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

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

36.7(4) A nursing facility that fails to pay the quality assurance assessment within the time frame specified above shall pay a penalty in the amount of 1.5 percent of the quality assurance assessment amount owed for each month or portion of a month that the payment is overdue. If the department determines that good cause is shown for failure to comply with payment of the quality assurance assessment, the department shall waive the penalty or a portion of the penalty. Requests for a good cause waiver must be submitted to the Iowa Medicaid Enterprise, Provider Cost Audit and Rate Setting Unit, 100 Army Post Road, Des Moines, Iowa 50315, within 30 days of notice to the facility that the penalty is due.

36.7(5) For facilities certified to participate in the Medicaid program, the department shall deduct the quarterly amount due from Medicaid payments to the facility if the department has not received the

quality assurance assessment amount due by the last day of the month in which the payment is due. The department shall also withhold an amount equal to the penalty owed from any payment due.
[**ARC 8258B**, IAB 11/4/09, effective 1/1/10; **ARC 8894B**, IAB 6/30/10, effective 7/1/10; **ARC 9127B**, IAB 10/6/10, effective 11/10/10]

441—36.8 and **36.9** Reserved.

These rules are intended to implement 2009 Iowa Code Supplement chapter 249L.

DIVISION III
HEALTH CARE ACCESS ASSESSMENT FOR HOSPITALS

These rules describe the hospital health care access assessment authorized by 2010 Iowa Acts, Senate File 2388, enacted by the Eighty-third General Assembly. The rules explain how the assessment is determined and paid.
[**ARC 8894B**, IAB 6/30/10, effective 7/1/10; **ARC 9127B**, IAB 10/6/10, effective 11/10/10]

441—36.10(83GA,SF2388) Application of assessment.

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

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

a. Contractual adjustments,
b. Charity care,
c. Bad debt,
d. Medicare revenue, or
e. Other revenue derived from sources other than hospital operations including but not limited to:
(1) Nonoperating revenue,
(2) Other operating revenue,
(3) Skilled nursing facility revenue,
(4) Physician revenue, and
(5) Long-term care revenue.

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

441—36.11(83GA,SF2388) Determination and payment of assessment. The assessment shall be determined and paid as follows:

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

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

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

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

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

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

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

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

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

441—36.12(83GA,SF2388) Termination of health care access assessment. If the federal government fully funds Iowa's medical assistance program, if federal law changes to negatively impact the assessment program as determined by the department, or if a federal audit determines the assessment program is invalid, the assessment shall terminate on the date the federal statutory, regulatory, or interpretive change takes effect.

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

These rules are intended to implement 2010 Iowa Acts, Senate File 2388.

[Filed 11/18/02, Notice 10/2/02—published 12/11/02, effective 2/1/03]
[Filed emergency 11/19/03—published 12/10/03, effective 12/1/03]
[Filed emergency 8/12/04—published 9/1/04, effective 8/12/04]
[Filed 10/14/04, Notice 9/1/04—published 11/10/04, effective 12/15/04]
[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 5/14/08—published 6/4/08, effective 5/15/08]
[Filed ARC 8258B (Notice ARC 8086B, IAB 8/26/09), IAB 11/4/09, effective 1/1/10]
[Filed Emergency ARC 8894B, IAB 6/30/10, effective 7/1/10]
[Filed ARC 9127B (Notice ARC 8896B, IAB 6/30/10), IAB 10/6/10, effective 11/10/10]

CHAPTER 58
EMERGENCY ASSISTANCE

DIVISION I
IOWA DISASTER AID INDIVIDUAL ASSISTANCE GRANT PROGRAM

PREAMBLE

This division implements a state program of financial assistance to meet disaster-related expenses, food-related costs, or serious needs of individuals or families who are adversely affected by a state-declared disaster emergency. The program is intended to meet needs that cannot be met by other means of financial assistance.

441—58.1(29C) Definitions.

"Emergency management coordinator" means the person appointed by the local emergency management commission pursuant to Iowa Code sections 29C.9 and 29C.10 to be responsible for development of the countywide emergency operations plan and for coordination and assistance to government officials when an emergency or disaster occurs.

"Household" means all adults and children who lived in the pre-disaster residence who request assistance, as well as any persons, such as infants, spouses, or part-time residents, who were not present at the time of the disaster but who are expected to return during the assistance period.

"Necessary expense" means the cost associated with acquiring an item or items, obtaining a service, or paying for any other activity that meets a serious need.

"Safe, sanitary, and secure" means free from disaster-related health hazards.

"Serious need" means the item or service is essential to the household to prevent, mitigate, or overcome a disaster-related hardship, injury, or adverse condition.

441—58.2(29C) Program implementation.

58.2(1) *Disaster declaration.* The Iowa individual assistance grant program (IIAGP) shall be implemented when the governor issues a declaration of a state of disaster emergency that authorizes individual assistance. The program shall be in effect only in those counties named in the declaration. Assistance shall be provided for a period not to exceed 120 days from the date of declaration.

58.2(2) *Voucher system.* To implement a voucher system for IIAGP, the county board of supervisors shall authorize a local administrative entity to administer the system.

a. The local administrative entity may be, but is not limited to:

(1) A local community organization active in disaster (COAD),

(2) A local long-term recovery committee (LTRC),

(3) A nonprofit organization,

(4) A faith-based organization, or

(5) A regional or statewide LTRC.

b. The local administrative entity shall enter into a contract with the department of human services using Form FA 09-15-2010, Fiscal Agent Contract. The contract shall specify the terms for the administration of IIAGP benefits through a voucher system.

[**ARC 9128B**, IAB 10/6/10, effective 10/1/10]

441—58.3(29C) Application for assistance. To request assistance for disaster-related expenses, the household shall complete Form 470-4448, Individual Disaster Assistance Application, and submit it within 45 days of the disaster declaration to the county emergency management coordinator along with: (1) receipts for the claimed expenses, or (2) a request to participate in a voucher system.

58.3(1) Application forms are available from county emergency management coordinators and local offices of the department of human services, as well as the Internet Web site of the department at www.dhs.iowa.gov.

58.3(2) The application shall include:

a. A declaration of the household's annual income, accompanied by:

(1) A current pay stub, W-2 form, or income tax return, or

(2) Documentation of current enrollment in an assistance program administered by the department of human services, the Special Supplemental Nutrition Program for Women, Infants and Children (WIC), or other subsidy program.

b. A release of confidential information to personnel involved in administering the program.

c. A certification of the accuracy of the information provided.

d. An assurance that the household had no insurance coverage for claimed items.

e. A commitment to refund any part of a grant awarded that is duplicated by insurance or by any other assistance program, such as but not limited to local community development groups and charities, the Small Business Administration, or the Federal Emergency Management Administration.

f. A short, handwritten narrative of the disaster event and how the disaster caused the loss being claimed.

g. A copy of a picture identification document for each adult applicant.

h. When vehicle damage is claimed, current copies of the vehicle registration and liability insurance card.

[**ARC 9128B**, IAB 10/6/10, effective 10/1/10]

441—58.4(29C) Eligibility criteria. To be eligible for assistance, an applicant household must meet all of the following conditions:

58.4(1) The household's residence was located in the area identified in the disaster declaration during the designated incident period and the household verifies occupancy at that residence.

58.4(2) Household members are citizens of the United States or are legally residing in the United States.

58.4(3) The household's self-declared annual income is at or less than 200 percent of the federal poverty level for a household of that size.

a. Poverty guidelines are updated annually.

b. All income available to the household is counted, including wages, child support, interest from investments or bank accounts, social security benefits, and retirement income.

58.4(4) The household has disaster-related expenses or serious needs that are not covered by insurance or the claim is less than the deductible amount. This program will not reimburse the amount of the insurance deductible when the claim exceeds the deductible amount.

58.4(5) The household has not previously received assistance from this program or another program for the same loss.

441—58.5(29C) Eligible categories of assistance. The maximum assistance available to a household in a single disaster is $5,000. Reimbursement is available under the program for the following disaster-related expenses:

58.5(1) Reimbursement may be issued for personal property, including repair or replacement of the following items, based on the item's condition:

a. Kitchen items, up to a maximum of $560, including:

(1) Equipment and furnishings, up to a maximum of $560.

(2) Food, up to a maximum of $50 for one person plus $25 for each additional person in the household.

b. Personal hygiene items, up to a maximum of $30 per person and $150 per household.

c. Clothing and bedroom furnishings, up to a maximum of $875, including:

(1) Mattress, box spring, frame, and storage containers, up to a maximum of $250 per person.

(2) Clothing, up to a maximum of $145 per person.

d. Other items, including:

(1) Infant car seat, up to a maximum of $40.

(2) Dehumidifier, up to a maximum of $150.

(3) Sump pump (in a flood event only), up to a maximum of $200 installed.

(4) Electrical or mechanical repairs, up to a maximum of $1,000.

(5) Water heater, up to a maximum of $425 installed.

(6) Vehicle repair, up to a maximum of $500.

(7) Heating and air-conditioning systems, up to a maximum of $2,100 installed. Air conditioning is covered only with proof of medical necessity.

58.5(2) Reimbursement may be issued for home repair as needed to make the home safe, sanitary, and secure, up to a maximum of $5,000.

a. Assistance will be denied if preexisting conditions are the cause of the damage.

b. Reimbursement may be authorized for:

(1) The repair of structural components, such as the foundation and roof.

(2) The repair of floors, walls, ceilings, doors, windows, and carpeting of essential interior living space that was occupied at the time of the disaster.

(3) Debris removal, including trees, up to a maximum of $1,000.

c. Repairs to rental property are excluded under this program.

58.5(3) Reimbursement may be issued for temporary housing assistance, up to a limit of $50 per day, for lodging at a licensed establishment, such as a hotel or motel, if the household's home is destroyed, uninhabitable, inaccessible, or unavailable to the household.

441—58.6(29C) Eligibility determination and payment.

58.6(1) The county emergency management coordinator or designee shall:

a. Confirm that:

(1) The address provided on the application is a valid address and is reasonably believed to be in the disaster-affected area, and

(2) Disaster-related expenses were possible as a result of the current disaster.

b. If receipts are included, submit the household's application form and receipts to the Homeland Security and Emergency Management Division, Camp Dodge, Building W-4, 7105 NW 70th Avenue, Johnston, Iowa 50131. The envelope shall be marked "IIAGP application."

c. If the applicant requests to participate in the voucher system, forward the application to the local administrative entity for the county.

58.6(2) For applications with receipts:

a. The homeland security and emergency management division of the department of public defense shall:

(1) Review the application.

(2) Submit the household's application form and receipts to the DHS Office of the Deputy Director for Administration, 1305 East Walnut Street, Des Moines, Iowa 50319-0114. The envelope shall be marked "IIAGP application."

b. Designated staff in the department of human services shall:

(1) Determine eligibility and the amount of payment.

(2) Notify the applicant household of the eligibility decision.

(3) Authorize payment to an eligible household.

(4) Process appeals.

58.6(3) For applications with a voucher request:

a. The local administrative entity for the county shall:

(1) Determine eligibility and the amount of payment.

(2) Notify the applicant household of the eligibility decision.

(3) Authorize vouchers to an eligible household to purchase needed goods and services.

(4) Pay vendors for goods and services purchased with vouchers.

(5) Submit a claim to the department of human services for reimbursement for voucher purchases.

b. Designated staff in the department of human services shall:

(1) Process reimbursement to the local administrative entity for claims.

(2) Process appeals.

[**ARC 9128B**, IAB 10/6/10, effective 10/1/10]

441—58.7(29C) Contested cases.

58.7(1) *Reconsideration.* The household may request reconsideration of the department's decisions regarding eligibility and the amount of reimbursement awarded.

a. To request reconsideration, the household shall submit a written request to the DHS Division of Results-Based Accountability, 1305 East Walnut Street, Des Moines, Iowa 50319-0114, within 15 days of the date of the department's letter notifying the household of its decision.

b. The department shall review any additional evidence or documentation submitted and issue a reconsideration decision within 15 days of receipt of the request.

58.7(2) *Appeal.* The household may appeal the department's reconsideration decision according to procedures in 441—Chapter 7.

a. Appeals must be submitted in writing, either on Form 470-0487 or 470-0487(S), Appeal and Request for Hearing, or in any form that provides comparable information, to the DHS Appeals Section, 1305 East Walnut Street, Des Moines, Iowa 50319-0114, within 15 days of the date of the reconsideration decision.

b. A written appeal is filed on the date the envelope sent to the department is postmarked or, when the postmarked envelope is not available, on the date the appeal is stamped received by the agency.

441—58.8(29C) Discontinuance of program.

58.8(1) *Deferral to federal assistance.* Upon declaration of a disaster by the President of the United States under the Robert T. Stafford Disaster Relief and Emergency Assistance Act, 42 U.S.C. Sections 5121 to 5206, the Iowa individual assistance grant program administered under this chapter shall be discontinued in the geographic area included in the presidential declaration. Upon issuance of the presidential declaration:

a. No more applications shall be accepted.

b. Any applications that are in process but are not yet approved shall be denied.

c. Persons seeking assistance under this program shall be advised to apply for federal disaster assistance.

58.8(2) *Exhaustion of funds.* The program shall be discontinued when funds available for the program have been exhausted. To ensure equitable treatment, applications for assistance shall be approved on a first-come, first-served basis until all funds have been depleted. "First-come, first-served" is determined by the date the application is approved for payment.

a. Partial payment. Because funds are limited, applications may be approved for less than the amount requested. Payment cannot be approved beyond the amount of funds available.

b. Reserved funds. A portion of allocated funds shall be reserved for final appeal decisions reversing the department's denial that are received after funds for the program have been awarded.

c. Untimely applications. Applications received after the program is discontinued shall be denied.

These rules are intended to implement 2009 Iowa Code Supplement chapter 29C as amended by 2010 Iowa Acts, House File 2294.

441—58.9 to **58.20** Reserved.

DIVISION II
FAMILY INVESTMENT PROGRAM—EMERGENCY ASSISTANCE
[Prior to 10/13/93, 441—58.1 to 58.11]
Rescinded IAB 4/7/10, effective 5/12/10

441—58.21 to **58.40** Reserved.

DIVISION III
TEMPORARY MEASURES RELATED TO DISASTERS

441—58.41(217) Purpose. The rules in this division are intended to allow the department to deliver services more effectively during or following a disaster emergency declared by state or federal officials.

These rules temporarily supersede departmental rules that would otherwise apply, with the primary purpose of reducing barriers to accessing and receiving services that may result from the emergency. The rules shall be tailored to meet special circumstances that arise from a specific disaster emergency and shall be time-limited.

This rule is intended to implement Iowa Code section 217.6.

[**ARC 7577B**, IAB 2/25/09, effective 4/1/09]

441—58.42(234,237A,239B,249,249A,249J,514I) Extension of scheduled reporting and review requirements. Normal scheduled reporting, review, recertification, redetermination, or similar requirements related to continued eligibility are amended as follows:

58.42(1) *Scheduled actions due in June 2008.* For the month of June 2008, no quarterly report, six-month or 12-month review, or similar recertification or redetermination normally required under the following chapters shall be required of households residing in the most affected counties during the month. For all programs except food assistance, the designated counties are Black Hawk, Bremer, Butler, Johnson, and Linn.

1. 441—Chapter 40 (family investment program);
2. 441—Chapter 50 (state supplementary assistance);
3. 441—Chapter 65 (food assistance);
4. 441—Chapter 75, 76, or 83 (medical assistance and family planning waiver);
5. 441—Chapter 86 (HAWK-I);
6. 441—Chapter 92 (IowaCare); or
7. 441—Chapter 170 (child care assistance).

58.42(2) *Scheduled actions due in July and August 2008.* For the months of July and August 2008, no quarterly report, six-month or 12-month review, or similar recertification or redetermination normally required under the following chapters shall be required of households residing in any county of the state:

1. 441—Chapter 40 (family investment program);
2. 441—Chapter 50 (state supplementary assistance);
3. 441—Chapter 65 (food assistance);
4. 441—Chapter 75, 76, or 83 (medical assistance and family planning waiver);
5. 441—Chapter 86 (HAWK-I);
6. 441—Chapter 92 (IowaCare); or
7. 441—Chapter 170 (child care assistance).

58.42(3) *Next scheduled action due.* For those households affected under subrules 58.42(1) and 58.42(2), the next report, review, recertification, or redetermination shall be scheduled as if the action due in June, July, or August 2008 had occurred. For example, if a six-month review was to have occurred in June 2008, the next review will be due in December 2008. Likewise, if a 12-month recertification was due in July 2008, the next recertification will be due in July 2009.

58.42(4) *Continuing to report and act on changes.* Other than as provided by this rule, households shall continue to comply with program requirements for reporting changes in circumstances. Good cause provisions for not reporting changes timely shall apply as provided by existing rules. The department shall continue to act on all changes reported or otherwise known to the department that may affect eligibility or benefits during the extended reporting, review, recertification and redetermination periods provided under this rule.

This rule is intended to implement Iowa Code chapters 234, 237A, 239B, 249, 249A, 249J, and 514I.

[**ARC 7577B**, IAB 2/25/09, effective 4/1/09]

441—58.43(237A) Need for child care services. State child care assistance eligibility requirements concerning need for service in rule 441—170.2(237A,239B) shall be held in abeyance for households residing in governor-declared disaster counties during the months of June, July, and August 2008. Households in those counties that previously met the requirement shall be considered to continue to meet the requirement for those three months if the disaster and ensuing recovery temporarily prevent the household from otherwise meeting this requirement.

This rule is intended to implement Iowa Code section 237A.13.
[**ARC 7577B**, IAB 2/25/09, effective 4/1/09]

441—58.44(249A,249J,514I) Premium payments. Individuals residing in any Iowa county declared by the governor to be a disaster area who would otherwise have their assistance under 441—Chapter 75 (medical assistance), 441—Chapter 86 (HAWK-I), or 441—Chapter 92 (IowaCare) canceled for failure to make a premium payment in the months of June or July 2008 shall not have their assistance canceled for this reason.

This rule is intended to implement Iowa Code chapters 249A, 249J, and 514I.
[**ARC 7577B**, IAB 2/25/09, effective 4/1/09]

441—58.45(249A) Citizenship and identity. Citizenship and identity requirements under 441—Chapter 75 for medical assistance applicants shall be held in abeyance for the months of June, July, and August 2008, for individuals residing in counties declared disaster areas by the governor as provided in this rule.

58.45(1) An affidavit may be used to establish both citizenship and identity when other forms of verification are not available and the department is unable to obtain verification through a match with vital records maintained by the department of public health.

58.45(2) An individual approved for medical assistance under this rule shall be granted a certification period of only three months. At the end of the three-month period, the individual shall be required to provide documentation of citizenship and identity as otherwise required under 441—Chapter 75 to continue eligibility.

This rule is intended to implement Iowa Code chapter 249A.
[**ARC 7577B**, IAB 2/25/09, effective 4/1/09]

441—58.46 to **58.50** Reserved.

DIVISION IV
IOWANS HELPING IOWANS UNMET NEEDS DISASTER ASSISTANCE PROGRAM

PREAMBLE

This division implements a program of state assistance to address unmet disaster-related expenses that cannot be met by other financial assistance. The program provides assistance for repair or replacement of personal property, home repair, food assistance, child care, and temporary housing to households whose income is less than 300 percent of the federal poverty level. The amount of assistance available to a household is capped at $2,500.

The program is administered by the department of human services in coordination with the rebuild Iowa office and local administrative entities designated by the county boards of supervisors.
[**ARC 9130B**, IAB 10/6/10, effective 9/15/10]

441—58.51(234) Definitions.

"Department" means the Iowa department of human services.

"Household" means all adults and children who lived in the pre-disaster residence who request individual assistance (not including landlords or other businesses), as well as any persons, such as infants, spouses, or part-time residents, who were not present at the time of the disaster but who are expected to return during the assistance period.

"Local administrative entity" means a county-appointed fiscal entity that performs direct work with households seeking assistance for unmet needs. The local administrative entity certifies the assistance that each household may receive and issues direct reimbursement or purchase vouchers for certified goods or services.

"Unmet need" means an item or service needed to overcome a disaster-related hardship, injury, or adverse condition due to an eligible federally declared disaster resulting in costs or damages related to

personal property, home repair, food assistance, child care, or temporary housing for which the household has not received adequate assistance from any federal, state, nonprofit, or faith-based agency.
[**ARC 9130B**, IAB 10/6/10, effective 9/15/10]

441—58.52(234) Program implementation. The Iowans helping Iowans unmet needs disaster assistance program shall be in effect September 15, 2010. This program is available for households affected by natural disasters occurring after June 1, 2010, in areas that the President of the United States declared a disaster area for individual assistance.

58.52(1) *Funding.* Funding for the program is established by the governor of Iowa through the Iowans helping Iowans program. The rebuild Iowa office will establish a methodology to distribute the funding among the counties in presidentially declared disaster areas.

58.52(2) *Local administration.* To implement the program, the county board of supervisors shall appoint a local administrative entity to administer the program for that county.

a. The local administrative entity may be, but is not limited to:

(1) A local community organization active in disaster (COAD),

(2) A local long-term recovery committee (LTRC),

(3) A nonprofit organization,

(4) A faith-based organization, or

(5) A regional or statewide LTRC.

b. The appointed local administrative entity shall enter into a contract with the department on Form FA 08-30-2010, Fiscal Agent Contract. The contract shall specify the terms for the administration of unmet needs benefits.
[**ARC 9130B**, IAB 10/6/10, effective 9/15/10]

441—58.53(234) Application for assistance. To request financial assistance for unmet disaster needs expenses, the household shall complete Form 470-4689, Iowans Helping Iowans Unmet Needs Disaster Assistance Program, and submit the form to the local administrative entity.

58.53(1) Application forms are available from the local administrative entity. Individuals can find their local administrative entity by calling the rebuild Iowa office toll-free at (866)849-0323.

58.53(2) The application shall include:

a. A declaration of the household's annual gross income.

b. A release of confidential information to personnel involved in administering the program.

c. An assurance that the household had no insurance coverage for claimed items or services.

d. A commitment to refund any part of a grant awarded that is duplicated by insurance or by any other assistance program, such as but not limited to other state assistance, local community development groups, charities or faith-based agencies, the Small Business Administration, or the Federal Emergency Management Administration.

e. A copy of a photo identification document for each adult applicant.

f. When vehicle damage is claimed, current copies of the vehicle registration and liability insurance card.
[**ARC 9130B**, IAB 10/6/10, effective 9/15/10]

441—58.54(234) Eligibility criteria. To be eligible for assistance, an applicant household must meet all of the following conditions:

58.54(1) The household's residence was located in the disaster area identified by a presidential declaration as described in rule 441—58.52(234), and the household verifies occupancy at that residence.

58.54(2) Household members are citizens of the United States or are legally residing in the United States.

58.54(3) The household's self-declared annual income is at or less than 300 percent of the federal poverty level for a household of that size.

a. Poverty level guidelines are updated annually.

b. All income available to the household is counted, including wages, child support, interest from investments or bank accounts, social security benefits, and retirement income.

58.54(4) The household has disaster-related expenses not covered by insurance, or the claim is less than or equal to the deductible amount. This program will not reimburse the amount of the insurance deductible when the claim exceeds the deductible amount.

58.54(5) The household has not previously received assistance from this program or another program, such as but not limited to other state assistance, local community development groups, charities or faith-based agencies, the Small Business Administration, or the Federal Emergency Management Administration, for the same loss. The applicant has applied with the Small Business Administration and the Federal Emergency Management Administration but did not receive an award for the items or services included in the unmet needs application.

[**ARC 9130B**, IAB 10/6/10, effective 9/15/10]

441—58.55(234) Eligible categories of assistance. The maximum assistance available to a household for a single disaster is $2,500. Assistance is available under the program for the following disaster-related expenses:

1. Personal property.
2. Home repair.
3. Food assistance.
4. Child care.
5. Temporary housing.

[**ARC 9130B**, IAB 10/6/10, effective 9/15/10]

441—58.56(234) Eligibility determination and payment.

58.56(1) *Duties of local administrative entity.* The local administrative entity shall perform the following duties:

a. Accept the household's application.

b. Certify that:

(1) The address provided on the application is a valid address in the disaster-affected area,

(2) Disaster-related expenses were a result of the covered disaster,

(3) The household has presented reasonable documentation or receipts for expenses incurred or has reasonable estimates for eligible costs for issuance of a voucher to secure specific eligible goods or services, and

(4) Funds remain available.

c. Determine the amount of assistance the household is eligible to receive by category of assistance and provide the rationale for that amount.

d. Provide the signature of local administrative entity staff making the certification and the date of certification.

e. Notify the applicant household of the certification decision and issue to an approved household:

(1) Reimbursement for documented expenses, or

(2) A voucher to secure specific eligible goods or services.

f. Retain a copy of the household's Form 470-4689, Iowans Helping Iowans Unmet Needs Disaster Assistance Program, and all documentation.

g. Report weekly to the rebuild Iowa office regarding expenditures. Weekly reports shall be in the format prescribed in the agreement.

h. Complete a final reconciliation to substantiate expenditures.

i. Return any unexpended funds to the department within 30 days of the final expenditure or June 30, 2011.

58.56(2) *Local administrative expenses.* A local administrative entity may allocate no more than 5 percent of the amount of assistance provided to households as an administrative expense. Administrative expenses shall be detailed on the weekly report of expenditures.

58.56(3) *Duties of disaster case management office.* Designated staff in the rebuild Iowa disaster case management office shall:

a. Ensure that a local administrative entity is designated in each county affected.

b. Coordinate contact between applicants and their local administrative entity.

c. Support the reconsideration process.

58.56(4) *Duties of the department.* Designated department staff shall:

a. Process grant payments to the local administrative entity or its designee.

b. Process appeals.

[**ARC 9130B**, IAB 10/6/10, effective 9/15/10]

441—58.57(234) Contested cases.

58.57(1) *Reconsideration.* The household may request reconsideration of the local administrative entity's decision regarding certification of eligible unmet needs and the amount of reimbursement awarded.

a. To request reconsideration, the household shall submit a written request to the Rebuild Iowa Office, Wallace State Office Building, 502 East Ninth Street, Des Moines, Iowa 50319, within 15 days of the date of the local administrative entity's notification to the household of its decision.

b. The rebuild Iowa disaster recovery case management office shall:

(1) Review any additional evidence or documentation submitted,

(2) Issue a reconsideration decision within 15 days of receipt of the request, and

(3) Notify the household of the reconsideration decision.

58.57(2) *Appeal.* The household may appeal the rebuild Iowa office reconsideration decision according to procedures in 441—Chapter 7.

a. Appeals must be submitted:

(1) In writing, either on Form 470-0487 or 470-0487(S), Appeal and Request for Hearing, or in any form that provides comparable information;

(2) To the DHS Appeals Section, 1305 East Walnut Street, Des Moines, Iowa 50319-0114;

(3) Within 15 days of the date of the reconsideration decision.

b. A written appeal is filed on the date the envelope sent to the department is postmarked or, when the postmarked envelope is not available, on the date the appeal is stamped received by the department.

[**ARC 9130B**, IAB 10/6/10, effective 9/15/10]

441—58.58(234) Discontinuance of program. The Iowans helping Iowans unmet needs disaster assistance program administered under this division shall be discontinued upon exhaustion of allocated funds or on June 30, 2011, whichever occurs first.

[**ARC 9130B**, IAB 10/6/10, effective 9/15/10]

These rules are intended to implement Iowa Code section 234.6.

441—58.59 and **58.60** Reserved.

DIVISION V
TICKET TO HOPE PROGRAM

PREAMBLE

This division implements the ticket to hope program, a mental health counseling program funded through a social services emergency disaster relief grant that was authorized by Public Law 110-329, the Consolidated Security, Disaster Assistance, and Continuing Appropriations Act of 2009. The program pays for professional mental health evaluation and treatment services for individuals and families who have been affected by the weather-related disasters of 2008.

[**ARC 7641B**, IAB 3/25/09, effective 3/1/09; **ARC 7830B**, IAB 6/3/09, effective 7/8/09]

441—58.61(234) Definitions.

"Department" means the Iowa department of human services.

"Ticket to hope" means the mental health counseling program for individuals and families who have been directly affected by the weather-related disasters of 2008.

[**ARC 7641B**, IAB 3/25/09, effective 3/1/09; **ARC 7830B**, IAB 6/3/09, effective 7/8/09]

441—58.62(234) Application process. The process for obtaining assistance from the ticket to hope program is as follows:

58.62(1) A person requesting assistance shall contact the Iowa concern hotline by telephone at 1-800-447-1985.

58.62(2) The Iowa concern hotline shall gather information and determine eligibility for ticket to hope services based on criteria established in this division.

58.62(3) The Iowa concern hotline shall send to each eligible applicant a packet of information that includes:

a. An introductory cover letter;

b. A list of participating providers;

c. An authorization form for one 45- to 50-minute session (valid for 30 days); and

d. A demographic data form that includes a unique numeric client identifier.

58.62(4) The eligible applicant shall:

a. Make an appointment with an approved provider; and

b. Give the authorization and demographic data forms to the provider at the time of the appointment.

58.62(5) After the eligible applicant meets with the provider, the applicant may call the Iowa concern hotline and receive authorization for up to seven additional sessions. A new authorization form shall be issued for each session.

[**ARC 7641B**, IAB 3/25/09, effective 3/1/09; **ARC 7830B**, IAB 6/3/09, effective 7/8/09]

441—58.63(234) Eligibility criteria. To be eligible for assistance, a person living in Iowa must report:

1. That the impact of the 2008 disaster has impaired the person's ability to carry out normal daily functions to some extent; and

2. That the person has no insurance coverage for mental health services, or has insurance with a high deductible that will deter the person from accessing necessary mental health services.

[**ARC 7641B**, IAB 3/25/09, effective 3/1/09; **ARC 7830B**, IAB 6/3/09, effective 7/8/09]

441—58.64(234) Provider participation. A mental health professional with an active professional license issued by the Iowa department of public health who is qualified to provide individual psychotherapy (i.e., Current Procedural Terminology code 90806, "individual psychotherapy, insight-oriented behavior modification or support, provided face to face with the patient in an office or outpatient setting") according to the Iowa Plan vendor requirements shall be allowed to participate as a ticket to hope provider.

58.64(1) A mental health professional applying to participate in the program shall submit a copy of the professional license to the Iowa concern hotline.

58.64(2) The mental health professional shall agree to the terms of participation in the ticket to hope program by:

a. Signing a professional services agreement with the department; and

b. Returning the signed agreement to the Iowa concern hotline.

[**ARC 7641B**, IAB 3/25/09, effective 3/1/09; **ARC 7830B**, IAB 6/3/09, effective 7/8/09]

441—58.65(234) Provider reimbursement. A provider approved to participate shall be reimbursed as follows:

58.65(1) The provider shall submit a completed demographic data form and the authorization form to the Iowa concern hotline within 30 days after each completed session with an approved applicant.

58.65(2) The provider shall be reimbursed at the lower of:

a. A rate of $93 per assessment or counseling session, or

b. The prevailing Iowa Medicaid rate.

[**ARC 7641B**, IAB 3/25/09, effective 3/1/09; **ARC 7830B**, IAB 6/3/09, effective 7/8/09]

441—58.66(234) Reconsideration. An applicant may request reconsideration of a denial of access to services. A mental health professional may request reconsideration of a denial to be a part of the professional provider panel.

58.66(1) To request reconsideration, the person shall submit a written request to the DHS Division of Mental Health and Disability Services, 1305 East Walnut Street, Des Moines, Iowa 50319-0114.

58.66(2) The department shall review any additional evidence or documentation submitted and issue a reconsideration decision within 15 days from receipt of the request.

[**ARC 7641B**, IAB 3/25/09, effective 3/1/09; **ARC 7830B**, IAB 6/3/09, effective 7/8/09]

441—58.67(234) Appeal. The person may appeal the department's reconsideration decision according to procedures in 441—Chapter 7.

58.67(1) Appeals must be submitted in writing, either on Form 470-0487 or 470-0487(S), Appeal and Request for Hearing, or in any form that provides comparable information, to the DHS Appeals Section, 1305 East Walnut Street, Des Moines, Iowa 50319-0114, within 15 days of the date of the reconsideration decision.

58.67(2) A written appeal is filed on the date the envelope sent to the department is postmarked or, when the postmarked envelope is not available, on the date the appeal is stamped received by the department.

[**ARC 7641B**, IAB 3/25/09, effective 3/1/09; **ARC 7830B**, IAB 6/3/09, effective 7/8/09]

441—58.68(234) Discontinuance of program. The program shall end on June 30, 2010, or when the funds are expended, whichever occurs first.

[**ARC 7641B**, IAB 3/25/09, effective 3/1/09; **ARC 7830B**, IAB 6/3/09, effective 7/8/09]

These rules are intended to implement Iowa Code section 234.6.

[Filed emergency 10/12/90 after Notice 8/22/90—published 10/31/90, effective 11/1/90]
[Filed emergency 6/14/91—published 7/10/91, effective 7/1/91]
[Filed without Notice 9/18/91—published 10/16/91, effective 11/21/91]
[Filed 9/18/91, Notice 7/10/91—published 10/16/91, effective 12/1/91]
[Filed emergency 10/10/91—published 10/30/91, effective 11/21/91]
[Filed 1/29/92, Notice 10/16/91—published 2/19/92, effective 3/25/92]
[Filed 5/14/92, Notice 3/18/92—published 6/10/92, effective 8/1/92]
[Filed emergency 9/17/93—published 10/13/93, effective 10/1/93]
[Filed emergency 11/12/93—published 12/8/93, effective 1/1/94]
[Filed 12/16/93, Notice 10/13/93—published 1/5/94, effective 3/1/94]
[Filed 2/10/94, Notice 12/8/93—published 3/2/94, effective 5/1/94]
[Filed emergency 1/15/97—published 2/12/97, effective 3/1/97]
[Filed 4/11/97, Notice 2/12/97—published 5/7/97, effective 7/1/97]
[Filed emergency 9/12/02 after Notice 7/24/02—published 10/2/02, effective 10/1/02]
[Filed emergency 3/5/07—published 3/28/07, effective 3/5/07]
[Filed emergency 6/13/07 after Notice 3/28/07—published 7/4/07, effective 7/1/07]
[Filed emergency 6/11/08—published 7/2/08, effective 7/1/08]
[Filed emergency 7/9/08—published 7/30/08, effective 7/9/08]
[Filed 10/14/08, Notice 7/2/08—published 11/5/08, effective 12/10/08]
[Filed 12/15/08, Notice 10/22/08—published 1/14/09, effective 3/1/09]
[Filed ARC 7577B (Notice ARC 6995B, IAB 7/30/08), IAB 2/25/09, effective 4/1/09]
[Filed Emergency ARC 7603B, IAB 3/11/09, effective 2/11/09]
[Filed Emergency ARC 7641B, IAB 3/25/09, effective 3/1/09]
[Filed ARC 7830B (Notice ARC 7642B, IAB 3/25/09), IAB 6/3/09, effective 7/8/09]
[Filed ARC 8007B (Notice ARC 7604B, IAB 3/11/09), IAB 7/29/09, effective 9/2/09]
[Filed ARC 8640B (Notice ARC 8460B, IAB 1/13/10), IAB 4/7/10, effective 5/12/10]
[Filed Emergency ARC 9130B, IAB 10/6/10, effective 9/15/10]
[Filed Emergency ARC 9128B, IAB 10/6/10, effective 10/1/10]

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, therapeutically certified 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. Payment will not be made for biological supplies and drugs provided free of charge to practitioners by the state department of public health. Rate of payment shall be established as in subrule 78.2(2), but no professional fee shall be paid.

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."

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. All physicians who administer vaccines which are available through the Vaccines for Children program to Medicaid members shall enroll in the Vaccines for Children program. Vaccines available through the Vaccines for Children program shall be obtained from the department of public health for Medicaid members. Physicians shall, however, receive reimbursement for the administration of these vaccines to Medicaid members.

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 will not be approved for vaccines which are available through 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.

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 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 subrule 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 lemphocytic 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 artesia 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]

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, therapeutically certified optometrist, physician assistant, or advanced registered nurse practitioner).

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. 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. 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 to cause anorexia, weight gain, or weight loss, except for lipase inhibitor drugs prescribed for weight loss with prior authorization as provided in paragraph *"a."*

(3) Drugs used for cosmetic purposes or hair growth.

(4) Drugs used to promote smoking cessation, except for varenicline with prior authorization as provided in paragraph *"a"* above and generic, sustained-release bupropion products that are indicated for smoking cessation by the U.S. Food and Drug Administration.

(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)).

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 1250 mg (500 mg elemental calcium)
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 patch 7 mg/day, 14 mg/day and 21 mg/day
Pediatric oral electrolyte solutions
Permethrin liquid 1%
Pseudoephedrine hydrochloride tablets 30 mg, 60 mg
Pseudoephedrine hydrochloride liquid 30 mg/5 ml
Pseudoephedrine/dextromethorphan 15 mg/7.5 mg/5 mL liquid
Pseudoephedrine/dextromethorphan 20 mg/10 mg/5 mL liquid
Pseudoephedrine/dextromethorphan 30 mg/15 mg/5 mL liquid
Pseudoephedrine/dextromethorphan 20 mg/10 mg/5 mL elixir
Pseudoephedrine/dextromethorphan 15 mg/7.5 mg/5 mL syrup
Pseudoephedrine/dextromethorphan 30 mg/15 mg/5 mL syrup
Pseudoephedrine/dextromethorphan 7.5 mg/2.5 mg/0.8 mL solution

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]

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 Foundation for Medical Care (IFMC). 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. Readmissions to the same facility due to premature discharge shall not be paid a new DRG. 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 IFMC, 6000 Westown Parkway, Suite 350E, West Des Moines, Iowa 50265-7771, 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. 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.

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) 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.

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.

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. Payment will also be made for the following dental procedures subject to the exclusions for services to adults 21 years of age and older set forth in subrule 78.4(14):

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 physical or mental disability, 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 in a six-month period except for people who need more frequent applications because of physical or mental disability. (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 disability that impairs their ability to maintain adequate

oral hygiene. Replacement sealants are covered when medically necessary, as documented in the patient record.

78.4(2) *Diagnostic services.* Payment shall be made for the following diagnostic services:

a. A comprehensive oral evaluation is payable once per patient per dentist in a three-year period when the patient has not seen that dentist during the three-year period.

b. A periodic oral examination is payable once in a six-month period.

c. A complete mouth radiograph survey consisting of a minimum of 14 periapical films and bite-wing films is a payable service once in a five-year period, except when medically necessary to evaluate development, and to detect anomalies, injuries and diseases. Complete mouth radiograph surveys are not payable under the age of six. A panographic-type radiography with bitewings is considered the same as a complete 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 when requested by the Iowa Medicaid enterprise medical services unit's dental consultant.

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. Two laboratory-fabricated crowns using nonprecious materials, other than stainless steel, are payable per member in a 12-month period. Additional laboratory-fabricated crowns using nonprecious materials, other than stainless steel, are payable when prior authorization has been obtained. Noble metals are payable for crowns when members are allergic to all other restorative materials. Stainless steel crowns are payable when a more conservative procedure would not be serviceable. (Cross-reference 78.28(2)*"e"*)

e. Cast post and core, steel post and composite or amalgam in addition to a crown is 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 restorative procedures:

(1) Amalgam or acrylic buildups are considered part of the preparation for the completed restoration.

(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) A two-surface anterior composite restoration will be payable as a one-surface restoration if it involved the lingual surface.

(6) Tooth preparation, temporary restorations, cement bases, pulp capping, impressions, local anesthesia and inhaled 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 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 prophylasix or periodontal services are performed.

b. Periodontal scaling and root planing is payable when prior approval has been received. A request for approval must be accompanied by a plan for treatment, a completed copy of a periodontal probe chart that exhibits pocket depths, history and radiograph(s). Payment for periodontal scaling and root planing will be approved when interproximal and subgingival calculus is evident in X-rays or when justified and documented that curettage, scaling or root planing is required in addition to routine prophylaxis. (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. A request for approval must be accompanied by a plan for treatment, a completed copy of a periodontal probe chart that exhibits pocket depths, history and radiograph(s). 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 patient has demonstrated reasonable oral hygiene, unless the patient is unable to demonstrate reasonable oral hygiene because of physical or mental disability or in cases which demonstrate gingival hyperplasia resulting from drug therapy. (Cross-reference 78.28(2)*"a"*(2))

d. Pedicle soft tissue graft and free soft tissue graft are payable services with prior approval based on a written narrative describing medical necessity. (Cross-reference 78.28(2)*"a"*(3))

e. Periodontal maintenance therapy which includes oral prophylaxis, measurement of pocket depths and limited root planing and scaling is a payable service when prior approval has been received. A request for approval must be accompanied by a periodontal treatment plan, a completed copy of a periodontal probe chart which exhibits pocket depths, periodontal history and radiograph(s). Payment for periodontal maintenance therapy may be approved after periodontal scaling and root planing or periodontal surgical procedures have been provided. Periodontal maintenance therapy may be approved once per three-month interval for moderate to advanced cases if the condition would deteriorate without treatment. (Cross-reference 78.28(2)*"a"*(4))

f. Payment as indicated will be made for the following periodontal services:

(1) Periodontal scaling and root planing, gingivoplasty, osseous surgery will be paid per quadrant.

(2) Gingivoplasty will be paid per tooth.

(3) Osseous allograft will be paid as a single site if one site is involved, or if more than one site is involved, payment will be made for multiple sites.

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 extensive posttreatment restorative procedures are not necessary and when missing teeth do not jeopardize the integrity or function of the dental arches.

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 is payable when prior approval has been received. Payment for 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 will be approved when nonsurgical treatment has been attempted and a reasonable time 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)*"d"*)

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, and failure has been demonstrated with a radiograph and narrative history.

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. General anesthesia, intravenous sedation, and non-intravenous conscious sedation are payable services when the extensiveness of the procedure indicates it or there is a concomitant disease or impairment which warrants its use.

j. Routine postoperative care is considered part of the fee for surgical procedures and may not be billed separately.

k. 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 and a first-time complete denture including six months' postdelivery care. An immediate denture and a first-time complete denture are payable when the denture is provided to establish masticatory function. An immediate denture or a first-time complete denture is payable only once following the removal of teeth it replaces. A complete denture is payable only once in a five-year period except when the denture is broken beyond repair, lost or stolen, or no longer fits due to growth or changes in jaw structure and is required to prevent significant dental problems. Replacement of complete dentures due to resorption in less than a five-year period is not payable.

b. A removable partial denture replacing anterior teeth, including six months' postdelivery care. A removable partial denture replacing anterior teeth is payable only once in a five-year period unless the removable partial denture is broken beyond repair, lost or stolen, or no longer fits due to growth or changes in jaw structure and is required to prevent significant dental problems. Replacement of a removable partial denture replacing anterior teeth due to resorption in less than a five-year period is not payable.

c. A removable partial denture replacing posterior teeth including six months' postdelivery care when prior approval has been received. A removable partial denture replacing posterior teeth shall be approved when the member has fewer than eight posterior teeth in occlusion 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. A removable partial denture replacing posterior teeth is payable only once in a five-year period unless the removable partial denture is broken beyond

repair, lost or stolen, or no longer fits due to growth or changes in jaw structure and is required to prevent significant dental problems. Replacement of a removable partial denture replacing posterior teeth due to resorption in less than a five-year period is not payable. (Cross-reference 78.28(2)*"c"*(1))

d. A fixed partial denture (including an acid etch fixed partial denture) replacing anterior teeth when prior approval has been received. A fixed partial denture (including an acid etch fixed partial denture) replacing anterior teeth shall be approved for members whose medical condition precludes the use of a removable partial denture. High noble or noble metals shall be approved only when the member is allergic to all other restorative materials. A fixed partial denture replacing anterior teeth is payable only once in a five-year period unless the fixed partial denture is broken beyond repair. (Cross-reference 78.28(2)*"c"*(2))

e. A fixed partial denture (including an acid etch fixed partial denture) replacing posterior teeth when prior approval has been received. A fixed partial denture (including an acid etch fixed partial denture) replacing posterior teeth shall be approved for the member whose medical condition precludes the use of a removable partial denture and who has fewer than eight posterior teeth in occlusion or if 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 fixed partial denture brings eight posterior teeth in occlusion, no additional fixed partial denture will be approved. High noble or noble metals will be approved only when the member is allergic to all other restorative materials. A fixed partial denture replacing posterior teeth is payable only once in a five-year period unless the fixed partial denture is broken beyond repair. (Cross-reference 78.28(2)*"c"*(3))

f. Obturator for surgically excised palatal tissue or deficient velopharyngeal function of cleft palate patients.

g. Chairside relines are payable only once per prosthesis every 12 months.

h. Laboratory processed relines are payable only once per prosthesis every 12 months.

i. Tissue conditioning is a payable service twice per prosthesis in a 12-month period.

j. Two repairs per prosthesis in a 12-month period are payable.

k. 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.

l. 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.

78.4(8) *Orthodontic procedures.* Payment may be made for the following orthodontic procedures:

a. When prior approval has been given for orthodontic services to treat the most handicapping malocclusions in a manner consistent with "Handicapping Malocclusion Assessment to Establish Treatment Priority," by J.A. Salzmann, D.D.S., American Journal of Orthodontics, October 1968.

A handicapping malocclusion is a condition that constitutes a hazard to the maintenance of oral health and interferes with the well-being of the patient by causing impaired mastication, dysfunction of the temporomandibular articulation, susceptibility to periodontal disease, susceptibility to dental caries, and impaired speech due to malpositions of the teeth. Treatment of handicapping malocclusions will be approved only for the severe and the most handicapping. Assessment of the most handicapping malocclusion is determined by the magnitude of the following variables: degree of malalignment, missing teeth, angle classification, overjet and overbite, openbite, and crossbite.

A request to perform an orthodontic procedure must be accompanied by an interpreted cephalometric radiograph and study models trimmed so that the models simulate centric occlusion of the patient. A written plan of treatment must accompany the diagnostic aids. Posttreatment records must be furnished upon request of the Iowa Medicaid enterprise.

Approval may be made for eight units of a three-month active treatment period. Additional units may be approved by the Iowa Medicaid enterprise's orthodontic consultant if found to be medically necessary. (Cross-reference 78.28(2)*"d"*)

b. Space management services shall be payable when there is too little dental ridge to accommodate either the number or the size of teeth and if not corrected significant dental disease will result.

c. Tooth guidance for a limited number of teeth or interceptive orthodontics is a payable service when extensive treatment is not required. Pretreatment records are not required.

78.4(9) *Treatment in a hospital.* Payment will be approved for dental treatment rendered a hospitalized patient only when the mental, physical, or emotional condition of the patient prevents the dentist from providing necessary care in the office.

78.4(10) *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.

78.4(11) *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 exams are not billed for that visit.

78.4(12) *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.

78.4(13) *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 writing prescriptions.

78.4(14) *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.

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 rule 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 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.

d. Single vision and multifocal lens service, verification and subsequent service. When lenses are necessary, the following enumerated professional and technical optometric services are to be provided:

(1) When 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 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) Protective lenses 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 six years of age.
3. When there is a prescribed 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.

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 once every 12 months for adults aged 21 and over, except for people with a mental or physical disability.

i. Fitting of contact lenses when required following cataract surgery, documented keratoconus, aphakia, or for treatment of acute or chronic eye disease. Up to eight pairs of contact lenses are allowed for children up to one year of age with aphakia. Up to four pairs of contact lenses per year are allowed for children one to three years of age with aphakia.

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, manufactured by reputable American manufacturers.

b. Standard plastic, plastic and metal combination, or metal frames manufactured by reputable American manufacturers, if available.

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.

a. Materials payable by fee schedule are:

(1) 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) Protective lenses and safety frames.

(5) Subnormal visual aids.

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 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.

(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 protective purposes including glasses for eye safety, sunglasses, or glasses with photogray lenses. An exception to this is in 78.6(3)*"b"*(4).

c. A second pair of glasses or spare glasses.

d. Cosmetic surgery and experimental medical and surgical procedures.

e. Contact lenses if vision is correctable with noncontact lenses except as found at paragraph 78.6(1)*"i."*

78.6(6) *Therapeutically certified optometrists.* Therapeutically certified optometrists may provide services and employ pharmaceutical agents in accordance with Iowa Code chapter 154 regulating the practice of optometry. A therapeutically certified optometrist is an optometrist who is licensed to practice optometry in this state and who is certified by the board of optometry to employ the agents and perform the procedures provided by the Iowa Code.

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

[**ARC 7548B**, IAB 2/11/09, effective 4/1/09]

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		
		724.8	Other symptoms referable to back, facet syndrome		
		729.1	Myalgia and myositis, unspecified		

ICD-9	CATEGORY I	ICD-9	CATEGORY II	ICD-9	CATEGORY III
		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 date of the signature shall be within the certification period.

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.* Home health agencies which 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. Home health agencies may provide Vaccines for Children clinics and be reimbursed for vaccine administration to provide Vaccines for Children program vaccines to Medicaid children in other than the home setting.

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

[**ARC 7548B**, IAB 2/11/09, effective 4/1/09]

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 diagnosis, prognosis, and length of time the item is to be required.

For items requiring prior approval, 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 approval is made on Form 470-0829, Request for Prior Authorization. See rule 441—78.28(249A) for prior approval 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 patient, e.g., elevators, stairway elevators and posture chairs.

e. The amount payable is based on the least expensive item which meets the patient's medical needs. Payment will not be approved for duplicate items.

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 will be maintained on a rental basis for the duration of use.

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.

78.10(2) *Durable medical equipment.* DME is equipment which 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 will not be provided in a hospital, nursing facility, or intermediate care facility for persons with mental retardation. EXCEPTION: Medicaid will provide payment to medical equipment and supply dealers to provide oxygen services in a nursing facility or an intermediate care facility for persons with mental retardation when all of the following requirements and conditions have been met:

(1) A physician's, physician assistant's, or advanced registered nurse practitioner's prescription documents that the member has significant hypoxemia as defined by Medicare and evidenced by supporting medical documentation and the member requires oxygen for 12 hours or more per day for at least 30 days. Oxygen prescribed "PRN" or "as necessary" is not allowed. The documentation maintained in the provider record must contain the following:

1. The number of hours oxygen is required per day;
2. The diagnosis of the disease requiring continuous oxygen, prognosis, and length of time the oxygen will be needed;
3. The oxygen flow rate and concentration; the type of system ordered, i.e., cylinder gas, liquid gas, or concentrator;
4. A specific estimate of the frequency and duration of use; and
5. The initial reading on the time meter clock on each concentrator, where applicable.

(2) The maximum Medicaid payment shall be based on the least costly method of oxygen delivery.

(3) Medicaid payment shall be made for the rental of equipment only. All accessories and disposable supplies related to the oxygen delivery system, servicing and repairing of equipment are included in the Medicaid payment.

(4) Oxygen logs must be maintained by the provider. When random postpayment review of these logs indicates less than an average of 12 hours per day of oxygen was provided over a 30-day period, recoupment of the overpayment may occur.

(5) Payment will be made for only one mode of oxygen even if the physician's, physician assistant's, or advanced registered nurse practitioner's prescription allows for multiple modes of delivery.

(6) Payment will not be made for oxygen that is not documented according to department of inspections and appeals 481—subrule 58.21(8).

b. Only the following types of durable medical equipment can be covered through the Medicaid program:

Alternating pressure pump.

Automated medication dispenser. See 78.10(2)*"d"* for prior authorization requirements.

Bedpan.

Blood glucose monitors, subject to the limitation in 78.10(2)*"e."*

Blood pressure cuffs.

Cane.

Cardiorespiratory monitor (rental and supplies).

Commode.

Commode pail.

Crutches.

Decubitus equipment.

Dialysis equipment.

Diaphragm (contraceptive device).

Enclosed bed. See 78.10(2)*"d"* for prior authorization requirements.

Enuresis alarm system (bed-wetting alarm device) for members five years of age or older.
Hospital bed.
Hospital bed accessories.
Inhalation equipment.
Insulin infusion pump. See 78.10(2)*"d"* for prior authorization requirements.
Lymphedema pump.
Neuromuscular stimulator.
Oximeter.
Oxygen, subject to the limitations in 78.10(2)*"a"* and 78.10(2)*"c."*
Patient lift (Hoyer).
Phototherapy bilirubin light.
Pressure unit.
Protective helmet.
Respirator.
Resuscitator bags and pressure gauge.
Seat lift chair.
Suction machine.
Traction equipment.
Urinal (portable).
Vaporizer.
Ventilator.
Vest airway clearance system. See 78.10(2)*"d"* for prior authorization requirements.
Walker.
Wheelchair—standard and adaptive.
Whirlpool bath.

c. Coverage of home oxygen equipment and oxygen will be considered reasonable and necessary only for members with significant hypoxemia as defined by Medicare and shown by supporting medical documentation. The physician's, physician assistant's, or advanced registered nurse practitioner's prescription 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 at one year of age and at two years of age and documented in the provider record.

(1) To identify the medical necessity for oxygen therapy, the supplier and a physician, physician assistant, or advanced registered nurse practitioner shall jointly submit Medicare Form B-7401, Physician's Certification for Durable Medical Equipment, or a reasonable facsimile. The following information is required:

1. A diagnosis of the disease requiring home use of oxygen;
2. The oxygen flow rate and concentration;
3. The type of system ordered, i.e., cylinder gas, liquid gas, or concentrator;
4. A specific estimate of the frequency and duration of use; and
5. The initial reading on the time meter clock on each concentrator, where applicable.

Oxygen prescribed "PRN" or "as necessary" is not allowed.

(2) If the patient'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 (doctor of medicine or osteopathy), physician assistant, or advanced registered nurse practitioner of the medical necessity for portable oxygen for specific activities.

(4) Payment for concentrators shall be made only on a rental basis.

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

d. Prior authorization is required for the following medical equipment and supplies (Cross-reference 78.28(1)):

(1) Enclosed beds. Payment for an enclosed bed will be approved when prescribed for a patient who meets all of the following conditions:

1. The patient has a diagnosis-related cognitive or communication impairment that results in risk to safety.
2. The patient's mobility puts the patient at risk for injury.
3. The patient has suffered injuries when getting out of bed.

(2) External insulin infusion pumps. Payment will be approved according to Medicare coverage criteria.

(3) Vest airway clearance systems. Payment will be approved for a vest airway clearance system when prescribed by a pulmonologist for a patient 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 of lung function.
2. The patient 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.

(4) 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 a 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.

(5) Blood glucose monitors and diabetic test strips produced by a manufacturer that does not have a current agreement to provide a rebate to the department for monitors or test strips provided through the Medicaid program. Prior approval shall be granted when the member's medical condition necessitates use of a blood glucose monitor or diabetic test strips produced by a manufacturer that does not have a current rebate agreement with the department.

e. Blood glucose monitors are covered through the Medicaid program only if:

(1) The monitor is produced by a manufacturer that has a current agreement to provide a rebate to the department for monitors provided through the Medicaid program; or

(2) Prior authorization based on medical necessity is received pursuant to rule 441—79.8(249A) for a monitor produced by a manufacturer that does not have a current rebate agreement with the department.

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 patient's condition may improve sometime in the future.

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

b. Only the following types of prosthetic devices shall be covered through the Medicaid program:

(1) Artificial eyes.

(2) Artificial limbs.

(3) Augmentative communications systems provided for members unable to communicate their basic needs through oral speech or manual sign language. Payment will be made for the most cost-effective item that meets basic communication needs commensurate with the member's cognitive and language abilities. See 78.10(3)*"c"* for prior approval requirements.

(4) Enteral delivery supplies and products. See 78.10(3)*"c"* for prior approval requirements.

(5) Hearing aids. See rule 441—78.14(249A).

(6) Oral nutritional products. See 78.10(3)*"c"* for prior approval requirements. Nutritional products consumed orally are not covered for members in nursing facilities or intermediate care facilities for the mentally retarded.

(7) Orthotic devices. See 78.10(3)*"d"* for limitations on coverage of cranial orthotic devices.

(8) Ostomy appliances.

(9) 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.

(10) Prosthetic shoes. See rule 441—78.15(249A).

(11) Tracheotomy tubes.

(12) 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. Prior approval is required for the following prosthetic devices:

(1) Augmentative communication systems. Form 470-2145, Augmentative Communication System Selection, completed by a speech pathologist and a physician's, physician assistant's, or advanced registered nurse practitioner's prescription for a particular device shall be submitted to the Iowa Medicaid enterprise medical services unit to request prior approval. Information requested on the prior approval form includes a medical history, diagnosis, and prognosis completed by a physician, physician assistant, or advanced registered nurse practitioner. In addition, a speech or language pathologist needs to describe current functional abilities in the following areas: communication skills, motor status, sensory status, cognitive status, social and emotional status, and language status. Also needed from the speech or language pathologist is information on educational ability and needs, vocational potential, anticipated duration of need, prognosis regarding oral communication skills, prognosis with a particular device, and recommendations. The department's consultants with expertise in speech pathology will evaluate the prior approval requests and make recommendations to the department. (Cross-reference 78.28(1)*"c"*)

(2) Enteral products and enteral delivery pumps and supplies. Daily enteral nutrition therapy shall be approved as medically necessary only for a member who either has a metabolic or digestive disorder that prevents the member from obtaining the necessary nutritional value from usual foods in any form and cannot be managed by avoidance of certain food products or has a severe pathology of the body that does not allow ingestion or absorption of sufficient nutrients from regular food to maintain weight and strength commensurate with the member's general condition.

A request for prior approval shall include a physician's, physician assistant's, or advanced registered nurse practitioner's written order or prescription and documentation to establish the medical necessity for enteral products and enteral delivery pumps and supplies pursuant to the above standards. The documentation shall include:

1. A statement of the member's total medical condition that includes a description of the member's metabolic or digestive disorder or pathology.

2. Documentation of the medical necessity for commercially prepared products. The information submitted must identify other methods attempted to support the member's nutritional status and indicate that the member's nutritional needs were not or could not be met by regular food in pureed form.

3. Documentation of the medical necessity for an enteral pump, if the request includes an enteral pump. The information submitted must identify the medical reasons for not using a gravity feeding set.

Examples of conditions that will not justify approval of enteral nutrition therapy are: weight-loss diets, wired-shut jaws, diabetic diets, milk or food allergies (unless the member is under five years of

age and coverage through the Women, Infant and Children's program is not available), and the use of enteral products for convenience reasons when regular food in pureed form would meet the medical need of the member.

Basis of payment for nutritional therapy supplies shall be the least expensive method of delivery that is reasonable and medically necessary based on the documentation submitted.

(3) Oral nutritional products. Payment for oral nutritional products shall be approved as medically necessary only 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 the mentally retarded. A request for prior approval shall include a physician's, physician assistant's, or advanced registered nurse practitioner's written order or prescription and documentation to establish the medical necessity for oral supplementation pursuant to these standards. The documentation shall include:

1. A statement of the member's total medical condition that includes a description of the member's metabolic, digestive, or psychological disorder or pathology.

2. Documentation of the medical necessity for commercially prepared products. The information submitted must identify other methods attempted to support the member's nutritional status and indicate that the member's nutritional needs were not or could not be met by regular food in pureed form.

3. Documentation to support the fact that regular foods will not provide sufficient nutritional value to the member. Examples of conditions that will not justify approval of oral supplementation are: weight-loss diets, wired-shut jaws, diabetic diets, milk or food allergies (unless the member is under five years of age and coverage through the Women, Infant and Children's program is not available), supplementation to boost calorie or protein intake by less than 51 percent of the daily intake, and the absence of severe pathology of the body or psychological pathology or disorder.

d. 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 photographic evidence supporting moderate to severe nonsynostotic positional plagiocephaly and either:

(1) The member is between 3 and 5 months of age and has failed to respond to a two-month trial of repositioning therapy; or

(2) The member is between 6 and 18 months 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. Medical supplies are not to be dispensed at any one time for quantities exceeding a three-month supply. 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. Only the following types of medical supplies and supplies necessary for the effective use of a payable item can be purchased through the medical assistance program:

Catheter (indwelling Foley).

Colostomy and ileostomy appliances.

Colostomy and ileostomy care dressings, liquid adhesive, and adhesive tape.

Diabetic blood glucose test strips, subject to the limitation in 78.10(4)*"c."*

Diabetic supplies, other than blood glucose test strips (needles, syringes, and diabetic urine test supplies).

Dialysis supplies.

Diapers (for members aged four and above).
Disposable catheterization trays or sets (sterile).
Disposable irrigation trays or sets (sterile).
Disposable saline enemas (e.g., sodium phosphate type).
Disposable underpads.
Dressings.
Elastic antiembolism support stocking.
Enema.
Hearing aid batteries.
Respirator supplies.
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 the mentally retarded when prescribed by the physician, physician assistant, or advanced registered nurse practitioner:

Catheter (indwelling Foley).
Colostomy and ileostomy appliances.
Colostomy and ileostomy care dressings, liquid adhesive and adhesive tape.
Diabetic supplies (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).

c. Diabetic blood glucose test strips are covered through the Medicaid program only if:

(1) The strips are produced by a manufacturer that has a current agreement to provide a rebate to the department for test strips provided through the Medicaid program, or

(2) Prior authorization is received pursuant to rule 441—79.8(249A) for test strips produced by a manufacturer that does not have a current rebate agreement with the department, based on medical necessity.

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]

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 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) Remedial services. Payment will be made for remedial services not otherwise covered under this chapter that are designed to minimize or, if possible, eliminate the symptoms or causes of a psychological disorder, subject to the limitations in this rule.

78.12(1) *Covered services.* Medicaid covers the following remedial services:

a. Community psychiatric supportive treatment, which offers intensive interventions to modify psychological, behavioral, emotional, cognitive, and social factors affecting a member's functioning when less intensive remedial services do not meet the member's needs.

(1) Interventions must focus on the member's remedial needs to minimize or eliminate psychological barriers to a member's ability to effectively manage symptoms associated with a psychological disorder in an age-appropriate manner.

(2) Interventions may assist the member in skills such as conflict resolution, problem solving, social skills, interpersonal relationship skills, and communication.

(3) Community psychiatric supportive treatment is covered only for Medicaid members who are aged 20 or under.

(4) Community psychiatric supportive treatment is not intended for members in congregate care.

(5) Community psychiatric supportive treatment is not intended to be provided in a group.

b. Crisis intervention 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.

c. Health or behavior intervention, used 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: conflict resolution skills, problem-solving skills, social skills, interpersonal relationship skills, and communication skills.

(2) The purpose of intervention shall be to minimize or eliminate psychological barriers to the member's ability to effectively manage symptoms associated with a psychological disorder in an age-appropriate manner.

(3) Health or behavior intervention is covered only for Medicaid members aged 20 or under.

d. Rehabilitation program, which consists of interventions to enhance a member's independent living, social, and communication skills; to minimize or eliminate psychological barriers to a member's

ability to effectively manage symptoms associated with a psychological disorder; and to maximize the member's ability to live and participate in the community.

(1) Interventions may address the following skills for effective functioning with family, peers, and community: communication skills, conflict resolution skills, problem-solving skills, social skills, interpersonal relationship skills, and employment-related skills.

(2) Rehabilitation program services are covered only for Medicaid members who are aged 18 or over.

e. Skills training and development, which consists of interventions to enhance independent living, social, and communication skills; to minimize or eliminate psychological barriers to a member's ability to effectively manage symptoms associated with a psychological disorder; and to maximize a member's ability to live and participate in the community.

(1) Interventions may include the following skills for effective functioning with family, peers, and community: communication skills, conflict resolution skills, problem-solving skills, social skills, interpersonal relationship skills, and employment-related skills.

(2) Skills training and development services are covered only for Medicaid members aged 18 or over.

78.12(2) *Excluded services.* Services that are habilitative in nature are not covered as remedial services. 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.

78.12(3) *Coverage requirements.* Medicaid covers remedial services 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. For example, licensed practitioners of the healing arts include physicians (M.D. or D.O.), advanced registered nurse practitioners (ARNP), psychologists (Ph.D. or Psy.D.), independent social workers (LISW), marital and family therapists (LMFT), and mental health counselors (LMHC). For purposes of this rule, the licensed practitioner of the healing arts must be:

(1) Enrolled in the Iowa Plan pursuant to 441—Chapter 88, Division IV; and

(2) Qualified to provide clinical assessment services under the Iowa Plan pursuant to 441—Chapter 88, Division IV (Current Procedural Terminology code 90801).

b. The licensed practitioner of the healing arts has recommended the remedial services as part of a plan of treatment designed to treat the member's psychological disorder. 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 using the same instrument every six months thereafter if continued services are ordered.

d. The remedial services provider has prepared a written remedial services implementation plan that has been approved by:

(1) The member or the member's parent or guardian; and

(2) The medical services unit of the Iowa Medicaid enterprise.

78.12(4) *Approval of plan.* The remedial services provider shall submit the treatment plan, the results of the formal assessment, and the remedial services implementation plan to the Iowa Medicaid enterprise (IME) medical services unit for approval before providing the services.

a. Initial plan. The IME medical services unit shall approve the provider's initial remedial services implementation plan if:

(1) The plan conforms to the medical necessity requirements in subrule 78.12(3);

(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 can demonstrate that the provider possesses the skills and resources necessary to implement the plan, as required in rule 441—77.12(249A);

(5) The plan does not exceed six months' duration; and

(6) The plan requires that written progress notes be submitted no less often than every six weeks to the IME medical services unit.

b. Subsequent plans. The IME medical services unit may approve a subsequent remedial services implementation plan according to the conditions in paragraph *"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;

(3) Evaluated the member's progress, including a formal assessment as required by 78.12(3)*"c"*(3); and

(4) Submitted the results of the formal assessment with the recommendation for continued services.

c. Quality review. The IME medical services unit will establish a quality review process. Reviews will evaluate:

(1) The time elapsed from referral to remedial plan development;

(2) The continuity of treatment;

(3) The affiliation of the licensed practitioner of the healing arts with the remedial services provider;

(4) Gaps in service;

(5) The results achieved; and

(6) Member satisfaction.

78.12(5) *Medical necessity.* Nothing in this rule shall be deemed to exempt coverage of remedial services from the requirement that services be medically necessary. "Medically necessary" means that the service is:

a. Consistent with the diagnosis and treatment of the member's condition;

b. Required to meet the medical needs of the member and is needed for reasons other than the convenience of the member or the member's caregiver;

c. The least costly type of service that can reasonably meet the medical needs of the member; and

d. In accordance with the standards of good medical practice. The standards of good practice for each field of medical and remedial care covered by the Iowa Medicaid program are those standards of good practice identified by:

(1) Knowledgeable Iowa clinicians practicing or teaching in the field; and

(2) The professional literature regarding best practices in the field.

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

[**ARC 8504B**, IAB 2/10/10, effective 3/22/10]

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) Vaccines available through the Vaccines for Children program under Section 1928 of the Social Security Act are not covered as screening center services. Screening centers that wish to administer those vaccines to Medicaid members shall enroll in the Vaccines for Children program and obtain the vaccines from the department of public health. Screening centers shall receive reimbursement for the administration of vaccines to Medicaid members.

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.

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 recipient'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 a recipient residing in a nursing facility or residential care facility are payable when a statement is submitted signed by the facility 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 recipient residing in an intermediate care facility for the mentally retarded since these facilities are responsible for providing or paying for services required by recipients.

(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.

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.* Vaccines available through the Vaccines for Children program under Section 1928 of the Social Security Act are not covered as rural health center services. Rural health clinics that wish to administer those vaccines to Medicaid members shall enroll in the Vaccines for Children

program and obtain the vaccines from the department of public health. However, the administration of vaccines is a covered service.

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

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) Vaccines available through the Vaccines for Children program under Section 1928 of the Social Security Act are not covered as family planning clinic services. Family planning clinics that wish to administer those vaccines for Medicaid members who receive services at the clinic shall enroll in the Vaccines for Children program and obtain the vaccines from the department of public health. Family planning clinics shall receive reimbursement for the administration of vaccines to Medicaid members.

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

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.* Vaccines available through the Vaccines for Children program under Section 1928 of the Social Security Act are not covered as clinic services. Clinics that wish to administer those vaccines to Medicaid members shall enroll in the Vaccines for Children program and obtain the vaccines from the department of public health. Clinics shall receive reimbursement for the administration of vaccines to Medicaid members.

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

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).)

Vaccines available through the Vaccines for Children program under Section 1928 of the Social Security Act are not covered as maternal health center services. Maternal health centers that wish to administer those vaccines to Medicaid members shall enroll in the Vaccines for Children program and obtain the vaccines from the department of public health. Maternal health centers shall receive reimbursement for the administration of vaccines to Medicaid members.

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.

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

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.

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.

"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.

"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 has completed an assessment of the member's need for service, and, based on that assessment, the Iowa Medicaid enterprise medical services unit has determined that the member is in need of home- and community-based habilitation services. A member who is not eligible for Medicaid case management services under 441—Chapter 90 shall receive case management as a home- and community-based habilitation service. The designated case manager 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 has approved the member's plan for home- and community-based habilitation services. A service plan that has been validated through ISIS shall be considered approved by the department. Home- and community-based habilitation services provided before department approval of a member's eligibility for the program cannot be reimbursed.

(1) The member's comprehensive service plan shall be completed annually according to the requirements of subrule 78.27(4). A service plan may change at any time due to a significant change in the member's needs.

(2) The member's habilitation services shall not exceed the maximum number of units established for each service in 441—subrule 79.1(2).

(3) The cost of the habilitation services shall not exceed unit expense maximums established in 441—subrule 79.1(2).

78.27(3) *Application for services.* The case manager shall apply for services on behalf of a member by entering a program request for habilitation services in ISIS.

a. Assignment of payment slot. The number of persons who may be approved for home- and community-based habilitation services is subject to a yearly total to be served. The total is set by the department based on available funds and is contained in the Medicaid state plan approved by the federal

Centers for Medicare and Medicaid Services. The limit is maintained through the awarding of payment slots to members applying for services.

(1) The case manager shall contact the Iowa Medicaid enterprise through ISIS to determine if a payment slot is available for each member applying for home- and community-based habilitation services.

(2) When a payment slot is assigned, the case manager shall give written notice to the member.

(3) The department shall hold the assigned payment slot for the member as long as reasonable efforts are being made to arrange services and the member 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 applicant on the waiting list, if applicable. The member must reapply for a new slot.

b. Waiting list for payment slots. When the number of applications exceeds the number of members specified in the state plan and there are no available payment slots to be assigned, the member's application for habilitation services shall be denied. The department shall issue a notice of decision stating that the member's name will be maintained on a waiting list.

(1) The Iowa Medicaid enterprise shall enter the member on a waiting list based on the date and time when the member's request for habilitation services was entered into ISIS. In the event that more than one application is received at the same time, members shall be entered on the waiting list on the basis of the month of birth, January being month one and the lowest number.

(2) When a payment slot becomes available, the Iowa Medicaid enterprise shall notify the member's case manager, based on the member's order on the waiting list. The case manager shall give written notice to the member within five working days.

(3) The department shall hold the payment slot for 20 calendar days to allow the case manager to reapply for habilitation services by entering a program request through ISIS. If a request for habilitation services has not been entered within 20 calendar days, the slot shall revert for use by the next member on the waiting list, if applicable. The member assigned the slot must reapply for a new slot.

(4) The case manager shall notify the Iowa Medicaid enterprise within five working days of the withdrawal of an application.

c. Notice of decision. The department shall issue a notice of decision to the applicant when financial eligibility, determination of needs-based eligibility, and approval of the service 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 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 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 shall establish an interdisciplinary team for the member. The team shall include the case manager 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 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.

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 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 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 any health and safety issues applicable to the individual member based on information gathered before the team meeting, including a risk assessment.

(2) The interdisciplinary team shall identify an emergency backup support and crisis response system to address problems or issues arising when support services are interrupted or delayed or the member's needs change.

(3) Providers of applicable services shall provide for emergency backup staff.

e. Plan approval. Services shall be entered into ISIS based on the comprehensive service plan. A service 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. Exclusion. 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 an hour. A maximum of 26 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 determines that:

(1) A payment slot is not available to the member pursuant to paragraph 78.27(3)*"a."*

(2) The member is not eligible for or in need of home- and community-based habilitation services.

(3) The service is not identified in the member's comprehensive service plan.

(4) Needed services are not available or received from qualifying providers, or no qualifying providers are available.

(5) The member's service needs exceed the unit or reimbursement maximums for a service as set forth in 441—subrule 79.1(2).

(6) Completion or receipt of required documents for the program has not occurred.

b. Reduction. A particular home- and community-based habilitation service may be reduced when the department determines that continued provision of service at its current level is not necessary.

c. Termination. A particular home- and community-based habilitation service may be terminated when the department determines that:

(1) The member's income exceeds the allowable limit, or the member no longer meets other eligibility criteria for the program established by the department.

(2) The service is not identified in the member's comprehensive service plan.

(3) Needed services are not available or received from qualifying providers, or no qualifying providers are available.

(4) The member's service needs are not being met by the services provided.

(5) The member has received care in a medical institution for 30 consecutive days in any one stay. When a member has been an inpatient in a medical institution for 30 consecutive days, the department will issue a notice of decision to inform the member of the service termination. If the member returns home before the effective date of the notice of decision and the member's condition has not substantially changed, the decision shall be rescinded, and eligibility for home- and community-based habilitation services shall continue.

(6) The member's service needs exceed the unit or reimbursement maximums for a service as established by the department.

(7) Duplication of services provided during the same period has occurred.

(8) The member or the member's legal representative, through the interdisciplinary process, requests termination of the service.

(9) Completion or receipt of required documents for the program has not occurred, or the member refuses to allow documentation of eligibility as to need and income.

d. Appeal rights. The department shall give notice of any adverse action and the right to appeal in accordance with 441—Chapter 7. The member is entitled to have a review of the determination of needs-based eligibility by the Iowa Medicaid enterprise medical services unit by sending a letter requesting a review to the medical services unit. If dissatisfied with that decision, the member may file an appeal with the department.

78.27(12) *County reimbursement.* The county board of supervisors of the member's county of legal settlement shall reimburse the department for all of the nonfederal share of the cost of home- and community-based habilitation services provided to an adult member with a chronic mental illness as defined in 441—Chapter 90. The department shall notify the county's central point of coordination administrator through ISIS of the approval of the member's service plan.

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)]

441—78.28(249A) List of medical services and equipment requiring prior approval, preprocedure review or preadmission review.

78.28(1) Services, procedures, and medications prescribed by a physician (M.D. or D.O.) which are subject to prior approval or preprocedure review are as follows or as specified in the preferred drug list published by the department pursuant to Iowa Code Supplement 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. (Cross-reference 78.10(2)*"b"*) 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 a 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.

c. Enteral products and enteral delivery pumps and supplies require prior approval. Daily enteral nutrition therapy shall be approved as medically necessary only for a member who either has a metabolic or digestive disorder that prevents the member from obtaining the necessary nutritional value from usual foods in any form and cannot be managed by avoidance of certain food products or has a severe pathology of the body that does not allow ingestion or absorption of sufficient nutrients from regular food

to maintain weight and strength commensurate with the member's general condition. (Cross-reference 78.10(3)*"c"*(2))

(1) A request for prior approval shall include a physician's, physician assistant's, or advanced registered nurse practitioner's written order or prescription and documentation to establish the medical necessity for enteral products and enteral delivery pumps and supplies pursuant to the above standards. The documentation shall include:

1. A statement of the member's total medical condition that includes a description of the member's metabolic or digestive disorder or pathology.

2. Documentation of the medical necessity for commercially prepared products. The information submitted must identify other methods attempted to support the member's nutritional status and indicate that the member's nutritional needs were not or could not be met by regular food in pureed form.

3. Documentation of the medical necessity for an enteral pump, if the request includes an enteral pump. The information submitted must identify the medical reasons for not using a gravity feeding set.

(2) Examples of conditions that will not justify approval of enteral nutrition therapy are: weight-loss diets, wired-shut jaws, diabetic diets, milk or food allergies (unless the member is under five years of age and coverage through the Women, Infant and Children's program is not available), and the use of enteral products for convenience reasons when regular food in pureed form would meet the medical need of the member.

(3) Basis of payment for nutritional therapy supplies shall be the least expensive method of delivery that is reasonable and medically necessary based on the documentation submitted.

d. Rescinded IAB 5/11/05, effective 5/1/05.

e. Augmentative communication systems, which are provided to persons unable to communicate their basic needs through oral speech or manual sign language, require prior approval. Form 470-2145, Augmentative Communication System Selection, completed by a speech pathologist and a physician's prescription for a particular device shall be submitted to request prior approval. (Cross-reference 78.10(3)*"c"*(1))

(1) Information requested on the prior authorization form includes a medical history, diagnosis, and prognosis completed by a physician. In addition, a speech or language pathologist needs to describe current functional abilities in the following areas: communication skills, motor status, sensory status, cognitive status, social and emotional status, and language status.

(2) Also needed from the speech or language pathologist is information on educational ability and needs, vocational potential, anticipated duration of need, prognosis regarding oral communication skills, prognosis with a particular device, and recommendations.

(3) The department's consultants with an expertise in speech pathology will evaluate the prior approval requests and make recommendations to the department.

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. Prior authorization is required for enclosed beds. (Cross-reference 78.10(2)*"c"*) The department shall approve payment for an enclosed bed when prescribed for a patient who meets all of the following conditions:

(1) The patient has a diagnosis-related cognitive or communication impairment that results in risk to safety.

(2) The patient's mobility puts the patient at risk for injury.

(3) The patient has suffered injuries when getting out of bed.

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. Prior authorization is required for oral nutritional products. (Cross-reference 78.10(2)*"c"*) The department shall approve payment for oral nutritional products 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.

(1) A request for prior approval shall include a written order or prescription from a physician, physician assistant, or advanced registered nurse practitioner and documentation to establish the medical necessity for oral nutritional products pursuant to these standards. The documentation shall include:

1. A statement of the member's total medical condition that includes a description of the member's metabolic, digestive, or psychological disorder or pathology.

2. Documentation of the medical necessity for commercially prepared products. The information submitted must identify other methods attempted to support the member's nutritional status and indicate that the member's nutritional needs were not or could not be met by regular food in pureed form.

3. Documentation to support the fact that regular foods will not provide sufficient nutritional value to the member, if the request includes oral supplementation of a regular diet.

(2) Examples of conditions that will not justify approval of oral nutritional products are: weight-loss diets, wired-shut jaws, diabetic diets, and milk or food allergies (unless the member is under five years of age and coverage through the Special Supplemental Nutrition Program for Women, Infants, and Children is not available).

j. Prior authorization is required for vest airway clearance systems. (Cross-reference 78.10(2)*"c"*) The department shall approve payment for a vest airway clearance system when prescribed by a pulmonologist for a patient with a medical diagnosis related to a lung disorder if all of the following conditions are met:

(1) Pulmonary function tests for the 12 months before initiation of the vest demonstrate an overall significant decrease of lung function.

(2) The patient 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.

k. Prior authorization is required for blood glucose monitors and diabetic test strips produced by a manufacturer that does not have a current agreement to provide a rebate to the department for monitors or test strips provided through the Medicaid program. The department shall approve payment when a blood glucose monitor or diabetic test strips produced by a manufacturer that does not have a current rebate agreement with the department are medically necessary.

78.28(2) Dental services. Dental services which require prior approval are as follows:

a. The following periodontal services:

(1) Payment for periodontal scaling and root planing will be approved when interproximal and subgingival calculus is evident in X-rays or when justified and documented that curettage, scaling or root planing is required in addition to routine prophylaxis. (Cross-reference 78.4(4)*"b"*)

(2) Payment for pedicle soft tissue graft and free soft tissue graft will be approved when the written narrative describes medical necessity. Payment for other periodontal surgical procedures will be approved after periodontal scaling and root planing has been provided, a reevaluation examination has been completed, and the patient has demonstrated reasonable oral hygiene, unless the patient is unable to demonstrate reasonable oral hygiene because of physical or mental disability or in cases which demonstrate gingival hyperplasia resulting from drug therapy. (Cross-reference 78.4(4)*"c"*)

(3) Payment for pedicle soft tissue graft and free soft tissue graft will be approved when the written narrative describes medical necessity. (Cross-reference 78.4(4)*"d"*)

(4) Payment for periodontal maintenance therapy may be approved after periodontal scaling and root planing or periodontal surgical procedures have been provided. Periodontal maintenance therapy may be approved once per three-month interval for moderate to advanced cases if the condition would deteriorate without treatment. (Cross-reference 78.4(4)*"e"*)

b. Surgical endodontic treatment which includes 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 will be approved when nonsurgical treatment has been attempted and a reasonable time 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 78.4(5)*"c"*)

c. The following prosthetic services:

(1) A removable partial denture replacing posterior teeth will be approved when the member has fewer than eight posterior teeth in occlusion 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. A removable partial denture replacing posterior teeth is payable only once in a five-year period unless the removable partial denture is broken beyond repair, lost or stolen, or no longer fits due to growth or changes in jaw structure, and is required to prevent significant dental problems. Replacement of a removable partial denture replacing posterior teeth due to resorption in less than a five-year period is not payable. (Cross-reference 78.4(7)*"c"*)

(2) A fixed partial denture (including an acid etch fixed partial denture) replacing anterior teeth will be approved for members whose medical condition precludes the use of a removable partial denture. High noble or noble metals will be approved only when the member is allergic to all other restorative materials. A fixed partial denture replacing anterior teeth is payable only once in a five-year period unless the fixed partial denture is broken beyond repair. (Cross-reference 78.4(7)*"d"*)

(3) A fixed partial denture (including an acid etch fixed partial denture) replacing posterior teeth will be approved for members whose medical condition precludes the use of a removable partial denture and who have fewer than eight posterior teeth in occlusion or if 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 fixed partial denture brings eight posterior teeth in occlusion, no additional fixed partial denture will be approved. High noble or noble metals will be approved only when the member is allergic to all other restorative materials. A fixed partial denture replacing posterior teeth is payable only once in a five-year period unless the fixed partial denture is broken beyond repair. (Cross-reference 78.4(7)*"e"*)

(4) Dental implants and related services will be authorized 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.

d. Orthodontic services will be approved when it is determined that a patient has the most handicapping malocclusion. This determination is made in a manner consistent with the "Handicapping Malocclusion Assessment to Establish Treatment Priority," by J. A. Salzmann, D.D.S., American Journal of Orthodontics, October 1968.

(1) A handicapping malocclusion is a condition that constitutes a hazard to the maintenance of oral health and interferes with the well-being of the patient by causing impaired mastication, dysfunction of the temporomandibular articulation, susceptibility to periodontal disease, susceptibility to dental caries, and impaired speech due to malpositions of the teeth. Treatment of handicapping malocclusions will be approved only for the severe and the most handicapping. Assessment of the most handicapping malocclusion is determined by the magnitude of the following variables:

1. Degree of malalignment;
2. Missing teeth;

3. Angle classification;
4. Overjet and overbite;
5. Openbite; and
6. Crossbite.

(2) A request to perform an orthodontic procedure must be accompanied by an interpreted cephalometric radiograph and study models trimmed so that the models simulate centric occlusion of the patient. A written plan of treatment must accompany the diagnostic aids. Posttreatment records must be furnished upon request of the Iowa Medicaid enterprise medical services unit.

(3) Approval may be made for eight units of a three-month active treatment period. Additional units may be approved by the department's orthodontic consultant if the additional units are found to be medically necessary. (Cross-reference 78.4(8)*"a"*)

e. More than two laboratory-fabricated crowns will be approved in a 12-month period for anterior teeth that cannot be restored with a composite or amalgam restoration and for posterior teeth that cannot be restored with a composite or amalgam restoration or stainless steel crown. (Cross-reference 78.4(3)*"d"*)

f. Endodontic retreatment of a tooth will be authorized when the conventional treatment has been completed, a reasonable time has elapsed, and failure has been demonstrated with a radiograph and narrative history.

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.

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) Rescinded IAB 6/4/08, effective 5/15/08.

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]

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, or master social worker 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.

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.* Vaccines available through the Vaccines for Children program under Section 1928 of the Social Security Act are not covered as birth center services. Birth centers that wish to administer those vaccines to Medicaid members shall enroll in the Vaccines for Children program and obtain the vaccines from the department of public health. Birth centers shall receive reimbursement for the administration of vaccines to Medicaid members.

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

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. Hospital outpatient programs 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. Hospital outpatient programs receive payment via the APC reimbursement for the administration of vaccines to Medicaid members.

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 disrhythmia and be able to initiate emergency action if necessary. The nurse shall assess and implement a plan of care for cardiac risk factor modification. The nurse shall have at least one year of experience in a coronary care unit.

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

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

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

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

Postmyocardial infarction (within three months postdischarge).

Postcardiac surgery (within three months postdischarge).

Poststreptokinase.

Postpercutaneous transluminal angioplasty (within three months postdischarge).

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

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

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

Referral form.

Physician's orders.

Laboratory reports.

Electrocardiogram reports.

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

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

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

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

d. Mental health.

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

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

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

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

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

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

The number of the above staff employed by the facility must be appropriate to the facility's patient load. The staff may be employees of the hospital, on contract, or the service may be provided through referral.

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

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

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

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

Any history of physical abuse.

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

A determination of current and past psychiatric and psychological abnormality.

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

The family's history of mental health problems.

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

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

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

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

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

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

Legal problems if applicable.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

e. Pain management.

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

(2) General characteristics. A chronic pain management program shall provide coordinated, goal-oriented, interdisciplinary team services to reduce pain, improve quality of life, and decrease

dependence on the health care system for persons with pain which interferes with physical, psychosocial, and vocational functioning.

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

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

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

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

The person cannot be toxic on any addictive drugs.

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

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

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

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

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

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

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

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

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

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

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

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

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

f. Diabetic education.

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

(2) General characteristics. An outpatient diabetes self-management education program shall provide instruction which will enable people with diabetes and their families to understand the diabetes disease process and the daily management of diabetes. People with diabetes must learn to balance their special diet and exercise requirements with drug therapy (insulin or oral agents). They must learn self-care techniques such as monitoring their own blood glucose. And often, they must learn to self-treat insulin reactions, protect feet that are numb and have seriously compromised circulation, and accommodate their regimen to changes in blood glucose because of stress or infections.

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

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

The person must have Type I or Type II diabetes.

The person must be referred by the attending physician.

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

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

(6) Restrictions and limitations on payment. Medicaid will pay for a diabetic self-management education program. Diabetic education programs will include follow-up assessments at 3 and 12 months without charge. 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.

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

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

441—78.33(249A) Case management services. Payment on a monthly payment per enrollee basis will be approved for the case management functions required in 441—Chapter 90.

78.33(1) Payment will be approved for MR/CMI/DD case management services pursuant to 441—Chapter 90 to:

a. Recipients 18 years of age or over with a primary diagnosis of mental retardation, developmental disabilities, or chronic mental illness as defined in rule 441—90.1(249A).

b. Rescinded IAB 1/8/03, effective 1/1/03.

c. Recipients under 18 years of age receiving HCBS MR waiver or HCBS children's mental health waiver services.

78.33(2) Payment for services pursuant to 441—Chapter 90 to recipients under age 18 who have a primary diagnosis of mental retardation or developmental disabilities as defined in rule 441—90.1(249A) and are residing in a child welfare decategorization county shall be made when the following conditions are met:

a. The child welfare decategorization county has entered into an agreement with the department certifying that the state match for case management is available within funds allocated for the purpose of decategorization.

b. The child welfare decategorization county has executed an agreement to remit the nonfederal share of the cost of case management services to the enhanced mental health, mental retardation and developmental disabilities services fund administered by the department.

c. The child welfare decategorization county has certified that the funds remitted for the nonfederal share of the cost of case management services are not federal funds.

78.33(3) Rescinded IAB 10/12/05, effective 10/1/05.

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

441—78.34(249A) HCBS ill and handicapped waiver services. Payment will be approved for the following services to clients eligible for HCBS ill and handicapped waiver services as established in 441—Chapter 83. Services must be billed in whole units.

78.34(1) *Homemaker services.* Homemaker services are those services provided when the client lives alone or when the person who usually performs these functions for the client needs assistance with performing the functions. A unit of service is one hour. Components of the service are directly related to the care of the client and include:

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 client, and dishes.

c. Rescinded IAB 9/30/92, effective 12/1/92.

d. 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 a half day (1 to 4 hours), a full day (4 to 8 hours), or an extended day (8 to 12 hours). Components of the service are as set forth in rule 441—171.6(234) or the department of elder affairs rule 321—24.7(231).

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 consumer that give temporary relief to the usual caregiver and provide all the necessary care that the usual caregiver would provide during that time period. The purpose of respite care is to enable the consumer to remain in the consumer's current living situation.

a. Services provided outside the consumer'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. Staff-to-consumer ratios shall be appropriate to the individual needs of the consumer as determined by the consumer's interdisciplinary team.

c. A unit of service is one hour.

d. Respite care is not to be provided to persons during the hours in which the usual caregiver is employed except when the consumer is attending a camp. Respite cannot be provided to a consumer whose usual caregiver is a consumer-directed attendant care provider for the consumer.

e. The interdisciplinary team shall determine if the consumer will receive basic individual respite, specialized respite, or group respite as defined in rule 441—83.1(249A).

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.

78.34(6) *Counseling services.* Counseling services are face-to-face mental health services provided to the client and caregiver by a mental health professional as defined in rule 441—24.61(225C,230A) to facilitate home management of the client 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 client's family or other caregiver to provide care, and for the purpose of helping the client and those caring for the client to adjust to the client's disability or terminal condition. Counseling services may be provided to the client's caregiver only when included in the case plan for the client.

Payment will be made for individual and group counseling. A unit of individual counseling for the waiver client or the waiver client and the client's caregiver is 15 minutes. A unit of group counseling is one hour. 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 consumer with self-care tasks which the consumer would typically do independently if the consumer were otherwise able.

a. The service activities may include helping the consumer with any of the following nonskilled service activities:

(1) Dressing.

(2) Bath, shampoo, hygiene, and grooming.

(3) Access to and from bed or a wheelchair, transferring, ambulation, and mobility in general. It is recommended that the provider receive certification of training and return demonstration for transferring. Certification for this is available through the area community colleges.

(4) Toilet assistance, including bowel, bladder, and catheter assistance. It is recommended that the provider receive certification of training and return demonstration for catheter assistance. Certification for this is available through the area community colleges.

(5) Meal preparation, cooking, eating and feeding but not the cost of meals themselves.

(6) Housekeeping services which are essential to the consumer's health care at home.

(7) Medications ordinarily self-administered including those ordered by a physician or other qualified health care provider. It is recommended the provider successfully complete a medication aide course administered by an area community college.

(8) Wound care.

(9) Assistance needed to go to or return from a place of employment and assistance with job-related tasks while the consumer is on the job site. The cost of transportation for the consumer and assistance with understanding or performing the essential job functions are not included in consumer-directed attendant care services.

(10) Cognitive assistance with tasks such as handling money and scheduling.

(11) Fostering communication through interpreting and reading services as well as assistive devices for communication.

(12) Assisting or accompanying a consumer in using transportation essential to the health and welfare of the consumer. The cost of the transportation is not included.

b. The service activities may include helping the consumer with any of the following skilled services under the supervision of a licensed nurse or licensed therapist working under the direction of a physician. The licensed nurse or therapist shall retain accountability for actions that are delegated. The licensed nurse or therapist shall ensure appropriate assessment, planning, implementation, and evaluation. The licensed nurse or therapist shall make on-site supervisory visits every two weeks with the provider present. The cost of the supervision provided by the licensed nurse or therapist shall be paid

from private insurance and other third-party payment sources, Medicare, the regular Medicaid program, or the early periodic screening diagnosis and treatment program before accessing the HCBS waiver.

(1) Tube feedings of consumers 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, reteaching the activities of daily living, respiratory care and breathing programs, reality orientation, reminiscing therapy, remotivation, and behavior modification.

(8) Colostomy care.

(9) Care of medical conditions out of control which includes 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.

c. A unit of service is 1 hour, or one 8- to 24-hour day provided by an individual or an agency. Each service shall be billed in whole units.

d. The consumer, parent, guardian, or attorney in fact under a durable power of attorney for health care shall be responsible for selecting the person or agency who will provide the components of the attendant care services to be provided.

e. The consumer, parent, guardian, or attorney in fact under a durable power of attorney for health care shall determine the components of the attendant care services to be provided with the person who is providing the services to the consumer.

f. The service activities may not include parenting or child care for or on behalf of the consumer.

g. The consumer, parent, guardian, or attorney in fact under a durable power of attorney for health care and the provider shall complete and sign Form 470-3372, HCBS Consumer-Directed Attendant Care Agreement. A copy of the completed agreement shall be attached to the service plan, which is signed by the service worker prior to the initiation of services, and kept in the consumer's and department's records.

h. If the consumer has a guardian or attorney in fact under a durable power of attorney for health care, the care plan shall address how consumer-directed attendant care services will be monitored to ensure the consumer'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.

i. If the consumer has a guardian or attorney in fact under a durable power of attorney for health care, the guardian or attorney in fact shall sign the claim form in place of the consumer, indicating that the service has been provided as presented on the claim.

j. The frequency or intensity of services shall be indicated in the service plan.

k. Consumer-directed attendant care services may not be simultaneously reimbursed with any other HCBS waiver services.

l. Consumer-directed attendant care services may be provided to a recipient of in-home health-related care services, but not at the same time.

m. Services may be provided in the absence of a parent or guardian if the parent or guardian has given advanced direction for the service provision.

78.34(8) *Interim medical monitoring and treatment services.* Interim medical monitoring and treatment services are monitoring and treatment of a medical nature requiring specially trained caregivers beyond what is normally available in a day care setting. The services must be needed to allow the consumer's usual caregivers to be employed or, for a limited period of time, for academic or vocational training of a usual caregiver; due to the hospitalization, treatment for physical or mental illness, or death of a usual caregiver; or during a search for employment by a usual caregiver.

a. Service requirements. Interim medical monitoring and treatment services shall:

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

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

(3) Include medical assessment, medical monitoring, and medical intervention as needed on a regular or emergency basis.

b. Interim medical monitoring and treatment services may include supervision to and from school.

c. Limitations.

(1) A maximum of 12 one-hour units 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.

(4) Interim medical monitoring and treatment services may be provided only in the consumer's home, in a registered group child care home, in a registered family child care home, in a licensed child care center, or during transportation to and from school.

(5) The staff-to-consumer ratio shall not be less than one to six.

d. A unit of service is one hour.

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

a. Modifications that are necessary or desirable without regard to the consumer'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, roof repair, or adding square footage to the residence, are excluded except as specifically included below. 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 consumer'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 department approval of a binding contract between the enrolled home and vehicle modification provider and the consumer.

f. The contract shall include, at a minimum, the work to be performed, cost, time frame for work completion, and assurance of liability and workers' compensation coverage.

g. Service payment shall be made to the enrolled home and vehicle modification provider. If applicable, payment will be forwarded to the subcontracting agency by the enrolled home and vehicle modification provider following completion of the approved modifications. Payment of up to $6,060 per year may be made to certified providers upon satisfactory completion of the service. The service worker shall encumber up to $505 per month within the monthly dollar cap allowed for the consumer until the amount of the modification is reached within the 12-month period.

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

78.34(10) *Personal emergency response system.* A personal emergency response system is an electronic device that transmits a signal to a central monitoring station to summon assistance in the event of an emergency when the consumer is alone.

a. The required components of the system are:
(1) An in-home medical communications transmitter and receiver.
(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 consumer.

b. The service shall be identified in the consumer's service plan.

c. A unit of service is a one-time installation fee or one month of service.

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

78.34(11) *Home-delivered meals.* Home-delivered meals means meals prepared elsewhere and delivered to a waiver recipient at the recipient's residence. Each meal shall ensure the recipient 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. When a restaurant provides the home-delivered meal, the recipient is required to have a nutritional consultation. The nutritional consultation includes contact with the restaurant to explain the dietary needs of the client and what constitutes the minimum one-third daily dietary allowance.

A maximum of 14 meals is allowed per week. 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 ill and handicapped 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.

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

[**ARC 9045B**, IAB 9/8/10, effective 11/1/10]

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 consumers eligible for the HCBS elderly waiver services as established in 441—Chapter 83. The consumer shall have a billable waiver service each calendar quarter. Services must be billed in whole units.

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 a half day (1 to 4 hours), a full day (4 to 8 hours), or an extended day (8 to 12 hours). Components of the service are set forth in rule 441—171.6(234) or as indicated in the Iowa department of elder affairs Annual Service and Fiscal Reporting Manual.

78.37(2) *Emergency response system.* The emergency response system allows a person experiencing a medical emergency at home to activate electronic components that transmit a coded signal via digital equipment over telephone lines to a central monitoring station. The necessary components of a system are:

a. An in-home medical communications transceiver.

b. A remote, portable activator.

c. A central monitoring station with backup systems staffed by trained attendants 24 hours per day, seven days per week.

d. Current data files at the central monitoring station containing preestablished response protocols and personal, medical, and emergency information for each client.

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 client lives alone or when the person who usually performs these functions for the client is incapacitated or occupied providing direct care to the client. A unit of service is one hour. Components of the service include:

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, and washing and mending clothes.

c. Accompaniment to medical or psychiatric services.

d. Meal preparation: planning and preparing balanced meals.

e. Bathing and dressing for self-directing recipients.

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 consumer that give temporary relief to the usual caregiver and provide all the necessary care that the usual caregiver would provide during that time period. The purpose of respite care is to enable the consumer to remain in the consumer's current living situation.

a. Services provided outside the consumer'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. Staff-to-consumer ratios shall be appropriate to the individual needs of the consumer as determined by the consumer's interdisciplinary team.

c. A unit of service is one hour.

d. The interdisciplinary team shall determine if the consumer will receive basic individual respite, specialized respite or group respite as defined in rule 441—83.21(249A).

e. When respite care is provided, the provision of, or payment for, other duplicative services under the waiver is precluded.

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 care is not to be provided to persons during the hours in which the usual caregiver is employed except when the consumer is attending a camp. Respite cannot be provided to a consumer whose usual caregiver is a consumer-directed attendant care provider for the consumer.

78.37(7) *Chore services.* Chore services include the following services: window and door maintenance, such as hanging screen windows and doors, replacing windowpanes, and washing windows; minor repairs to walls, floors, stairs, railings and handles; heavy cleaning which includes cleaning attics or basements to remove fire hazards, moving heavy furniture, extensive wall washing, floor care or painting and trash removal; and yard work such as mowing lawns, raking leaves and shoveling walks. A unit of service is one-half hour.

78.37(8) *Home-delivered meals.* Home-delivered meals means meals prepared elsewhere and delivered to a waiver recipient at the recipient's residence. Each meal shall ensure the recipient 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. When a restaurant provides the home-delivered meal, the recipient is required to have a nutritional consultation. The nutritional consultation includes contact with the restaurant to explain the dietary needs of the client and explain what constitutes the minimum one-third daily dietary allowance.

A maximum of 14 meals is allowed per week. A unit of service is a meal.

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

a. Modifications that are necessary or desirable without regard to the consumer'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, roof repair, or adding square footage to the residence, are excluded except as specifically included below. 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 consumer'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 department approval of a binding contract between the enrolled home and vehicle modification provider and the consumer.

f. The contract shall include, at a minimum, the work to be performed, cost, time frame for work completion, and assurance of liability and workers' compensation coverage.

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

h. Services shall be included in the consumer'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 recipients to conduct business errands, essential shopping, to receive medical services not reimbursed through medical transportation, and to reduce social isolation. A unit of service is per mile, per trip, or rate established by area agency on aging.

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.

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 one hour.

78.37(15) *Consumer-directed attendant care service.* Consumer-directed attendant care services are service activities performed by a person to help a consumer with self-care tasks which the consumer would typically do independently if the consumer were otherwise able.

a. The service activities may include helping the consumer with any of the following nonskilled service activities:

(1) Dressing.

(2) Bath, shampoo, hygiene, and grooming.

(3) Access to and from bed or a wheelchair, transferring, ambulation, and mobility in general. It is recommended that the provider receive certification of training and return demonstration for transferring. Certification for this is available through the area community colleges.

(4) Toilet assistance, including bowel, bladder, and catheter assistance. It is recommended that the provider receive certification of training and return demonstration for catheter assistance. Certification for this is available through the area community colleges.

(5) Meal preparation, cooking, eating and feeding but not the cost of meals themselves.

(6) Housekeeping services which are essential to the consumer's health care at home.

(7) Medications ordinarily self-administered including those ordered by a physician or other qualified health care provider. It is recommended the provider successfully complete a medication aide course administered by an area community college.

(8) Wound care.

(9) Assistance needed to go to or return from a place of employment and assistance with job-related tasks while the consumer is on the job site. The cost of transportation for the consumer and assistance with understanding or performing the essential job functions are not included in consumer-directed attendant care services.

(10) Cognitive assistance with tasks such as handling money and scheduling.

(11) Fostering communication through interpreting and reading services as well as assistive devices for communication.

(12) Assisting or accompanying a consumer in using transportation essential to the health and welfare of the consumer. The cost of the transportation is not included.

b. The service activities may include helping the consumer with any of the following skilled services under the supervision of a licensed nurse or licensed therapist working under the direction of a physician. The licensed nurse or therapist shall retain accountability for actions that are delegated. The licensed nurse or therapist shall ensure appropriate assessment, planning, implementation, and evaluation. The licensed nurse or therapist shall make on-site supervisory visits every two weeks with the provider present. The cost of the supervision provided by the licensed nurse or therapist shall be paid from private insurance and other third-party payment sources, Medicare, the regular Medicaid program, or the early periodic screening diagnosis and treatment program before accessing the HCBS waiver.

(1) Tube feedings of consumers 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, reteaching the activities of daily living, respiratory care and breathing programs, reality orientation, reminiscing therapy, remotivation, and behavior modification.

(8) Colostomy care.

(9) Care of medical conditions out of control which includes 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.

c. A unit of service provided by an individual or an agency, other than an assisted living program, is 1 hour, or one 8- to 24-hour day. When provided by an assisted living program, a unit of service is one calendar month. If services are provided by an assisted living program for less than one full calendar month, the monthly reimbursement rate shall be prorated based on the number of days service is provided. Except for services provided by an assisted living program, each service shall be billed in whole units.

d. The consumer, parent, guardian, or attorney in fact under a durable power of attorney for health care shall be responsible for selecting the person or agency who will provide the components of the attendant care services to be provided.

e. The consumer, parent, guardian, or attorney in fact under a durable power of attorney for health care shall determine the components of the attendant care services to be provided with the person who is providing the services to the consumer.

f. The service activities may not include parenting or child care for or on behalf of the consumer.

g. The consumer, parent, guardian, or attorney in fact under a durable power of attorney for health care and the provider shall complete and sign Form 470-3372, HCBS Consumer-Directed Attendant Care Agreement. A copy of the completed agreement shall be attached to the service plan, which is signed by the service worker prior to the initiation of services, and kept in the consumer's and department's records.

h. If the consumer has a guardian or attorney in fact under a durable power of attorney for health care, the care plan shall address how consumer-directed attendant care services will be monitored to ensure the consumer'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.

i. If the consumer has a guardian or attorney in fact under a durable power of attorney for health care, the guardian or attorney in fact shall sign the claim form in place of the consumer, indicating that the service has been provided as presented on the claim.

j. The frequency or intensity of services shall be indicated in the service plan.

k. Consumer-directed attendant care services may not be simultaneously reimbursed with any other HCBS waiver services.

l. Consumer-directed attendant care services may be provided to a recipient of in-home health-related care services, but not at the same time.

m. Services may be provided in the absence of a parent or guardian if the parent or guardian has given advanced direction for the service provision.

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.

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]

441—78.38(249A) HCBS AIDS/HIV waiver services. Payment will be approved for the following services to clients eligible for the HCBS AIDS/HIV waiver services as established in 441—Chapter 83. Services must be billed in whole units.

78.38(1) *Counseling services.* Counseling services are face-to-face mental health services provided to the client and caregiver by a mental health professional as defined in rule 441—24.61(225C,230A) to facilitate home management of the client 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 client's family or other caregiver to provide care, and for the purpose of helping the client and those caring for the client to adjust to the client's disability or terminal condition. Counseling services may be provided to the client's caregiver only when included in the case plan for the client.

Payment will be made for individual and group counseling. A unit of individual counseling for the waiver client or the waiver client and the client's caregiver is 15 minutes. A unit of group counseling is one hour. 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 client lives alone or when the person who usually performs these functions for the client needs assistance with performing the functions. A unit of service is one hour. Components of the service are directly related to the care of the client and are:

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 client, and dishes.

c. Accompaniment to medical or psychiatric services or for children aged 18 and under to school.

d. 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 consumer that give temporary relief to the usual caregiver and provide all the necessary care that the usual caregiver would provide during that time period. The purpose of respite care is to enable the consumer to remain in the consumer's current living situation.

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

b. Staff-to-consumer ratios shall be appropriate to the individual needs of the consumer as determined by the consumer's interdisciplinary team.

c. A unit of service is one hour.

d. The interdisciplinary team shall determine if the consumer will receive basic individual respite, specialized respite or group respite as defined in rule 441—83.41(249A).

e. When respite care is provided, the provision of, or payment for, other duplicative services under the waiver is precluded.

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 care is not to be provided to persons during the hours in which the usual caregiver is employed except when the consumer is attending a camp. Respite cannot be provided to a consumer whose usual caregiver is a consumer-directed attendant care provider for the consumer.

78.38(6) *Home-delivered meals.* Home-delivered meals means meals prepared elsewhere and delivered to a waiver recipient at the recipient's residence. Each meal shall ensure the recipient 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. A maximum of 14 meals is allowed per week. 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 a half day (1 to 4 hours), a full day (4 to 8 hours), or an extended day (8 to 12 hours). Components of the service are as set forth in rule 441—171.6(234) or the department of elder affairs rule 321—24.7(231).

78.38(8) *Consumer-directed attendant care service.* Consumer-directed attendant care services are service activities performed by a person to help a consumer with self-care tasks which the consumer would typically do independently if the consumer were otherwise able.

a. The service activities may include helping the consumer with any of the following nonskilled service activities:

(1) Dressing.

(2) Bath, shampoo, hygiene, and grooming.

(3) Access to and from bed or a wheelchair, transferring, ambulation, and mobility in general. It is recommended that the provider receive certification of training and return demonstration for transferring. Certification for this is available through the area community colleges.

(4) Toilet assistance, including bowel, bladder, and catheter assistance. It is recommended that the provider receive certification of training and return demonstration for catheter assistance. Certification for this is available through the area community colleges.

(5) Meal preparation, cooking, eating and feeding but not the cost of meals themselves.

(6) Housekeeping services which are essential to the consumer's health care at home.

(7) Medications ordinarily self-administered including those ordered by a physician or other qualified health care provider. It is recommended the provider successfully complete a medication aide course administered by an area community college.

(8) Wound care.

(9) Assistance needed to go to or return from a place of employment and assistance with job-related tasks while the consumer is on the job site. The cost of transportation for the consumer and assistance with understanding or performing the essential job functions are not included in consumer-directed attendant care services.

(10) Cognitive assistance with tasks such as handling money and scheduling.

(11) Fostering communication through interpreting and reading services as well as assistive devices for communication.

(12) Assisting or accompanying a consumer in using transportation essential to the health and welfare of the consumer. The cost of the transportation is not included.

b. The service activities may include helping the consumer with any of the following skilled services under the supervision of a licensed nurse or licensed therapist working under the direction of

a physician. The licensed nurse or therapist shall retain accountability for actions that are delegated. The licensed nurse or therapist shall ensure appropriate assessment, planning, implementation, and evaluation. The licensed nurse or therapist shall make on-site supervisory visits every two weeks with the provider present. The cost of the supervision provided by the licensed nurse or therapist shall be paid from private insurance and other third-party payment sources, Medicare, the regular Medicaid program, or the early periodic screening diagnosis and treatment program before accessing the HCBS waiver.

(1) Tube feedings of consumers 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, reteaching the activities of daily living, respiratory care and breathing programs, reality orientation, reminiscing therapy, remotivation, and behavior modification.

(8) Colostomy care.

(9) Care of medical conditions out of control which includes 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.

c. A unit of service is 1 hour, or one 8- to 24-hour day provided by an individual or an agency. Each service shall be billed in whole units.

d. The consumer, parent, guardian, or attorney in fact under a durable power of attorney for health care shall be responsible for selecting the person or agency who will provide the components of the attendant care services to be provided.

e. The consumer, parent, guardian, or attorney in fact under a durable power of attorney for health care shall determine the components of the attendant care services to be provided with the person who is providing the services to the consumer.

f. The service activities may not include parenting or child care for or on behalf of the consumer.

g. The consumer, parent, guardian, or attorney in fact under a durable power of attorney for health care and the provider shall complete and sign Form 470-3372, HCBS Consumer-Directed Attendant Care Agreement. A copy of the completed agreement shall be attached to the service plan, which is signed by the service worker prior to the initiation of services, and kept in the consumer's and department's records.

h. If the consumer has a guardian or attorney in fact under a durable power of attorney for health care, the care plan shall address how consumer-directed attendant care services will be monitored to ensure the consumer'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.

i. If the consumer has a guardian or attorney in fact under a durable power of attorney for health care, the guardian or attorney in fact shall sign the claim form in place of the consumer, indicating that the service has been provided as presented on the claim.

j. The frequency or intensity of services shall be indicated in the service plan.

k. Consumer-directed attendant care services may not be simultaneously reimbursed with any other HCBS waiver services.

l. Consumer-directed attendant care services may be provided to a recipient of in-home health-related care services, but not at the same time.

m. Services may be provided in the absence of a parent or guardian if the parent or guardian has given advanced direction for the service provision.

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.

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

[**ARC 9045B**, IAB 9/8/10, effective 11/1/10]

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.* Vaccines available through the Vaccines for Children program under Section 1928 of the Social Security Act are not covered services. Federally qualified health centers that wish to administer those vaccines to Medicaid members shall enroll in the Vaccines for Children program and obtain the vaccines from the department of public health. However, vaccine administration is a covered service.

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

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) *Vaccine administration.* Vaccines available through the Vaccines for Children program under Section 1928 of the Social Security Act are not covered services. Advanced registered nurse practitioners who wish to administer those vaccines to Medicaid members shall enroll in the Vaccines for Children program and obtain the vaccines from the department of public health. Advanced registered nurse practitioners shall receive reimbursement for the administration of vaccines to Medicaid members.

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.

441—78.41(249A) HCBS MR waiver services. Payment will be approved for the following services to consumers eligible for the HCBS MR waiver services as established in 441—Chapter 83 and as identified in the consumer's service plan. All services include the applicable and necessary instruction, supervision, assistance and support as required by the consumer in achieving the consumer's life goals. The services, amount and supports provided under the HCBS MR waiver shall be delivered in the least restrictive environment and in conformity with the consumer's service plan.

Reimbursement shall not be available under the waiver for any services that the consumer can obtain through the Medicaid state plan.

All services shall be billed in whole units.

78.41(1) *Supported community living services.* Supported community living services are provided by the provider within the consumer's home and community, according to the individualized consumer need as identified in the service plan pursuant to rule 441—83.67(249A).

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 those activities which assist a consumer to develop or maintain skills for self-care, self-directedness, and care of the immediate environment.

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

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

1. Personal management skills training services are activities which assist a person to maintain or develop skills necessary to sustain oneself in the physical environment and are essential to the management of one'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; ability to use community resources such as public transportation, libraries, etc., and ability to select foods at the grocery store.

2. Socialization skills training services are those activities which assist a consumer 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 person 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" means activities and expenditures provided to or on behalf of a person in the areas of personal needs in order to allow the person to function in the least restrictive environment.

(5) "Transportation services" means activities and expenditures designed to assist the person to travel from one place to another to obtain services or carry out life's activities. The service excludes transportation to and from work.

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

1. Physiological treatment means activities including medication regimens designed to prevent, halt, control, relieve, or reverse symptoms or conditions which interfere with the normal functioning of the human body. The activities shall be provided by or under the supervision of a health care professional certified or licensed to provide the treatment activity specified.

2. Psychotherapeutic treatment means activities provided 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.

b. The supported community living services are intended to provide for the daily living needs of the consumer 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 consumers 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 time periods when another resource is not available.

(2) Supported community living services shall be available at an hourly rate to consumers for whom a daily rate is not established.

c. Services may be provided to a child or an adult. A maximum of three consumers receiving community-supported alternative living arrangements or HCBS MR services may reside in a living unit except providers meeting requirements set forth in 441—paragraph 77.37(14)*"e."*

(1) Consumers may live within the home of their family or legal representative or within other types of typical community living arrangements.

(2) Consumers of services living with families or legal representatives are not subject to the maximum of three consumers in a living unit.

(3) Consumers may not live in licensed medical or health care facilities or in settings required to be licensed as medical or health care facilities.

(4) Consumers aged 17 or under living within the home of their family, legal representative, or foster families 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.

d. Rescinded IAB 2/5/03, effective 2/1/03.

e. Transportation to and from a day program is not a reimbursable service. Maintenance and room and board costs are not reimbursable.

f. Provider budgets shall reflect all staff-to-consumer ratios and shall reflect costs associated with consumers' specific support needs for travel and transportation, consulting, instruction, and environmental modifications and repairs, as determined necessary by the interdisciplinary team for each consumer. The specific support needs must be identified in the Medicaid case manager's service plan, the total costs shall not exceed $1570 per consumer per year, and the provider must maintain records to support the expenditures. A unit of service is:

(1) One full calendar day when a consumer residing in the living unit receives on-site staff supervision for 14 or more hours per day as an average over a 7-day week and the consumer's individual comprehensive plan or case plan identifies and reflects the need for this amount of supervision.

(2) One hour when subparagraph (1) does not apply.

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

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

(2) 5,110 hourly units are available per state fiscal year except a leap year when 5,124 hourly units are available.

h. The service shall be identified in the consumer's individual comprehensive plan.

i. Services shall not be simultaneously reimbursed with other residential services, HCBS MR respite, Medicaid or HCBS MR nursing, or Medicaid or HCBS MR home health aide services.

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

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

b. Staff-to-consumer ratios shall be appropriate to the individual needs of the consumer as determined by the consumer's interdisciplinary team.

c. A unit of service is one hour.

d. Payment for respite services shall not exceed $7,050 per the consumer's waiver year.

e. The service shall be identified in the consumer's individual comprehensive plan.

f. Respite services shall not be simultaneously reimbursed with other residential or respite services, HCBS MR waiver supported community living services, Medicaid or HCBS MR nursing, or Medicaid or HCBS MR home health aide services.

g. Respite care is not to be provided to persons during the hours in which the usual caregiver is employed except when the consumer is attending a camp. Respite cannot be provided to a consumer whose usual caregiver is a consumer-directed attendant care provider for the consumer.

h. The interdisciplinary team shall determine if the consumer will receive basic individual respite, specialized respite or group respite as defined in rule 441—83.60(249A).

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

j. 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.

78.41(3) *Personal emergency response system.* The personal emergency response system is an electronic component that transmits a coded signal via digital equipment to a central monitoring station. The electronic device allows a person to access assistance in the event of an emergency when alone.

a. 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 24 hours per day, seven days per week.

(4) Current data files at the central monitoring station containing response protocols and personal, medical and emergency information for each consumer.

b. The service shall be identified in the consumer's individual comprehensive plan.

c. A unit is a one-time installation fee or one month of service.

d. Maximum units per state fiscal year are the initial installation and 12 months of service.

78.41(4) *Home and vehicle modifications*. Covered home and vehicle modifications are those physical modifications to the consumer's home or vehicle listed below that directly address the consumer's medical or remedial need. Covered modifications must be necessary to provide for the health, welfare, or safety of the consumer and enable the consumer to function with greater independence in the home or vehicle.

a. Modifications that are necessary or desirable without regard to the consumer'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, roof repair, or adding square footage to the residence, are excluded except as specifically included below. 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 consumer'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 department approval of a binding contract between the enrolled home and vehicle modification provider and the consumer.

f. The contract shall include, at a minimum, the work to be performed, cost, time frame for work completion, and assurance of liability and workers' compensation coverage.

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

h. Services shall be included in the consumer'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 consumer 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 MR 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 consumer's individual comprehensive 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 consumer 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 consumer 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 consumer's interdisciplinary team must determine that the identified services are necessary. Third, the consumer'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 consumer holds for 30 consecutive calendar days or more. Payment is available once the service is authorized in the member's service plan. A consumer may receive two units of job development services during a 12-month period. The activities provided to the consumer 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 consumer.

(2) Employer development services. The focus of employer development services is to support employers in hiring and retaining consumers 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 consumers who are reasonably expected to work for no more than 10 hours per week. A unit of service is one job placement that the consumer holds for 30 consecutive calendar days or more. Payment for this service may be made only after the consumer holds the job for 30 days. A consumer may receive two units of employer development services during a 12-month period if the consumer 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 consumers 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 consumer'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 consumer 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 consumer's employment goals. A unit of service is an hour. A maximum of 26 units may be provided in a 12-month period. The services provided may include:

1. Job opening identification with the consumer.

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 consumer 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 consumer 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 consumers in a team of no more than eight individuals with disabilities in a teamwork or "enclave" setting.

(3) A unit of service is one hour.

(4) A maximum of 40 units may be received per week.

c. The following requirements apply to all supported employment services:

(1) Employment-related adaptations required to assist the consumer within the performance of the consumer'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 consumers seek, obtain, or maintain employment must be persons without disabilities. In the performance of job duties at any site where consumers seek, obtain, or maintain employment, the consumer 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 consumer.

(6) All services shall be identified in the consumer'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 consumers 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 consumer 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 consumer with self-care tasks which the consumer would typically do independently if the consumer were otherwise able.

a. The service activities may include helping the consumer with any of the following nonskilled service activities:

(1) Dressing.

(2) Bath, shampoo, hygiene, and grooming.

(3) Access to and from bed or a wheelchair, transferring, ambulation, and mobility in general. It is recommended that the provider receive certification of training and return demonstration for transferring. Certification for this is available through the area community colleges.

(4) Toilet assistance, including bowel, bladder, and catheter assistance. It is recommended that the provider receive certification of training and return demonstration for catheter assistance. Certification for this is available through the area community colleges.

(5) Meal preparation, cooking, eating and feeding but not the cost of meals themselves.

(6) Housekeeping services which are essential to the consumer's health care at home.

(7) Medications ordinarily self-administered including those ordered by a physician or other qualified health care provider. It is recommended the provider successfully complete a medication aide course administered by an area community college.

(8) Wound care.

(9) Assistance needed to go to or return from a place of employment and assistance with job-related tasks while the consumer is on the job site. The cost of transportation for the consumer and assistance with understanding or performing the essential job functions are not included in consumer-directed attendant care services.

(10) Cognitive assistance with tasks such as handling money and scheduling.

(11) Fostering communication through interpreting and reading services as well as assistive devices for communication.

(12) Assisting or accompanying a consumer in using transportation essential to the health and welfare of the consumer. The cost of the transportation is not included.

b. The service activities may include helping the consumer with any of the following skilled services under the supervision of a licensed nurse or licensed therapist working under the direction of a physician. The licensed nurse or therapist shall retain accountability for actions that are delegated. The licensed nurse or therapist shall ensure appropriate assessment, planning, implementation, and evaluation. The licensed nurse or therapist shall make on-site supervisory visits every two weeks with the provider present. The cost of the supervision provided by the licensed nurse or therapist shall be paid

from private insurance and other third-party payment sources, Medicare, the regular Medicaid program, or the early periodic screening diagnosis and treatment program before accessing the HCBS waiver.

(1) Tube feedings of consumers 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, reteaching the activities of daily living, respiratory care and breathing programs, reality orientation, reminiscing therapy, remotivation, and behavior modification.

(8) Colostomy care.

(9) Care of medical conditions out of control which includes 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.

c. A unit of service is 1 hour, or one 8- to 24-hour day provided by an individual or an agency. Each service shall be billed in whole units.

d. The consumer, parent, guardian, or attorney in fact under a durable power of attorney for health care shall be responsible for selecting the person or agency who will provide the components of the attendant care services to be provided.

e. The consumer, parent, guardian, or attorney in fact under a durable power of attorney for health care shall determine the components of the attendant care services to be provided with the person who is providing the services to the consumer.

f. The service activities may not include parenting or child care for or on behalf of the consumer.

g. The consumer, parent, guardian, or attorney in fact under a durable power of attorney for health care and the provider shall complete and sign Form 470-3372, HCBS Consumer-Directed Attendant Care Agreement. A copy of the completed agreement shall be attached to the service plan, which is signed by the service worker or case manager prior to the initiation of services, and kept in the consumer's and department's records.

h. If the consumer has a guardian or attorney in fact under a durable power of attorney for health care, the care plan shall address how consumer-directed attendant care services will be monitored to ensure the consumer'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.

i. If the consumer has a guardian or attorney in fact under a durable power of attorney for health care, the guardian or attorney in fact shall sign the claim form in place of the consumer, indicating that the service has been provided as presented on the claim.

j. The frequency or intensity of services shall be indicated in the service plan.

k. Consumer-directed attendant care services may not be simultaneously reimbursed with any other HCBS waiver services.

l. Consumer-directed attendant care services may be provided to a recipient of in-home health-related care services, but not at the same time.

m. Services may be provided in the absence of a parent or guardian if the parent or guardian has given advanced direction for the service provision.

78.41(9) *Interim medical monitoring and treatment services.* Interim medical monitoring and treatment services are monitoring and treatment of a medical nature requiring specially trained caregivers beyond what is normally available in a day care setting. The services must be needed to allow the consumer's usual caregivers to be employed or, for a limited period of time, for academic or vocational training of a usual caregiver; due to the hospitalization, treatment for physical or mental illness, or death of a usual caregiver; or during a search for employment by a usual caregiver.

a. Service requirements. Interim medical monitoring and treatment services shall:

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

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

(3) Include medical assessment, medical monitoring, and medical intervention as needed on a regular or emergency basis.

b. Interim medical monitoring and treatment services may include supervision to and from school.

c. Limitations.

(1) A maximum of 12 one-hour units 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.

(4) Interim medical monitoring and treatment services may be provided only in the consumer's home, in a registered group child care home, in a registered family child care home, in a licensed child care center, or during transportation to and from school.

(5) The staff-to-consumer ratio shall not be less than one to six.

d. A unit of service is one hour.

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 consumers to conduct business errands and essential shopping, to receive medical services when not reimbursed through medical transportation, to travel to and from work or day programs, and to reduce social isolation. A unit of service is either per mile, per trip, or the unit established by an area agency on aging. Transportation may not be reimbursed simultaneously with HCBS MR waiver supported community living service.

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. A unit of service is a full day (4 to 8 hours) or a half-day (1 to 4 hours) or an extended day (8 to 12 hours).

78.41(13) *Prevocational services.* Prevocational services are services that are aimed at preparing a consumer eligible for the HCBS MR waiver for paid or unpaid employment, but are not job-task oriented. These services include teaching the consumer concepts necessary as job readiness skills, 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 consumer through a state or local education agency.

(2) Vocational rehabilitation services that are otherwise available to the consumer through a program funded under Section 110 of the Rehabilitation Act of 1973 (29 U.S.C. 730).

78.41(14) *Day habilitation services.*

a. Scope. Day habilitation services are services that assist or support the consumer in developing or maintaining life skills and community integration. Services must enable or enhance the consumer'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 consumer's home. The unit of service is an hour. The units of services payable are limited to a maximum of 10 hours per month.

c. Unit of service. Except as provided in paragraph *"b,"* the unit of service may be an hour, a half-day (1 to 4 hours), or a full day (4 to 8 hours).

d. Exclusions.

(1) Services shall not be provided in the consumer's home, except as provided in paragraph *"b."* For this purpose, services provided in a residential care facility where the consumer lives are not considered to be provided in the consumer'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.

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

[**ARC 9045B**, IAB 9/8/10, effective 11/1/10]

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 program administered by the department of public health if the pharmacy is enrolled in the vaccines for children program. No payment will be made for the vaccine.

[**ARC 9132B**, IAB 10/6/10, effective 11/1/10]

441—78.43(249A) HCBS brain injury waiver services. Payment shall be approved for the following services to consumers eligible for the HCBS brain injury services as established in 441—Chapter 83 and as identified in the consumer's service plan. All services shall include the applicable and necessary instructions, supervision, assistance and support as required by the consumer in achieving the goals

written specifically in the service plan. The services, amount and supports provided under the HCBS brain injury waiver shall be delivered in the least restrictive environment and in conformity with the consumer's service plan.

Reimbursement shall not be available under the waiver for any services that the consumer can obtain through regular Medicaid.

All services shall be billed in whole units.

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 at the ICF/MR level of care whose county has voluntarily chosen to participate in the HCBS brain injury waiver are eligible for targeted case management and, therefore, 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 consumer's home and community, according to the individualized consumer need as identified in the individual comprehensive plan (ICP) or department case plan. Intermittent service shall be provided as defined in rule 441—83.81(249A).

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 those activities which assist a consumer 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 individual's rights and interests in order to realize the rights to which the individual is entitled and to remove barriers to meeting the individual's needs.

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

1. Personal management skills training services are activities which assist a person to maintain or develop skills necessary to sustain oneself in the physical environment and are essential to the management of one'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 those activities which assist a consumer 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 person 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 person in the areas of personal needs in order to allow the person to function in the least restrictive environment.

(5) Transportation services are those activities and expenditures designed to assist the consumer 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 those activities designed to assist the person to maintain or improve physiological, emotional and behavioral functioning and to prevent conditions that would present barriers to a person's functioning. Treatment services include physical or physiological treatment and psychotherapeutic treatment.

Physiological treatment means activities including medication regimens designed to prevent, halt, control, relieve, or reverse symptoms or conditions which interfere with the normal functioning of the human body. The activities shall be provided by or under the supervision of a health care professional certified or licensed to provide the treatment activity specified.

Psychotherapeutic treatment means activities provided 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.

b. The supported community living services are intended to provide for the daily living needs of the consumer 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 consumers 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 time periods when another resource is not available.

(2) Supported community living services shall be available at an hourly rate to consumers for whom a daily rate is not established.

(3) Intermittent service shall be provided as defined in rule 441—83.81(249A).

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 three consumers may reside in a living unit, except when the provider meets the requirements set forth in 441—paragraph 77.39(13)*"e."*

(1) Consumers may live in the home of their family or legal representative or in other types of typical community living arrangements.

(2) Consumers of services living with families or legal representatives are not subject to the maximum of three consumers in a living unit.

(3) Consumers may not live in licensed medical or health care facilities or in settings required to be licensed as medical or health care facilities.

(4) Consumers aged 17 or under living in the home of their family, legal representative, or foster families 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.

d. Rescinded IAB 2/5/03, effective 2/1/03.

e. Provider budgets shall reflect all staff-to-consumer ratios and shall reflect costs associated with consumers' specific support needs for travel and transportation, consulting, instruction, and environmental modifications and repairs, as determined necessary by the interdisciplinary team for each consumer. The specific support needs must be identified in the Medicaid case manager's service plan, the total costs shall not exceed $1570 per consumer per year, and the provider must maintain records to support the expenditures. A unit of service is:

(1) One full calendar day when a consumer residing in the living unit receives on-site staff supervision for 19 or more hours during a 24-hour calendar day and the consumer's individual comprehensive plan identifies and reflects the need for this amount of supervision.

(2) One hour when subparagraph (1) does not apply.

f. The maximum numbers of units available per consumer are as follows:

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

(2) 8,395 hourly units are available per state fiscal year except a leap year, when 8,418 hourly units are available.

g. The service shall be identified in the consumer's individual comprehensive plan.

h. Services shall not be simultaneously reimbursed with other residential services, HCBS brain injury waiver respite, transportation or personal assistance services, Medicaid nursing, or Medicaid home health aide services.

78.43(3) *Respite services.* Respite care services are services provided to the consumer that give temporary relief to the usual caregiver and provide all the necessary care that the usual caregiver would provide during that time period. The purpose of respite care is to enable the consumer to remain in the consumer's current living situation.

a. Services provided outside the consumer'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. Staff-to-consumer ratios shall be appropriate to the individual needs of the consumer as determined by the consumer's interdisciplinary team.

c. A unit of service is one hour.

d. Respite care is not to be provided to persons during the hours in which the usual caregiver is employed except when the consumer is attending a camp. Respite cannot be provided to a consumer whose usual caregiver is a consumer-directed attendant care provider for the consumer.

e. Respite services shall not be simultaneously reimbursed with other residential or respite services, HCBS brain injury waiver supported community living services, Medicaid nursing, or Medicaid home health aide services.

f. The interdisciplinary team shall determine if the consumer will receive basic individual respite, specialized respite or group respite as defined in rule 441—83.81(249A).

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

h. 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.

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 consumer 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 consumer 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 consumer's employment needs. Second, the consumer's interdisciplinary team must determine that the identified services are necessary. Third, the consumer'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 consumer holds for 30 consecutive calendar days or more. Payment is available once the service is authorized in the member's service plan. A consumer may receive two units of job development services during a 12-month period. The activities provided to the consumer 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 consumer.

(2) Employer development services. The focus of employer development services is to support employers in hiring and retaining consumers 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 consumers who are reasonably expected to work for no more than 10 hours per week. A unit of service is one job placement that the consumer holds for 30 consecutive calendar days or more. Payment for this service may be made only after the consumer holds the job for 30 days. A consumer may receive two units of employer development services during a 12-month period if the consumer 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 consumers 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 consumer'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 consumer for a minimum of 30 days or with assisting the consumer 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 consumer's employment goals. A unit of service is an hour. A maximum of 26 units may be provided in a 12-month period. The services provided may include:

1. Job opening identification with the consumer.
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 consumer 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 consumer 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 consumers in a team of no more than eight individuals with disabilities in a teamwork or "enclave" setting.

(3) A unit of service is one hour.

(4) A maximum of 40 units may be received per week.

c. The following requirements apply to all supported employment services:

(1) Employment-related adaptations required to assist the consumer within the performance of the consumer'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 consumers seek, obtain, or maintain employment must be persons without disabilities. In the performance of job duties at any site where consumers seek, obtain, or maintain employment, the consumer 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 consumer.

(6) All services shall be identified in the consumer'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 consumers 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 consumer 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 modifications*. Covered home and vehicle modifications are those physical modifications to the consumer's home or vehicle listed below that directly address the consumer's medical or remedial need. Covered modifications must be necessary to provide for the health, welfare, or safety of the consumer and enable the consumer to function with greater independence in the home or vehicle.

a. Modifications that are necessary or desirable without regard to the consumer'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, roof repair, or adding square footage to the residence, are excluded except as specifically included below. 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 consumer'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 department approval of a binding contract between the enrolled home and vehicle modification provider and the consumer.

f. The contract shall include, at a minimum, the work to be performed, cost, time frame for work completion, and assurance of liability and workers' compensation coverage.

g. Service payment shall be made to the enrolled home and vehicle modification provider. If applicable, payment will be forwarded to the subcontracting agency by the enrolled home and vehicle modification provider following completion of the approved modifications. Payment of up to $6,060 per year may be made to certified providers upon satisfactory completion of the service. The service worker shall encumber up to $505 per month within the monthly dollar cap allowed for the consumer until the amount of the modification is reached within the 12-month period.

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

78.43(6) *Personal emergency response system.* The personal emergency response system allows a consumer experiencing a medical emergency at home to activate electronic components that transmit a coded signal via digital equipment over telephone lines to a central monitoring station. The necessary components of a system are:

a. An in-home medical communications transceiver.

b. A remote, portable activator.

c. A central monitoring station with backup systems staffed by trained attendants 24 hours per day, seven days per week.

d. Current data files at the central monitoring station containing response protocols and personal, medical and emergency information for each consumer.

e. The service shall be identified in the consumer's individual and comprehensive plan.

f. A unit is a one-time installation fee or one month of service.

g. Maximum units per state fiscal year are the initial installation and 12 months of service.

78.43(7) *Transportation.* Transportation services may be provided for consumers to conduct business errands and essential shopping, to receive medical services when not reimbursed through medical transportation, to travel to and from work or day programs, and to reduce social isolation. A unit of service is either per mile, per trip, or the unit established by an area agency on aging. Transportation may not be reimbursed simultaneously with HCBS brain injury waiver supported community living service.

78.43(8) *Specialized medical equipment.* Specialized medical equipment shall include medically necessary items for personal use by consumers with a brain injury which provide for health and safety of the consumer which are not ordinarily covered by Medicaid, and are not funded by educational or vocational rehabilitation programs, and are not provided by voluntary means. This includes, but is

not limited to: electronic aids and organizers, medicine dispensing devices, communication devices, bath aids, and noncovered environmental control units. This includes repair and maintenance of items purchased through the waiver in addition to the initial purchase cost.

a. Consumers may receive specialized medical equipment once per month until a maximum yearly usage of $6,060 has been reached.

b. The need for specialized medical equipment shall be documented by a health care professional as necessary for the consumer's health and safety and identified in the consumer's individual comprehensive plan.

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 a full day (4 to 8 hours) or a half day (1 to 4 hours) or an extended day (8 to 12 hours). Components of the service are set forth in rule 441—171.6(234).

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 aimed at preparing a consumer eligible for the HCBS brain injury waiver for paid or unpaid employment, but which are not job task oriented. These services include teaching the consumer concepts necessary as job readiness skills, such as following directions, attending to tasks, task completion, problem solving, and safety and mobility training. 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 more generalized habilitative goals and are reflected in a habilitative plan which focuses on general habilitative rather than specific employment objectives.

Prevocational services do not include 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 individual through a state or local education agency or vocational rehabilitation services which are otherwise available to the individual through a program funded under Section 110 of the Rehabilitation Act of 1973 (29 U.S.C. 730).

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 consumer with self-care tasks which the consumer would typically do independently if the consumer were otherwise able.

a. The service activities may include helping the consumer with any of the following nonskilled service activities:

(1) Dressing.

(2) Bath, shampoo, hygiene, and grooming.

(3) Access to and from bed or a wheelchair, transferring, ambulation, and mobility in general. It is recommended that the provider receive certification of training and return demonstration for transferring. Certification for this is available through the area community colleges.

(4) Toilet assistance, including bowel, bladder, and catheter assistance. It is recommended that the provider receive certification of training and return demonstration for catheter assistance. Certification for this is available through the area community colleges.

(5) Meal preparation, cooking, eating and feeding but not the cost of meals themselves.

(6) Housekeeping services which are essential to the consumer's health care at home.

(7) Medications ordinarily self-administered including those ordered by a physician or other qualified health care provider. It is recommended the provider successfully complete a medication aide course administered by an area community college.

(8) Wound care.

(9) Assistance needed to go to or return from a place of employment and assistance with job-related tasks while the consumer is on the job site. The cost of transportation for the consumer and assistance with understanding of performing the essential job functions are not included in consumer-directed attendant care services.

(10) Cognitive assistance with tasks such as handling money and scheduling.

(11) Fostering communication through interpreting and reading services as well as assistive devices for communication.

(12) Assisting or accompanying a consumer in using transportation essential to the health and welfare of the consumer. The cost of the transportation is not included.

b. The service activities may include helping the consumer with any of the following skilled services under the supervision of a licensed nurse or licensed therapist working under the direction of a physician. The licensed nurse or therapist shall retain accountability for actions that are delegated. The licensed nurse or therapist shall ensure appropriate assessment, planning, implementation, and evaluation. The licensed nurse or therapist shall make on-site supervisory visits every two weeks with the provider present. The cost of the supervision provided by the licensed nurse or therapist shall be paid from private insurance and other third-party payment sources, Medicare, the regular Medicaid program, or the early periodic screening diagnosis and treatment program before accessing the HCBS waiver.

(1) Tube feedings of consumers 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, reteaching the activities of daily living, respiratory care and breathing programs, reality orientation, reminiscing therapy, remotivation, and behavior modification.

(8) Colostomy.

(9) Care of medical conditions out of control which includes 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.

c. A unit of service is 1 hour, or one 8- to 24-hour day provided by an individual or an agency. Each service shall be billed in whole units.

d. The consumer, parent, guardian, or attorney in fact under a durable power of attorney for health care shall be responsible for selecting the person or agency who will provide the components of the attendant care services to be provided.

e. The consumer, parent, guardian, or attorney in fact under a durable power of attorney for health care shall determine the components of the attendant care services to be provided with the person who is providing the services to the consumer.

f. The service activities may not include parenting or child care for or on behalf of the consumer.

g. The consumer, parent, guardian, or attorney in fact under a durable power of attorney for health care and the provider shall complete and sign Form 470-3372, HCBS Consumer-Directed Attendant Care Agreement. A copy of the completed agreement shall be attached to the service plan, which is signed by the service worker or case manager prior to the initiation of services, and kept in the consumer's and department's records.

h. If the consumer has a guardian or attorney in fact under a durable power of attorney for health care, the care plan shall address how consumer-directed attendant care services will be monitored to ensure the consumer'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.

i. If the consumer has a guardian or attorney in fact under a durable power of attorney for health care, the guardian or attorney in fact shall sign the claim form in place of the consumer, indicating that the service has been provided as presented on the claim.

j. The frequency or intensity of services shall be indicated in the service plan.

k. Consumer-directed attendant care services may not be simultaneously reimbursed with any other HCBS waiver services.

l. Consumer-directed attendant care services may be provided to a recipient of in-home health-related care services, but not at the same time.

m. Services may be provided in the absence of a parent or guardian if the parent or guardian has given advanced direction for the service provision.

78.43(14) *Interim medical monitoring and treatment services.* Interim medical monitoring and treatment services are monitoring and treatment of a medical nature requiring specially trained caregivers beyond what is normally available in a day care setting. The services must be needed to allow the consumer's usual caregivers to be employed or, for a limited period of time, for academic or vocational training of a usual caregiver; due to the hospitalization, treatment for physical or mental illness, or death of a usual caregiver; or during a search for employment by a usual caregiver.

a. Service requirements. Interim medical monitoring and treatment services shall:

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

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

(3) Include medical assessment, medical monitoring, and medical intervention as needed on a regular or emergency basis.

b. Interim medical monitoring and treatment services may include supervision to and from school.

c. Limitations.

(1) A maximum of 12 one-hour units 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.

(4) Interim medical monitoring and treatment services may be provided only in the consumer's home, in a registered group child care home, in a registered family child care home, in a licensed child care center, or during transportation to and from school.

(5) The staff-to-consumer ratio shall not be less than one to six.

d. A unit of service is one hour.

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.

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.

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]

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) Teleconsultive services. Rescinded IAB 9/6/00, effective 11/1/00.

441—78.46(249A) Physical disability waiver service. Payment shall be approved for the following services to consumers eligible for the HCBS physical disability waiver established in 441—Chapter 83 when identified in the consumer's service plan. All services shall include the applicable and necessary instructions, supervision, assistance and support as required by the consumer in achieving the goals written specifically in the service plan and those delineated in Form 470-3372, HCBS Consumer-Directed Attendant Care Agreement. The service shall be delivered in the least restrictive environment consistent with the consumer's needs and in conformity with the consumer's service plan.

Reimbursement shall not be available under the waiver for any services that the consumer can obtain through regular Medicaid or from any other funding source.

All services shall be billed in whole units as specified in the following subrules.

78.46(1) *Consumer-directed attendant care service.* Consumer-directed attendant care services are service activities listed below performed by a person to help a consumer with self-care tasks which the consumer would typically do independently if the consumer were otherwise able. The services must be cost-effective and necessary to prevent institutionalization.

Providers must demonstrate proficiency in delivery of the services in the consumer's plan of care. Proficiency must be demonstrated through documentation of prior training or experience or a certificate of formal training. All training or experience will be detailed on Form 470-3372, HCBS Consumer-Directed Attendant Care Agreement, which must be reviewed and approved by the service worker for appropriateness of training or experience prior to the provision of services. Form 470-3372 becomes an attachment to and part of the case plan. Consumers shall give direction and training for activities which are not medical in nature to maintain independence. Licensed registered nurses and therapists must provide on-the-job training and supervision to the provider for skilled activities listed below and described on Form 470-3372. The training and experience must be sufficient to protect the health, welfare and safety of the consumer.

a. Nonskilled service activities covered are:

(1) Help with dressing.

(2) Help with bath, shampoo, hygiene, and grooming.

(3) Help with access to and from bed or a wheelchair, transferring, ambulation, and mobility in general. Certification for this is available through the area community colleges.

(4) Toilet assistance, including bowel, bladder, and catheter assistance which includes emptying the catheter bag, collecting a specimen and cleaning the external area around the catheter. Certification of training which includes demonstration of competence for catheter assistance is available through the area community colleges.

(5) Meal preparation, cooking, eating and feeding assistance but not the cost of meals themselves.

(6) Housekeeping services which are essential to the consumer's health care at home.

(7) Help with medications ordinarily self-administered including those ordered by a physician or other qualified health care provider. Certification of training in a medication aide course is available through the area community colleges.

(8) Minor wound care which does not require skilled nursing care.

(9) Assistance needed to go to or return from a place of employment and assistance with job-related tasks while the consumer is on the job site. The cost of transportation for the consumer and assistance with understanding or performing the essential job functions are not included in consumer-directed attendant care services.

(10) Cognitive assistance with tasks such as handling money and scheduling.

(11) Fostering communication through interpreting and reading services as well as assistance in use of assistive devices for communication.

(12) Assisting and accompanying a consumer in using transportation essential to the health and welfare of the consumer, but not the cost of the transportation.

b. Skilled service activities covered are the following performed under the supervision of a licensed nurse or licensed therapist working under the direction of a licensed physician. The licensed

nurse or therapist shall retain accountability for actions that are delegated. The licensed nurse or therapist shall ensure appropriate assessment, planning, implementation, and evaluation. The licensed nurse or therapist shall make on-site supervisory visits every two weeks with the provider present. The cost of the supervision provided by the licensed nurse or therapist shall not be included in the reimbursement for consumer-directed attendant care services.

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

(2) Assistance with intravenous therapy which is 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 bowel and bladder training, range of motion exercises, ambulation training, restorative nursing services, reteaching the activities of daily living, respiratory care and breathing programs, reality orientation, reminiscing therapy, remotivation, and behavior modification.

(8) Colostomy care.

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

(10) Postsurgical nurse-delegated activities under the supervision of the registered nurse.

(11) Monitoring medication reactions 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.

c. A unit of service is 1 hour for up to 7 hours per day or one 8- to 24-hour day provided by an individual or an agency. Each service shall be billed in whole units.

d. The consumer, parent, guardian, or attorney in fact under a durable power of attorney for health care shall be responsible for selecting the person or agency who will provide the components of the attendant care services to be provided.

e. The consumer, parent, guardian, or attorney in fact under a durable power of attorney for health care shall determine the components of the attendant care services to be provided with the person who is providing the services to the consumer.

f. The service activities may not include parenting or child care on behalf of the consumer.

g. The consumer, parent, guardian, or attorney in fact under a durable power of attorney for health care and the provider shall complete and sign Form 470-3372, HCBS Consumer-Directed Attendant Care Agreement. A copy of the completed agreement shall be attached to the service plan, which is signed by the service worker prior to the initiation of services, and kept in the consumer's and department's records.

h. If the consumer has a guardian or attorney in fact under a durable power of attorney for health care, the care plan shall address how consumer-directed attendant care services will be monitored to ensure the consumer'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.

i. If the consumer has a guardian or attorney in fact under a durable power of attorney for health care, the guardian or attorney in fact shall sign the claim form in place of the consumer, indicating that the service has been provided as presented on the claim.

j. The frequency or intensity of services shall be indicated in the service plan.

k. Consumer-directed attendant care services may not be simultaneously reimbursed with any other HCBS waiver services.

l. Consumer-directed attendant care services may be provided to a recipient of in-home health-related care services, but not at the same time.

m. Services may be provided in the absence of a parent or guardian if the parent or guardian has given advanced direction for the service provision.

78.46(2) *Home and vehicle modifications.* Covered home and vehicle modifications are those physical modifications to the consumer's home or vehicle listed below that directly address the consumer's medical or remedial need. Covered modifications must be necessary to provide for the health, welfare, or safety of the consumer and enable the consumer to function with greater independence in the home or vehicle.

a. Modifications that are necessary or desirable without regard to the consumer'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, roof repair, or adding square footage to the residence, are excluded except as specifically included below. 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 consumer'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 department approval of a binding contract between the enrolled home and vehicle modification provider and the consumer.

f. The contract shall include, at a minimum, the work to be performed, cost, time frame for work completion, and assurance of liability and workers' compensation coverage.

g. Service payment shall be made to the enrolled home and vehicle modification provider. If applicable, payment will be forwarded to the subcontracting agency by the enrolled home and vehicle modification provider following completion of the approved modifications. Payment of up to $6,060 per year may be made to certified providers upon satisfactory completion of the service. The service worker shall encumber up to $505 per month within the monthly dollar cap allowed for the consumer until the amount of the modification is reached within the 12-month period.

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

78.46(3) *Personal emergency response system.* The personal emergency response system allows a consumer experiencing a medical emergency at home to activate electronic components that transmit a coded signal via digital equipment over telephone lines to a central monitoring station. The service shall be identified in the consumer's service plan. A unit is a one-time installation fee or one month of service. Maximum units per state fiscal year are the initial installation and 12 months of service. The necessary components of a system are:

a. An in-home medical communications transceiver.

b. A remote, portable activator.

c. A central monitoring station with backup systems staffed by trained attendants 24 hours per day, seven days a week.

d. Current data files at the central monitoring station containing response protocols and personal, medical, and emergency information for each consumer.

78.46(4) *Specialized medical equipment.* Specialized medical equipment shall include medically necessary items for personal use by consumers with a physical disability which provide for the health and safety of the consumer that are not covered by Medicaid, are not funded by vocational rehabilitation programs, and are not provided by voluntary means. This includes, but is not limited to: electronic aids and organizers, medicine-dispensing devices, communication devices, bath aids and noncovered environmental control units. This includes repair and maintenance of items purchased through the waiver in addition to the initial costs.

a. Consumers may receive specialized medical equipment once a month until a maximum yearly usage of $6,060 has been reached.

b. The need for specialized medical equipment shall be documented by a health care professional as necessary for the consumer's health and safety and shall be identified in the consumer's service plan.

78.46(5) *Transportation.* Transportation services may be provided for consumers to conduct business errands and essential shopping, to receive medical services when not reimbursed through Medicaid as medical transportation, to travel to and from work or day programs, and to reduce social isolation. A unit of service is either per mile, per trip, or the unit established by an area agency on aging.

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.

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

[**ARC 9045B**, IAB 9/8/10, effective 11/1/10]

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) Rehabilitation services for adults with chronic mental illness. Rescinded IAB 8/1/07, effective 9/5/07.

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. Vaccines available through the Vaccines for Children program under Section 1928 of the Social Security Act are not covered as local education agency services. Agencies that wish to administer those

vaccines to Medicaid members shall enroll in the Vaccines for Children program and obtain the vaccines from the department of public health. However, the administration of vaccines is a covered service.

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.

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 consumers eligible for the HCBS children's mental health waiver as established in 441—Chapter 83. All services shall be provided in accordance with the general standards in subrule 78.52(1), as well as standards provided specific to each waiver service in subrules 78.52(2) through 78.52(5).

78.52(1) *General service standards.* All children's mental health waiver services shall be provided in accordance with the following standards:

a. Services must be based on the consumer's needs as identified in the consumer's service plan developed pursuant to 441—83.127(249A).

(1) Services must be delivered in the least restrictive environment consistent with the consumer's needs.

(2) Services must include the applicable and necessary instruction, supervision, assistance and support as required by the consumer to achieve the consumer's goals.

b. Payment for services shall be made only upon departmental approval of the services. Waiver services provided before approval of the consumer's eligibility for the waiver shall not be paid.

c. Services or service components must not be duplicative.

(1) Reimbursement shall not be available under the waiver for any services that the consumer may obtain through the Iowa Medicaid program outside of the waiver.

(2) Reimbursement shall not be available under the waiver for any services that the consumer may obtain through natural supports or community resources.

(3) Services may not be simultaneously reimbursed for the same period as nonwaiver Medicaid services or other Medicaid waiver services.

(4) Costs for waiver services are not reimbursable while the consumer is in a medical institution.

78.52(2) *Environmental modifications and adaptive devices.*

a. Environmental modifications and adaptive devices include items installed or used within the consumer's home that address specific, documented health, mental health, or safety concerns.

b. A unit of service is one modification or device.

c. For each unit of service provided, the case manager shall maintain in the consumer's case file a signed statement from a mental health professional on the consumer's interdisciplinary team that the service has a direct relationship to the consumer's diagnosis of serious emotional disturbance.

78.52(3) *Family and community support services.* Family and community support services shall support the consumer and the consumer'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 consumer's and the family's social and emotional strength.

a. Dependent on the needs of the consumer and the consumer's family members individually or collectively, family and community support services may be provided to the consumer, to the consumer's family members, or to the consumer 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 consumer's interdisciplinary team pursuant to 441—83.127(249A).

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 consumer and for the consumer's family.

(2) Modeling and coaching effective coping strategies for the consumer's family members.

(3) Building resilience to the stigma of serious emotional disturbance for the consumer 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 consumer's crisis intervention plan as defined in 441—24.1(225C) for life situations with the consumer's family and in the community.

(6) Developing medication management skills.

(7) Developing personal hygiene and grooming skills that contribute to the consumer'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 consumer 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 identify the transportation or therapeutic resource as a support need.

(2) The annual amount available for transportation and therapeutic resources must be listed in the consumer's service plan.

(3) The consumer's parent or legal guardian shall submit a signed statement that the transportation or therapeutic resource cannot be provided by the consumer or the consumer's family or legal guardian.

(4) The consumer's Medicaid targeted 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.

(6) Family and community support services providers shall maintain records to:

1. Ensure that the transportation and therapeutic resources provided to not exceed the maximum amount authorized; and

2. Support the annual reporting requirements in 441—subparagraph 79.1(15)*"a"*(1).

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 consumer care.

f. A unit of family and community support services is one hour.

78.52(4) *In-home family therapy.* In-home family therapy provides skilled therapeutic services to the consumer 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 consumer 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 one hour. Any period less than one hour shall be prorated.

78.52(5) *Respite care services.* Respite care services are services provided to the consumer that give temporary relief to the usual caregiver and provide all the necessary care that the usual caregiver would provide during that period. The "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.

a. Respite care shall not be provided to consumers during the hours in which the usual caregiver is employed, except when the consumer is attending a camp.

b. The usual caregiver cannot be absent from the home for more than 14 consecutive days during respite provision.

c. Staff-to-consumer ratios shall be appropriate to the individual needs of the consumer as determined by the consumer's interdisciplinary team. The team shall determine the type of respite care to be provided according to these definitions:

(1) Basic individual respite is provided on a ratio of one staff to one consumer. The consumer does not have specialized medical needs that require the direct services of a registered nurse or licensed practical nurse.

(2) Specialized respite is provided on a ratio of one or more nursing staff to one consumer. The consumer has specialized medical needs that require the direct services of a registered nurse or licensed practical nurse.

(3) Group respite is provided on a ratio of one staff to two or more consumers receiving respite. These consumers do not have specialized medical needs that require the direct services of a registered nurse or licensed practical nurse.

d. Respite services provided for a period exceeding 24 consecutive hours to three or more consumers 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.

e. Respite services provided outside the consumer'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.

f. A unit of service is one hour.

This rule is intended to implement Iowa Code section 249A.4 and 2005 Iowa Acts, chapter 167, section 13, and chapter 117, section 3.

[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]◊
[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]◊
[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]◊
[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[1]]
[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][2]
[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[3]]
[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][4]
[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]◊
[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◊—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]
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[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]
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[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]◊
[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]◊
[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[5]]
[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][6]
[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]◊
[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]◊
[Filed 9/22/03, Notice 7/9/03—published 10/15/03, effective 12/1/03]◊
[Filed emergency 11/19/03—published 12/10/03, effective 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]◊
[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]◊
[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][7]
[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]

◊ Two or more ARCs

1 Effective date of 78.3 and 78.31 delayed 70 days by the Administrative Rules Review Committee at its January 1, 1988 meeting.

2 Effective date of 4/1/90 delayed 70 days by the Administrative Rules Review Committee at its March 12, 1990, meeting.

3 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.

4 Effective date of 3/1/92 delayed until adjournment of the 1992 General Assembly by the Administrative Rules Review Committee at its meeting held February 3, 1992.

5 At a special meeting held January 24, 2002, the Administrative Rules Review Committee voted to delay until adjournment of the 2002 Session of the General Assembly the effective date of amendments published in the February 6, 2002, Iowa Administrative Bulletin as **ARC 1365B**.

6 Effective date of 12/15/02 delayed 70 days by the Administrative Rules Review Committee at its December 10, 2002, meeting.

7 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.

CHAPTER 79
OTHER POLICIES RELATING TO PROVIDERS OF MEDICAL AND REMEDIAL CARE

[Prior to 7/1/83, Social Services[770] Ch 79]

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

79.1(1) *Types of reimbursement.*

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

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

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

(1) The actual charge made by the provider of service.

(2) The maximum allowance under the fee schedule for the item of service in question.

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

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

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

d. Fee for service with cost settlement. Effective July 1, 2009, providers of case management services shall be reimbursed on the basis of a payment rate for a 15-minute unit of service based on reasonable and proper costs for service provision. The fee will be determined by the department with advice and consultation from the appropriate professional group and will reflect the amount of resources involved in service provision.

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

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

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

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

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

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

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

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

(3) The prospective rates paid to both new and established providers are subject to 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.

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.*

Provider category	Basis of reimbursement	Upper limit
Advanced registered nurse practitioners	Fee schedule	Fee schedule in effect 11/30/09 less 5%.
Ambulance	Fee schedule	Ground ambulance: Fee schedule in effect 11/30/09 less 5%. Air ambulance: Fee schedule in effect 11/30/09 less 5%.
Ambulatory surgical centers	Base rate fee schedule as determined by Medicare. See 79.1(3)	Fee schedule in effect 11/30/09 less 5%.
Area education agencies	Fee schedule	Fee schedule in effect 6/30/00 plus 0.7%.
Audiologists	Fee schedule	Fee schedule in effect 11/30/09 less 5%.
Behavioral health services	Fee schedule	Fee schedule in effect 11/30/09 less 5%.
Birth centers	Fee schedule	Fee schedule in effect 11/30/09 less 5%.
Chiropractors	Fee schedule	Fee schedule in effect 11/30/09 less 5%.
Clinics	Fee schedule	Maximum physician reimbursement rate.
Community mental health centers and providers of mental health services to county residents pursuant to a waiver approved under Iowa Code section 225C.7(3)	Retrospective cost-related. See 79.1(25)	100% of reasonable Medicaid cost as determined by Medicare cost reimbursement principles.
Dentists	Fee schedule	Fee schedule in effect 11/30/09 less 2.5%.
Durable medical equipment, prosthetic devices and medical supply dealers	Fee schedule. See 79.1(4)	Fee schedule in effect 11/30/09 less 5%.
Family planning clinics	Fee schedule	Fee schedule in effect 1/31/10.
Federally qualified health centers	Retrospective cost-related. See 441—88.14(249A)	1. Prospective payment rate as required by the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA 2000) or an alternative methodology allowed thereunder, as specified in "2" below. 2. 100% of reasonable cost as determined by Medicare cost reimbursement principles. 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.
HCBS waiver service providers, including:		Except as noted, limits apply to all waivers that cover the named provider.

Provider category	Basis of reimbursement	Upper limit
1. Adult day care	Fee schedule	For AIDS/HIV, brain injury, elderly, and ill and handicapped waivers: Veterans Administration contract rate or $21.57 per half-day, $42.93 per full day, or $64.38 per extended day if no Veterans Administration contract. For intellectual disabilities waiver: County contract rate or, in the absence of a contract rate, $28.73 per half-day, $57.36 per full day, or $73.13 per extended day.
2. Emergency response system	Fee schedule	Initial one-time fee $48.29. Ongoing monthly fee $37.56.
3. Home health aides	Retrospective cost-related	For AIDS/HIV, elderly, and ill and handicapped waivers: Lesser of maximum Medicare rate in effect 11/30/09 or maximum Medicaid rate in effect 11/30/09 less 5%. For intellectual disabilities waiver: Lesser of maximum Medicare rate in effect 11/30/09 or maximum Medicaid rate in effect 11/30/09 less 5%, converted to an hourly rate.
4. Homemakers	Fee schedule	Maximum of $19.31 per hour.
5. Nursing care	For elderly and intellectual disabilities waivers: Fee schedule as determined by Medicare.	For elderly waiver: $80.85 per visit. For intellectual disabilities waiver: Lesser of maximum Medicare rate in effect 11/30/09 or maximum Medicaid rate in effect 11/30/09 less 5%, converted to an hourly rate.
	For AIDS/HIV and ill and handicapped waivers: Agency's financial and statistical cost report and Medicare percentage rate per visit.	For AIDS/HIV and ill and handicapped waivers: Cannot exceed $80.85 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	Lesser of maximum Medicare rate in effect 11/30/09 or maximum Medicaid rate in effect 11/30/09 less 2.5%, converted to an hourly rate, not to exceed $296.94 per day.

Provider category	Basis of reimbursement	Upper limit
Basic individual respite	Cost-based rate for home health aide services provided by a home health agency	Lesser of maximum Medicare rate in effect 11/30/09 or maximum Medicaid rate in effect 11/30/09 less 2.5%, converted to an hourly rate, not to exceed $296.94 per day.
Group respite	Retrospectively limited prospective rates. See 79.1(15)	$12.79 per hour not to exceed $296.94 per day.
Home care agency:		
Specialized respite	Retrospectively limited prospective rates. See 79.1(15)	$32.91 per hour not to exceed $296.94 per day.
Basic individual respite	Retrospectively limited prospective rates. See 79.1(15)	$17.56 per hour not to exceed $296.94 per day.
Group respite	Retrospectively limited prospective rates. See 79.1(15)	$12.79 per hour not to exceed $296.94 per day.
Nonfacility care:		
Specialized respite	Retrospectively limited prospective rates. See 79.1(15)	$32.91 per hour not to exceed $296.94 per day.
Basic individual respite	Retrospectively limited prospective rates. See 79.1(15)	$17.56 per hour not to exceed $296.94 per day.
Group respite	Retrospectively limited prospective rates. See 79.1(15)	$12.79 per hour not to exceed $296.94 per day.
Facility care:		
Hospital or nursing facility providing skilled care	Fee schedule	$12.79 per hour not to exceed daily per diem for skilled nursing facility level of care.
Nursing facility	Fee schedule	$12.79 per hour not to exceed daily per diem for nursing facility level of care.
Camps	Retrospectively limited prospective rates. See 79.1(15)	$12.79 per hour not to exceed $296.94 per day.
Adult day care	Fee schedule	$12.79 per hour not to exceed rate for regular adult day care services.
Intermediate care facility for the mentally retarded	Fee schedule	$12.79 per hour not to exceed daily per diem for ICF/MR level of care.
Residential care facilities for persons with mental retardation	Fee schedule	$12.79 per hour not to exceed contractual daily per diem.
Foster group care	Fee schedule	$12.79 per hour not to exceed daily per diem rate for child welfare services.
Child care facilities	Fee schedule	$12.79 per hour not to exceed contractual daily per diem.
7. Chore service	Fee schedule	$7.52 per half hour.
8. Home-delivered meals	Fee schedule	$7.52 per meal. Maximum of 14 meals per week.

Provider category	Basis of reimbursement	Upper limit
9. Home and vehicle modification	Fee schedule	For elderly waiver: $1,010 lifetime maximum. For intellectual disabilities waiver: $5,050 lifetime maximum. For brain injury, ill and handicapped and physical disability waivers: $6,060 per year.
10. Mental health outreach providers	Fee schedule	On-site Medicaid reimbursement rate for center or provider. Maximum of 1440 units per year.
11. Transportation	Fee schedule	County contract rate or, in the absence of a contract rate, the rate set by the area agency on aging.
12. Nutritional counseling	Fee schedule	$8.04 per unit.
13. Assistive devices	Fee schedule	$107.30 per unit.
14. Senior companion	Fee schedule	$6.44 per hour.
15. Consumer-directed attendant care provided by:		
Agency (other than an elderly waiver assisted living program)	Fee agreed upon by consumer and provider	$19.70 per hour not to exceed the daily rate of $113.80 per day.
Assisted living program (for elderly waiver only)	Fee agreed upon by consumer and provider	For elderly waiver only: $1,089.08 per calendar month. Rate must be prorated per day for a partial month, at a rate not to exceed $35.79 per day.
Individual	Fee agreed upon by consumer and provider	Effective July 1, 2010, $13.47 per hour not to exceed the daily rate of $78.56 per day.
16. Counseling		
Individual:	Fee schedule	$10.52 per unit.
Group:	Fee schedule	$42.06 per hour.
17. Case management	Fee schedule with cost settlement. See 79.1(1)*"d."*	For brain injury waiver: Retrospective cost-settled rate. For elderly waiver: Quarterly revision of reimbursement rate as necessary to maintain projected expenditures within the amounts budgeted under the appropriations made for the medical assistance program for the fiscal year.
18. Supported community living	Retrospectively limited prospective rates. See 79.1(15)	$34.11 per hour, $76.91 per day not to exceed the maximum daily ICF/MR per diem less 2.5%.
19. Supported employment:		
Activities to obtain a job:		

Provider category	Basis of reimbursement	Upper limit
Job development	Fee schedule	$886.28 per unit (job placement). Maximum of two units per 12 months.
Employer development	Fee schedule	$886.28 per unit (job placement). Maximum of two units per 12 months.
Enhanced job search	Retrospectively limited prospective rates. See 79.1(15)	Maximum of $34.11 per hour and 26 hours per 12 months.
Supports to maintain employment	Retrospectively limited prospective rates. See 79.1(15)	Maximum of $34.11 per hour for all activities other than personal care and services in an enclave setting. Maximum of $19.31 per hour for personal care. Maximum of $6.04 per hour for services in an enclave setting. Total not to exceed $2,811.62 per month. Maximum of 40 units per week.
20. Specialized medical equipment	Fee schedule	$6,060 per year.
21. Behavioral programming	Fee schedule	$10.52 per 15 minutes.
22. Family counseling and training	Fee schedule	$42.06 per hour.
23. Prevocational services	Fee schedule	For the brain injury waiver: $36.50 per day. For the intellectual disabilities waiver: County contract rate or, in absence of a contract rate, $47.01 per day.
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	Lesser of maximum Medicare rate in effect 11/30/09 or maximum Medicaid rate in effect 11/30/09 less 5%, converted to an hourly rate.
Home health agency (provided by nurse)	Cost-based rate for nursing services provided by a home health agency	Lesser of maximum Medicare rate in effect 11/30/09 or maximum Medicaid rate in effect 11/30/09 less 5%, converted to an hourly rate.
Child development home or center	Fee schedule	$12.79 per hour.
25. Residential-based supported community living	Retrospectively limited prospective rates. See 79.1(15)	The maximum daily per diem for ICF/MR less 2.5%.
26. Day habilitation	Fee schedule	County contract rate or, in the absence of a contract rate, $12.88 per hour, $31.35 per half-day, or $62.68 per day.
27. Environmental modifications and adaptive devices	Fee schedule	$6,060 per year.
28. Family and community support services	Retrospectively limited prospective rates. See 79.1(15)	$34.11 per hour.
29. In-home family therapy	Fee schedule	$91.29 per hour.

Provider category	Basis of reimbursement	Upper limit
30. Financial management services	Fee schedule	$64.01 per enrolled member per month.
31. Independent support broker	Rate negotiated by member	$14.77 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.
Hearing aid dispensers	Fee schedule plus product acquisition cost	Fee schedule in effect 11/30/09 less 5%.
Home- and community-based habilitation services:		
1. Case management	Fee schedule with cost settlement. See 79.1(1)*"d."*	Retrospective cost-settled rate.
2. Home-based habilitation	Retrospective cost-related. See 79.1(24)	$46.70 per hour or $105.97 per day.
3. Day habilitation	Retrospective cost-related. See 79.1(24)	$13.21 per hour, $32.15 per half-day, or $64.29 per day.
4. Prevocational habilitation	Retrospective cost-related. See 79.1(24)	$9.91 per hour, $24.11 per half-day, or $48.22 per day.
5. Supported employment:		
Activities to obtain a job:		
Job development	Fee schedule	$909 per unit (job placement). Maximum of two units per 12 months.
Employer development	Fee schedule	$909 per unit (job placement). Maximum of two units per 12 months.
Enhanced job search	Retrospective cost-related. See 79.1(24)	Maximum of $34.98 per hour and 26 hours per 12 months.
Supports to maintain employment	Retrospective cost-related. See 79.1(24)	$6.19 per hour for services in an enclave setting; $19.81 per hour for personal care; and $34.98 per hour for all other services. Total not to exceed $2,883.71 per month. Maximum of 40 units per week.
Home health agencies		
1. Skilled nursing, physical therapy, occupational therapy, home health aide, and medical social services; home health care for maternity patients and children	Retrospective cost-related	Lesser of maximum Medicare rate in effect 11/30/09 or maximum Medicaid rate in effect 11/30/09 less 5%.
2. Private duty nursing and personal care for persons aged 20 or under	Interim fee schedule with retrospective cost settlement	Medicaid rate in effect 11/30/09 less 5%.
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"*)

Provider category	Basis of reimbursement	Upper limit
Hospitals (Critical access)	Retrospectively adjusted prospective rates. See 79.1(1)*"g"* and 79.1(5)	The reasonable cost of covered services provided to medical assistance recipients or the upper limits for other hospitals, whichever is greater.
Hospitals (Inpatient)	Prospective reimbursement. See 79.1(5)	Reimbursement rate in effect 11/30/09 less 5%.
Hospitals (Outpatient)	Prospective reimbursement or hospital outpatient fee schedule. See 79.1(16)*"c"*	Ambulatory payment classification rate or hospital outpatient fee schedule rate in effect 11/30/09 less 5%.
Independent laboratories	Fee schedule. See 79.1(6)	Medicare fee schedule less 5%. See 79.1(6)
Indian health service 638 facilities	1. Base rate as determined by the United States Office of Management and Budget for outpatient visits for American Indian and Alaskan native members.	1. Office of Management and Budget rate published in the Federal Register for outpatient visit rate.
	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 the mentally retarded	Prospective reimbursement. See 441—82.5(249A)	Eightieth percentile of facility costs as calculated from annual cost reports.
Lead inspection agency	Fee schedule	Fee schedule in effect 11/30/09 less 5%.
Local education agency services providers	Fee schedule	Fee schedule.
Maternal health centers	Reasonable cost per procedure on a prospective basis as determined by the department based on financial and statistical data submitted annually by the provider group	Fee schedule in effect 11/30/09 less 5%.
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	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.

Provider category	Basis of reimbursement	Upper limit
	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.	
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	Fee schedule in effect 11/30/09 less 5%.
Opticians	Fee schedule. Fixed fee for lenses and frames; other optical materials at product acquisition cost	Fee schedule in effect 11/30/09 less 5%.
Optometrists	Fee schedule. Fixed fee for lenses and frames; other optical materials at product acquisition cost	Fee schedule in effect 11/30/09 less 5%.
Orthopedic shoe dealers	Fee schedule	Fee schedule in effect 11/30/09 less 5%.
Pharmaceutical case management	Fee schedule. See 79.1(18)	Refer to 79.1(18).

Provider category	Basis of reimbursement	Upper limit
Pharmacy administration of influenza vaccine to children	Physician fee schedule for immunization administration	Fee schedule in effect 11/30/09 less 5%.
Physical therapists	Fee schedule	Fee schedule in effect 11/30/09 less 5%.
Physicians (doctors of medicine or osteopathy)	Fee schedule. See 79.1(7)*"a"*	Fee schedule in effect 11/30/09 less 5%.
Anesthesia services	Fee schedule	Fee schedule in effect 11/30/09 less 5%.
Podiatrists	Fee schedule	Fee schedule in effect 11/30/09 less 5%.
Prescribed drugs	See 79.1(8)	$4.34 dispensing fee. (See 79.1(8)*"a," "b,"* and *"e."*)
Psychiatric medical institutions for children		
1. Inpatient	Retrospective cost-related	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 less 5%.
2. Outpatient day treatment	Fee schedule	Fee schedule in effect 11/30/09 less 5%.
Psychologists	Fee schedule	Fee schedule in effect 11/30/09 less 5%.
Rehabilitation agencies	Fee schedule	Medicare fee schedule less 5%; refer to 79.1(21).
Remedial services	Retrospective cost-related plus 1%. 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	Reimbursement rate for center in effect 11/30/09 less 5%.
State-operated institutions	Retrospective cost-related	
Targeted case management providers	Fee for service with cost settlement. See 79.1(1)*"d."*	Retrospective cost-settled rate.

79.1(3) *Ambulatory surgical centers.*

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

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

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

79.1(5) *Reimbursement for hospitals.*

a. Definitions.

"Adolescent" shall mean a Medicaid patient 17 years or younger.

"Adult" shall mean a Medicaid patient 18 years or older.

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

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

"Blended base amount" shall mean the case-mix-adjusted, hospital-specific operating cost per discharge associated with treating Medicaid patients, plus the statewide average case-mix-adjusted operating cost per Medicaid discharge, divided by two. This base amount is the value to which payments for inflation and capital costs are added to form a final payment rate. The costs of hospitals receiving reimbursement as critical access hospitals during any of the period included in the base-year cost report shall not be used in determining the statewide average case-mix-adjusted operating cost per Medicaid discharge.

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

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

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

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

For purposes of calculating the disproportionate share rate only, separate capital costs shall be determined for any hospital that qualifies for a disproportionate share payment only as a children's

hospital based on a distinct area or areas serving children, using only the base year cost report information related to the distinct area or areas of the hospital where services are provided predominantly to children under 18 years of age.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

"GME/DSH fund implementation year" means 2009.

"Graduate medical education and disproportionate share fund" or *"GME/DSH fund"* means a reimbursement fund developed as an adjunct reimbursement methodology to directly reimburse qualifying hospitals for the direct and indirect costs associated with the operation of graduate medical education programs and the costs associated with the treatment of a disproportionate share of poor, indigent, nonreimbursed or nominally reimbursed patients for inpatient services.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

"Rebasing implementation year" means 2008 and every three years thereafter.

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

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

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

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

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

(2) Neonatal intensive care units certified pursuant to 79.1(5)*"r."* Three sets of weights are developed for DRGs concerning treatment of neonates. One set of weights is developed from charges associated with treating neonates in a designated level III neonatal intensive care unit for some portion of their hospitalization. The second set of weights is developed from charges associated with treating

neonates in a designated level II neonatal intensive care unit for some portion of their hospitalization. The third set of weights reflects charges associated with neonates not treated in a designated level II or level III setting. Hospitals are reimbursed using the weight that reflects the setting for neonate treatment.

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

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

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

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

(2) The hospital-specific case-mix index is computed by taking each hospital's trimmed claims that match the hospital's base year cost reporting period, summing the assigned DRG weights associated with those claims and dividing by the total number of Medicaid claims associated with that specific hospital for that period. Case-mix indices are not computed for hospitals receiving reimbursement as critical access hospitals.

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

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

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

1. The total calculated dollar expenditures based on hospitals' base-year cost reports for capital costs and medical education costs, and
2. The actual payments made for additional transfers, outliers, physical rehabilitation services, psychiatric services rendered on or after October 1, 2006, and indirect medical education.

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

(2) Calculation of hospital-specific case-mix-adjusted average cost per discharge. The hospital-specific case-mix-adjusted average cost per discharge is calculated by subtracting from the lesser of total Iowa Medicaid costs or covered reasonable charges, as determined by the hospital's base-year cost report or MMIS claims system, the actual dollar expenditures for capital costs,

direct medical education costs, and the payments made for nonfull DRG transfers, outliers, physical rehabilitation services, and psychiatric services rendered on or after October 1, 2006, if applicable. The remaining amount is case-mix adjusted, multiplied by inflation factors, and divided by the total number of Iowa Medicaid discharges from the MMIS claims system for that hospital during the applicable base year, less the nonfull DRG transfers and short stay outliers.

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

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

e. Add-ons to the base amount.

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

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

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

The 50/50 blend is calculated by adding the case-mix-adjusted hospital-specific per discharge capital cost to the statewide average case-mix-adjusted per discharge capital costs and dividing by two. Hospitals whose blended capital add-on exceeds one standard deviation off the mean Medicaid blended capital rate will be subject to a reduction in their capital add-on to equal the first standard deviation.

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

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

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

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

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

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

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

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

g. Billing for patient transfers and readmissions.

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

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

(3) Physical rehabilitation hospitals or units. When a patient requiring physical rehabilitation is discharged from an acute care hospital and admitted to a rehabilitation hospital or unit certified pursuant to 79.1(5)*"r,"* and the admission is medically appropriate, then payment for time spent in the unit is through a per diem. The discharging hospital will receive 100 percent of the DRG payment. When a patient is discharged from a certified physical rehabilitation hospital or unit and admitted to an acute care hospital, the acute care hospital will receive 100 percent of the DRG payment.

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

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

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

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

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 *"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 fund 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 made 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 $51 million and the actual IowaCare expansion population claims submitted and paid by the Iowa Medicaid enterprise.

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 all 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. 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.

(2) Allocation to fund for direct medical education. The total state fiscal year annual amount of funding that is allocated to the graduate medical education and disproportionate share fund for direct medical education related to inpatient services is $8,210,006. If a hospital fails to qualify for direct medical education payments from the fund because the hospital does not report direct medical education costs that qualify for payment as medical education costs under the Medicare program in the most recent cost report submitted before the start of the state fiscal year for which payments are being made, the amount of money that would have been paid to that hospital shall be removed from the fund.

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

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

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

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

(4) Qualifying for indirect medical education. 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.

(5) Allocation to fund for indirect medical education. The total state fiscal year annual amount of funding that is allocated to the graduate medical education and disproportionate share fund for indirect medical education related to inpatient services is $14,415,396. If a hospital fails to qualify for indirect medical education payments from the fund because the hospital does not report direct medical education costs that qualify for payment as medical education costs under the Medicare program in the most recent cost report submitted before the start of the state fiscal year for which payments are being made, the amount of money that would have been paid to that hospital shall be removed from the fund.

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

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

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

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

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

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.

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.

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.

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.

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.

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.

Hospitals qualify for disproportionate share payments from the fund without regard to the facility's status as a teaching facility or bed size.

Hospitals receiving reimbursement as critical access hospitals shall not qualify for disproportionate share payments from the fund.

(8) Allocation to fund for disproportionate share. The total state fiscal year annual amount of funding that is allocated to the graduate medical education and disproportionate share fund for disproportionate share payments is $6,890,959. If a hospital fails to qualify for disproportionate share payments from the fund due to closure or for any other reason, the amount of money that would have been paid to that hospital shall be removed from the fund.

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

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

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

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

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

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

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

1. Base year cost reports.

2. Medicaid claims data for children under the age of 18 at the time of admission to the hospital in all distinct areas of the hospital where services are provided predominantly to children under 18 years of age.

3. Other information needed to determine a disproportionate share rate encompassing the periods used to determine the disproportionate share rate and distribution amounts.

z. Final settlement for state-owned teaching hospital.

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

1. Payments for inpatient hospital services calculated in accordance with subrule 79.1(5), plus

2. Payment for outpatient hospital services calculated in accordance with subrule 79.1(16), plus

3. $9,900,000.

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

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

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

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

(1) The base rate upon which the DRG payment is built shall be changed after any retrospective adjustment to reflect, as accurately as is possible, the reasonable costs of providing the covered service to eligible fee-for-service Medicaid members for the coming year using the most recent utilization as submitted to the Iowa Medicaid enterprise provider cost audit and rate-setting unit and Medicare cost principles.

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

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. Supplemental payments. Rescinded IAB 7/6/05, effective 7/1/05.

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 October 7, 2008. 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. 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 *"g"*; 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 *"g."*

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

(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 *"g."*

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

b. 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 *"g"*; 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 *"g."*

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

c. No payment shall be made for sales tax.

d. 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.

e. The basis of payment for nonprescription drugs shall be the same as specified in paragraph *"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.

f. An additional reimbursement amount of one cent per dose shall be added to the allowable ingredient 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.

g. For services rendered on or after July 1, 2010, the professional dispensing fee is $4.34 or the pharmacy's usual and customary fee, whichever is lower.

h. 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."

i. Pharmacies and providers that are enrolled in the Iowa Medicaid program shall make available drug acquisition cost information, product availability information, and other information deemed necessary by the department to assist the department in monitoring and revising reimbursement rates subject to 79.1(8)*"a"*(3) and 79.1(8)*"c"* and for the efficient operation of the pharmacy benefit.

(1) Pharmacies and providers shall produce and submit the requested information in the manner and format requested by the department or its designee at no cost to the department or its designee.

(2) Pharmacies and providers shall submit information to the department or its designee within 30 days following receipt of a request for information unless the department or its designee grants an extension upon written request of the pharmacy or provider.

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

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 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.

79.1(14) *Reimbursement for hospice services.*

a. Medicaid hospice rates. The Medicaid hospice rates are based on the methodology used in setting Medicare rates, adjusted to disregard cost offsets attributable to Medicare coinsurance amounts, and with application of the appropriate area wage adjustments for the categories of care provided.

Hospices are reimbursed at one of four predetermined rates based on the level of care furnished to the individual for that day. Payments to a hospice for inpatient care are subject to the limitations imposed by Medicare. The levels of care into which each day of care is classified are as follows:

(1) Routine home care.

(2) Continuous home care.

(3) Inpatient respite care.

(4) General inpatient care.

b. Adjustment to hospice rates. An adjustment to hospice reimbursement is made when a recipient residing in a nursing facility elects the hospice benefit. The adjustment will be a room and board rate that is equal to the rate at which the facility is paid for reserved bed days or 95 percent of the facility's Medicaid reimbursement rate, whichever is greater. Room and board services include the performance of personal care services, including assistance in activities of daily living, socializing activities, administration of medication, maintaining the cleanliness of a resident's room and supervising and assisting in the use of durable medical equipment and prescribed therapies.

For hospice recipients entering a nursing facility the adjustment will be effective the date of entry. For persons in nursing facilities prior to hospice election, the adjustment rate shall be effective the date of election.

For individuals who have client participation amounts attributable to their cost of care, the adjustment to the hospice will be reduced by the amount of client participation as determined by the department. The hospice will be responsible for collecting the client participation amount due the hospice unless the hospice and the nursing facility jointly determine the nursing facility is to collect the client participation.

c. Payment for day of discharge. For the day of discharge from an inpatient unit, the appropriate home care rate is to be paid unless the recipient dies as an inpatient. When the recipient is discharged as deceased, the inpatient rate (general or respite) is to be paid for the discharge date.

d. Hospice cap. Overall aggregate payments made to a hospice during a hospice cap period are limited or capped. The hospice cap year begins November 1 and ends October 31 of the next year. The cap amount for each hospice is calculated by multiplying the number of beneficiaries electing hospice care from that hospice during the cap period by the base statutory amount, adjusted to reflect the percentage increase or decrease in the medical care expenditure category of the Consumer Price Index for all urban consumers published by the Bureau of Labor Statistics. Payments made to a hospice but not included in the cap include room and board payment to a nursing home. Any payment in excess of the cap must be refunded to the department by the hospice.

e. Limitation of payments for inpatient care. Payments to a hospice for inpatient care shall be limited according to the number of days of inpatient care furnished to Medicaid patients. During the 12-month period beginning November 1 of each year and ending October 31, the aggregate number of inpatient days (both for general inpatient care and inpatient respite care) shall not exceed 20 percent of the aggregate total number of days of hospice care provided to all Medicaid recipients during that same period. Medicaid recipients afflicted with acquired immunodeficiency syndrome (AIDS) are excluded in calculating this inpatient care limitation. This limitation is applied once each year, at the end of the

hospices' "cap period" (November 1 to October 31). For purposes of this computation, if it is determined that the inpatient rate should not be paid, any days for which the hospice receives payment at a home care rate will not be counted as inpatient days. The limitation is calculated as follows:

(1) The maximum allowable number of inpatient days will be calculated by multiplying the total number of days of Medicaid hospice care by 0.2.

(2) If the total number of days of inpatient care furnished to Medicaid hospice patients is less than or equal to the maximum, no adjustment will be necessary.

(3) If the total number of days of inpatient care exceeded the maximum allowable number, the limitation will be determined by:

1. Calculating a ratio of the maximum allowable days to the number of actual days of inpatient care, and multiplying this ratio by the total reimbursement for inpatient care (general inpatient and inpatient respite reimbursement) that was made.
2. Multiplying excess inpatient care days by the routine home care rate.
3. Adding together the amounts calculated in "1" and "2."
4. Comparing the amount in "3" with interim payments made to the hospice for inpatient care during the "cap period."

Any excess reimbursement shall be refunded by the hospice.

f. Location of services. Claims must identify the geographic location where the service is provided (as distinct from the location of the hospice).

79.1(15) *HCBS retrospectively limited prospective rates.* This methodology applies to reimbursement for HCBS supported community living; HCBS family and community support services; HCBS supported employment enhanced job search activities; HCBS interim medical monitoring and treatment when provided by an HCBS-certified supported community agency; HCBS respite when provided by nonfacility providers, camps, home care agencies, or providers of residential-based supported community living; and HCBS group respite provided by home health agencies.

a. Reporting requirements.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

c. Prospective rates for new providers other than respite.

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

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

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

d. Prospective rates for established providers other than respite.

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

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

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

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

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

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

f. Retrospective adjustments.

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

(2) Revenues exceeding 100 percent of adjusted actual costs shall be remitted to the department. Payment will be due upon notice of the new rates and retrospective adjustment.

(3) Providers who do not reimburse revenues exceeding 100 percent of actual costs 30 days after notice is given by the department will have the revenues over 100 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, shall mean 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"* shall mean a reimbursement fund developed as an adjunct reimbursement methodology to directly reimburse qualifying hospitals for the direct costs of interns and residents associated with the operation of graduate medical education programs for outpatient services.

"Healthcare common procedures coding system" or *"HCPCS"* means the national uniform coding method that is maintained by the Centers for Medicare and Medicaid Services (CMS) and that incorporates the American Medical Association publication Physicians Current Procedural Terminology (CPT) and the three HCPCS unique coding levels I, II, and III.

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

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

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

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

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

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

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

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

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

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

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

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

"Quality improvement organization" or *"QIO"* shall mean the organization that performs medical peer review of Medicaid claims, including review of validity of hospital diagnosis and procedure coding

information; completeness, adequacy and quality of care; and appropriateness of prospective payments for outlier cases and nonemergent use of the emergency room. These activities undertaken by the QIO may be included in a contractual relationship with the Iowa Medicaid enterprise.

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

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

"Status indicator" or *"SI"* means a payment indicator that identifies whether a service represented by a CPT or HCPCS code is payable under the OPPS APC or another payment system. Only one status indicator is assigned to each CPT or HCPCS code.

b. Outpatient hospital services. Medicaid adopts the Medicare categories of hospitals and services subject to and excluded from the hospital outpatient prospective payment system (OPPS) at 42 CFR 419.20 through 419.22 as amended to October 1, 2007, except as indicated in this subrule.

(1) A teaching hospital that has approval from the Centers for Medicare and Medicaid Services to receive reasonable cost reimbursement for physician services under 42 CFR 415.160 through 415.162 as amended to October 1, 2007, is eligible for combined billing status if the hospital has filed the approval notice with the Iowa Medicaid enterprise provider cost audit and rate-setting unit. If a teaching hospital elects to receive reasonable cost payment for physician direct medical and surgical services furnished to Medicaid members, those services and the supervision of interns and residents furnishing the care to members are covered as hospital services and are combined with the bill for hospital service. Cost settlement for the reasonable costs related to physician direct medical and surgical services shall be made after receipt of the hospital's financial and statistical report.

(2) A hospital-based ambulance service must be an enrolled Medicaid ambulance provider and must bill separately for ambulance services. EXCEPTION: If the member's condition results in an inpatient admission to the hospital, the reimbursement for ambulance services is included in the hospital's DRG reimbursement rate for the inpatient services.

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

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

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

c. Payment for outpatient hospital services.

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

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

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

(3) The APC payment is calculated as follows:

1. The applicable APC relative weight is multiplied by the blended base APC rate determined according to paragraph 79.1(16)*"e."*

2. The resulting APC payment is multiplied by a discount factor of 50 percent and by units of service when applicable.

3. For a procedure started but discontinued before completion, the department will pay 50 percent of the APC for the service.

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

Indicator	Item, Code, or Service	OPPS Payment Status
A	Services furnished to a hospital outpatient that are paid by Medicare under a fee schedule or payment system other than OPPS, such as: ● Ambulance services. ● Clinical diagnostic laboratory services. ● Diagnostic mammography. ● Screening mammography. ● Nonimplantable prosthetic and orthotic devices. ● Physical, occupational, and speech therapy. ● Erythropoietin for end-stage renal dialysis (ESRD) patients. ● Routine dialysis services provided for ESRD patients in a certified dialysis unit of a hospital.	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. ● May be paid when submitted on a different bill type other than outpatient hospital (13x). ● An alternate code that is payable when submitted on an outpatient hospital bill type (13x) may be available.
C	Inpatient procedures	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	Items, codes, and services: ● That are not covered by Medicare based on statutory exclusion and may or may not be covered by Iowa Medicaid; or ● That are not covered by Medicare for reasons other than statutory exclusion and may or may not be covered by Iowa Medicaid; or ● That are not recognized by Medicare but for which an alternate code for the same item or service may be available under Iowa Medicaid; or ● For which separate payment is not provided by Medicare but may be provided by Iowa Medicaid.	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."* If not covered by Iowa Medicaid, the item, code, or service is not paid under OPPS APC or any other Medicaid payment system.

F	Certified registered nurse anesthetist services Corneal tissue acquisition Hepatitis B vaccines	If covered by Iowa Medicaid, the item or service is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)*"c."* If not covered by Iowa Medicaid, the item or service is not paid under OPPS APC or any other Medicaid payment system.
G	Pass-through drugs and biologicals	If covered by Iowa Medicaid, the item is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)*"c."* If not covered by Iowa Medicaid, the item is not paid under OPPS APC or any other Medicaid payment system.
H	Pass-through device categories	If covered by Iowa Medicaid, the device is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)*"c."* If not covered by Iowa Medicaid, the device is not paid under OPPS APC or any other Medicaid payment system.
K	Non-pass-through drugs and biologicals Therapeutic radiopharmaceuticals	If covered by Iowa Medicaid, the item is: ● Paid under OPPS APC with a separate APC payment when both an APC and an APC weight are established. ● Paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)*"c"* when either no APC or APC weight is established. If not covered by Iowa Medicaid, the item is not paid under OPPS APC or any other Medicaid payment system.
L	Influenza vaccine Pneumococcal pneumonia vaccine	If covered by Iowa Medicaid, the vaccine is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)*"c."* If not covered by Iowa Medicaid, the vaccine is not paid under OPPS APC or any other Medicaid payment system.
M	Items and services not billable to the Medicare fiscal intermediary	If covered by Iowa Medicaid, the item or service is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)*"c."* If not covered by Iowa Medicaid, the item or service is not paid under OPPS APC or any other Medicaid payment system.

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. ● Packaged APC payment if billed on the same date of service as HCPCS code assigned status indicator "S," "T," "V," or "X." ● In all other circumstances, payment is made through a separate APC payment.
Q2	T-packaged codes	Paid under OPPS APC. ● Packaged APC payment if billed on the same date of service as HCPCS code assigned status indicator "T." ● In all other circumstances, payment is made through a separate APC payment.
Q3	Codes that may be paid through a composite APC	If covered by Iowa Medicaid, the code is paid under OPPS APC with separate APC payment. If not covered by Iowa Medicaid, the code is not paid under OPPS APC or any other Medicaid payment system.
R	Blood and blood products	If covered by Iowa Medicaid, the item is paid under OPPS APC with separate APC payment. If not covered by Iowa Medicaid, the item is not paid under OPPS APC or any other Medicaid payment system.
S	Significant procedure, not discounted when multiple	If covered by Iowa Medicaid, the procedure is paid under OPPS APC with separate APC payment. If not covered by Iowa Medicaid, the procedure is not paid under OPPS APC or any other Medicaid payment system.
T	Significant procedure, multiple reduction applies	If covered by Iowa Medicaid, the procedure is paid under OPPS APC with separate APC payment subject to multiple reduction. If not covered by Iowa Medicaid, the procedure is not paid under OPPS APC or any other Medicaid payment system.
U	Brachytherapy sources	If covered by Iowa Medicaid, the procedure is paid under OPPS APC with separate APC payment. If not covered by Iowa Medicaid, the procedure is not paid under OPPS APC or any other Medicaid payment system.
V	Clinic or emergency department visit	If covered by Iowa Medicaid, the service is paid under OPPS APC with separate APC payment. If not covered by Iowa Medicaid, the service is not paid under OPPS APC or any other Medicaid payment system.

X	Ancillary services	If covered by Iowa Medicaid, the service is paid under OPPS APC with separate APC payment. If not covered by Iowa Medicaid, the service is not paid under OPPS 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 OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospitals 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 that APC payment amounts for out-of-state hospitals may be based on either the Iowa statewide base APC rate or the Iowa blended base APC rate for the out-of-state hospital.

(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) If an out-of-state hospital qualifies for reimbursement for direct medical education under Medicare guidelines, it shall qualify for such reimbursement from the Iowa Medicaid program for services to Iowa Medicaid members.

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—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. Payment for outpatient services delivered in the emergency room. Rescinded IAB 07/02/08, effective 07/01/08.

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 all 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. 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.

(2) Allocation to fund for direct medical education. The total annual state fiscal year funding that is allocated to the graduate medical education and disproportionate share fund for direct medical education related to outpatient services is $2,776,336. If a hospital fails to qualify for direct medical education payments from the fund because the hospital does not report direct medical education costs that qualify for payment as medical education costs under the Medicare program in the most recent cost report submitted before the start of the state fiscal year for which payments are being made, the amount of money that would have been paid to that hospital shall be removed from the fund.

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

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

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

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

w. Final settlement for state-owned teaching hospital.

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

1. Payments for inpatient hospital services calculated in accordance with subrule 79.1(5), plus

2. Payment for outpatient hospital services calculated in accordance with subrule 79.1(16), plus

3. $9,900,000.

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

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

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

79.1(17) *Reimbursement for home- and community-based services home and vehicle modification.* Payment is made for home and vehicle modifications at the amount of payment to the subcontractor provided in the contract between the supported community living provider and subcontractor. All contracts shall be awarded through competitive bidding, shall be approved by the department, and shall be justified by the consumer's service plan. Payment for completed work shall be made to the supported community living provider.

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.

Service	Payment amount	Number of payments
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 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.

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

(6) A projected cost report shall be submitted when a new remedial services provider enters the program or an existing remedial 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. Cost reports as filed shall be subject to review and audit by the Iowa Medicaid enterprise to determine the actual cost of services rendered to Medicaid members, using an accepted method of cost apportionment (as specified in OMB Circular A-87).

(1) A reasonable cost for a member is one that does not exceed 110 percent of the average allowable costs reported by Iowa Medicaid providers for providing similar remedial services to members who have similar diagnoses and live in similar settings, less 5 percent.

(2) When the reasonable and proper costs of operation are determined, a retroactive adjustment shall be made. The retroactive adjustment represents the difference between the amount received by the

provider through an interim rate during the year for covered services and the reasonable and proper costs of operation determined in accordance with this subrule.

79.1(24) *Reimbursement for home- and community-based habilitation services.* Reimbursement for case management, job development, and employer development is based on a fee schedule developed using the methodology described in paragraph 79.1(1)*"d."* Reimbursement for home-based habilitation, day habilitation, prevocational habilitation, enhanced job search and supports to maintain employment is based on a retrospective cost-related rate calculated using the methodology in this subrule. All rates are subject to the upper limits established in subrule 79.1(2).

a. Units of service.

(1) Effective July 1, 2009, a unit of case management is 15 minutes.

(2) A unit of home-based habilitation is one hour. EXCEPTIONS:

1. A unit of service is one day when a member receives direct supervision for 14 or more hours per day, averaged over a calendar month. The member's comprehensive service plan must identify and reflect the need for this amount of supervision. The provider's documentation must support the number of direct support hours identified in the comprehensive service plan.

2. When cost-effective, a daily rate may be developed for members needing fewer than 14 hours of direct supervision per day. The provider must obtain approval from the Iowa Medicaid enterprise for a daily rate for fewer than 14 hours of service per day.

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

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

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

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

2. One hour for enhanced job search.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(4) Providers shall submit completed cost reports to the IME Provider Cost Audit and Rate Setting Unit, P.O. Box 36450, Des Moines, Iowa 50315. A provider that is not hospital-based shall submit Form 470-4419 on or before the last day of the third month after the end of the provider's fiscal year. A hospital-based provider shall submit both Form 470-4419 and CMS Form 2552-96 on or before the last day of the fifth month after the end of the provider's fiscal year.

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

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

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

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

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

79.2(1) *Definitions.*

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

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

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

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

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

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

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

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

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

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

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

b. Submitting or causing to be submitted false information for the purpose of obtaining greater compensation than that to which the provider is legally entitled, including charges in excess of usual and customary charges.

c. Submitting or causing to be submitted false information for the purpose of meeting prior authorization requirements.

d. Failure to disclose or make available to the department or its authorized agent, records of services provided to medical assistance recipients and records of payments made for those services.

e. Failure to provide and maintain the quality of services to medical assistance recipients within accepted medical community standards as adjudged by professional peers.

f. Engaging in a course of conduct or performing an act which is in violation of state or federal regulations of the medical assistance program, or continuing that conduct following notification that it should cease.

g. Failure to comply with the terms of the provider certification on each medical assistance check endorsement.

h. Overutilization of the medical assistance program by inducing, furnishing or otherwise causing the recipient to receive services or merchandise not required or requested by the recipient.

i. Rebating or accepting a fee or portion of a fee or a charge for medical assistance patient referral.

j. Violating any provision of Iowa Code chapter 249A, or any rule promulgated pursuant thereto.

k. Submission of a false or fraudulent application for provider status under the medical assistance program.

l. Violations of any laws, regulations, or code of ethics governing the conduct of occupations or professions or regulated industries.

m. Conviction of a criminal offense relating to performance of a provider agreement with the state or for negligent practice resulting in death or injury to patients.

n. Failure to meet standards required by state or federal law for participation, for example, licensure.

o. Exclusion from Medicare because of fraudulent or abusive practices.

p. Documented practice of charging recipients for covered services over and above that paid for by the department, except as authorized by law.

q. Failure to correct deficiencies in provider operations after receiving notice of these deficiencies from the department.

r. Formal reprimand or censure by an association of the provider's peers for unethical practices.

s. Suspension or termination from participation in another governmental medical program such as workers' compensation, crippled children's services, rehabilitation services or Medicare.

t. Indictment for fraudulent billing practices, or negligent practice resulting in death or injury to the provider's patients.

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

a. A term of probation for participation in the medical assistance program.

b. Termination from participation in the medical assistance program.

c. Suspension from participation in the medical assistance program. This includes when the department is notified by the Centers for Medicare and Medicaid Services, Department of Health and Human Services, that a practitioner has been suspended from participation under the Medicare program. These practitioners shall be suspended from participation in the medical assistance program effective

on the date established by the Centers for Medicare and Medicaid Services and at least for the period of time of the Medicare suspension.

d. Suspension or withholding of payments to provider.

e. Referral to peer review.

f. Prior authorization of services.

g. One hundred percent review of the provider's claims prior to payment.

h. Referral to the state licensing board for investigation.

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

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

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

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

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

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

(1) Seriousness of the offense.

(2) Extent of violations.

(3) History of prior violations.

(4) Prior imposition of sanctions.

(5) Prior provision of provider education.

(6) Provider willingness to obey program rules.

(7) Whether a lesser sanction will be sufficient to remedy the problem.

(8) Actions taken or recommended by peer review groups or licensing boards.

79.2(5) *Scope of sanction.*

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

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

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

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

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

79.2(7) *Notice of violation.* Should the department have information that indicates that a provider may have submitted bills or has been practicing in a manner inconsistent with the program requirements,

or may have received payment for which the provider may not be properly entitled, the department shall notify the provider of the discrepancies noted. Notification shall set forth:

a. The nature of the discrepancies or violations,

b. The known dollar value of the discrepancies or violations,

c. The method of computing the dollar value,

d. Notification of further actions to be taken or sanctions to be imposed by the department, and

e. Notification of any actions required of the provider. The provider shall have 15 days subsequent to the date of the notice prior to the department action to show cause why the action should not be taken.

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

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

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

79.3(1) *Financial (fiscal) records.*

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

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

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

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

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

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

(1) The provision of each service and each activity billed to the program; and

(2) First and last name of the member receiving the service.

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

(1) Medically necessary;

(2) Consistent with the diagnosis of the member's condition; and

(3) Consistent with professionally recognized standards of care.

c. Components.

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

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

1. The member's complaint, symptoms, and diagnosis.
2. The member's medical or social history.
3. Examination findings.
4. Diagnostic test reports, laboratory test results, or X-ray reports.
5. Goals or needs identified in the member's plan of care.
6. Physician orders and any prior authorizations required for Medicaid payment.
7. Medication records, pharmacy records for prescriptions, or providers' orders.
8. Related professional consultation reports.
9. Progress or status notes for the services or activities provided.
10. All forms required by the department as a condition of payment for the services provided.
11. Any treatment plan, care plan, service plan, individual health plan, behavioral intervention plan, or individualized education program.
12. The provider's assessment, clinical impression, diagnosis, or narrative, including the complete date thereof and the identity of the person performing the assessment, clinical impression, diagnosis, or narrative.
13. Any additional documentation necessary to demonstrate the medical necessity of the service provided or otherwise required for Medicaid payment.

(3) Service documentation. The record for each service provided shall include information necessary to substantiate that the service was provided and shall include the following:

1. The specific procedures or treatments performed.
2. The complete date of the service, including the beginning and ending date if the service is rendered over more than one day.
3. The complete time of the service, including the beginning and ending time if the service is billed on a time-related basis. For those time-related services billed using Current Procedural Terminology (CPT) codes, the total time of the service shall be recorded, rather than the beginning and ending time.
4. The location where the service was provided if otherwise required on the billing form or in 441—paragraph 77.30(5)*"c"* or *"d,"* 441—paragraph 77.33(6)*"d,"* 441—paragraph 77.34(5)*"d,"* 441—paragraph 77.37(15)*"d,"* 441—paragraph 77.39(13)*"e,"* 441—paragraph 77.39(14)*"d,"* or 441—paragraph 77.46(5)*"i,"* or 441—subparagraph 78.9(10)*"a"*(1).
5. The name, dosage, and route of administration of any medication dispensed or administered as part of the service.
6. Any supplies dispensed as part of the service.
7. The first and last name and professional credentials, if any, of the person providing the service.
8. The signature of the person providing the service, or the initials of the person providing the service if a signature log indicates the person's identity.
9. For 24-hour care, documentation for every shift of the services provided, the member's response to the services provided, and the person who provided the services.

(4) Outcome of service. The medical record shall indicate the member's progress in response to the services rendered, including any changes in treatment, alteration of the plan of care, or revision of the diagnosis.

d. Basis for service requirements for specific services. The medical record for the following services must include, but is not limited to, the items specified below (unless the listed item is not routinely received or created in connection with the particular service or activity and is not required to document the reason for performing the service or activity, its medical necessity, or the level of care associated with it). These items will be specified on Form 470-4479, Documentation Checklist, when the Iowa Medicaid enterprise surveillance and utilization review services 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) Remedial services and rehabilitation services for adults with a chronic mental illness:
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.

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]

441—79.4(249A) Reviews and audits.

79.4(1) *Definitions.*

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(1) The department has correctly paid claims for goods or services.

(2) The provider has furnished the services to Medicaid members.

(3) The provider has retained clinical and fiscal records that substantiate claims submitted for payment.

(4) The goods or services provided were in accordance with Iowa Medicaid policy.

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

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

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

Please sign this form and return it with the information requested.
Follow the checklist to ensure that all documents requested for each patient have been copied and enclosed with this request. The documentation must support the validity of the claim that was paid by the Medicaid program.
Please send copies. Do not send original records.
If you have any questions about this request or checklist, please contact the reviewer listed above.

	[specific documentation required]
	[specific documentation required]
	[specific documentation required]
	[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

470-4479 (4/08)

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

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

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

b. Extension of time limit for submission.

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

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

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

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

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

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

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

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

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

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

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

(1) Comparing clinical and fiscal records with each claim.

(2) Interviewing members who received goods or services and employees of providers.

(3) Examining third-party payment records.

(4) Comparing Medicaid charges with private-patient charges to determine that the charge to Medicaid is not more than the customary and prevailing fee.

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

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

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

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

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

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

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

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

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

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

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

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

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

(1) Be arranged and paid for by the provider.

(2) Be conducted by an individual or organization with expertise in coding, medical services, and Iowa Medicaid policy if the issues relate to clinical records.

(3) Be conducted by a certified public accountant if the issues relate to fiscal records.

(4) Demonstrate that bills and records that were not audited or reviewed in the department's sample are in compliance with program regulations.

(5) Be submitted to the department with all supporting documentation within 60 calendar days of the mailing of the preliminary finding of a tentative overpayment to the provider.

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

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

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

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

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

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

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

In these agreements, the provider agrees to the following:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

79.7(5) *Procedures.*

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

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

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

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

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

79.7(6) *Duties.*

a. Executive committee. Based upon the deliberations of the medical assistance advisory council and the executive committee, the executive committee shall make recommendations to the director regarding the budget, policy, and administration of the medical assistance program. Such recommendations may include:

(1) Recommendations on the reimbursement for medical services rendered by providers of services.

(2) Identification of unmet medical needs and maintenance needs which affect health.

(3) Recommendations for objectives of the program and for methods of program analysis and evaluation, including utilization review.

(4) Recommendations for ways in which needed medical supplies and services can be made available most effectively and economically to the program recipients.

(5) Advice on such administrative and fiscal matters as the director of the department of human services may request.

b. Council. The medical assistance advisory council shall:

(1) Advise the professional groups and business entities represented and act as liaison between them and the department.

(2) Report at least annually to the professional groups and business entities represented.

(3) Perform other functions as may be provided by state or federal law or regulation.

(4) Communicate information considered by the council to the professional groups and business entities represented.

79.7(7) *Responsibilities.*

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

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

(2) Implementation of medical assistance program policies.

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

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

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

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

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

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

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

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

79.8(1) *Making the request.*

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

e. The advice of an appropriate professional consultant.

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

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

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

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

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

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

79.9(2) The services covered by Medicaid shall:

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

b. Be in accordance with standards of good medical practice.

c. Be required to meet the medical need of the patient and be for reasons other than the convenience of the patient or the patient's practitioner or caregiver.

d. Be the least costly type of service which would reasonably meet the medical need of the patient.

e. Be eligible for federal financial participation unless specifically covered by state law or rule.

f. Be within the scope of the licensure of the provider.

g. Be provided with the full knowledge and consent of the recipient or someone acting in the recipient's behalf unless otherwise required by law or court order or in emergency situations.

h. Be supplied by a provider who is eligible to participate in the Medicaid program. The provider must use the billing procedures and documentation requirements described in 441—Chapters 78 and 80.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

79.11(4) The IME medical services unit shall issue a denial letter to the patient, the physician, and the facility when the requested procedure is not approved. The patient, the physician, or the facility may

request a reconsideration of the decision by filing a written request with the IME medical services unit within 60 days of the date of the denial letter.

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

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

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

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

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

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

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

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

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

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

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

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

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

441—79.14(249A) Provider enrollment.

79.14(1) Application request. A provider of medical or remedial services that wishes to enroll as an Iowa Medicaid provider shall begin the enrollment process by contacting the provider services unit at the Iowa Medicaid enterprise to request an application form.

a. A nursing facility shall also complete the process set forth in 441—subrule 81.13(1).

b. An intermediate care facility for persons with mental retardation 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 at P.O. Box 36450, Des Moines, Iowa 50315.

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. All other providers shall submit Form 470-0254, Iowa Medicaid Provider Enrollment Application.

c. 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.

79.14(3) Notification. Providers shall be notified of the decision on their application by the Iowa Medicaid enterprise provider services unit within 30 calendar days.

79.14(4) Providers not approved as the type of Medicaid provider requested shall have the right to appeal under 441—Chapter 7.

79.14(5) Effective date of approval. Applications 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 forms by the Iowa Medicaid enterprise provider services unit.

79.14(6) Providers approved for certification as a Medicaid provider shall complete a provider participation agreement as required by rule 441—79.6(249A).

79.14(7) No payment shall be made to a provider for care or services provided prior to the effective date of the department's approval of an application, unless the provider was enrolled and participating in the Iowa Medicaid program as of April 1, 1993.

79.14(8) 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 form, together with information on claim forms, or on rates paid the provider prior to April 1, 1993.

79.14(9) Amendments to application forms 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(10) Providers who have not submitted claims in the last 24 months will be sent a notice asking if they wish to continue participation. Providers failing to reply to the notice within 30 calendar days of the date on the notice will be terminated as providers. Providers who do not submit any claims in 48 months will be terminated as providers without further notification.

79.14(11) Report of changes. The provider shall inform the Iowa Medicaid enterprise of all pertinent changes to enrollment information within 60 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, and telephone number.

a. When a provider fails to provide current information within the 60-day period, the department may terminate the provider's Medicaid enrollment upon 30 days' notice. The termination may be appealed under 441—Chapter 7.

b. When the department incurs an informational tax-reporting fine because a provider submitted inaccurate information or failed to submit changes to the Iowa Medicaid enterprise in a timely manner, the fine shall be the responsibility of the individual provider to the extent that the fine 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 to the department within 30 days of notification by the department that the fine has been imposed.

(2) Payment of the fine may be appealed under 441—Chapter 7.

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

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 Surveillance and Utilization Review Services 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.

441—79.16(249A) Payment reductions pursuant to executive order. Rescinded IAB 6/30/10, effective 7/1/10.

[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[1]]
[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]◊
[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◊—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[2]]
[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◊—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[3]]
[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[4]]
[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[5]]
[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[6]]
[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]◊
[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][7]
[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]

◊ Two or more ARCs

1 Effective date of 79.1(2) and 79.1(5)*"t"* delayed 70 days by the Administrative Rules Review Committee at its January 1988, meeting.

2 Effective date of 4/1/90 delayed 70 days by the Administrative Rules Review Committee at its March 12, 1990, meeting; delay lifted by this Committee, effective May 11, 1990.

[3] Effective date of subrule 79.1(13) delayed until adjournment of the 1992 Sessions of the General Assembly by the Administrative Rules Review Committee at its meeting held July 12, 1991.

[4] Effective date of 3/1/92 delayed until adjournment of the 1992 General Assembly by the Administrative Rules Review Committee at its meeting held February 3, 1992.

[5] At a special meeting held January 24, 2002, the Administrative Rules Review Committee voted to delay until adjournment of the 2002 Session of the General Assembly the effective date of amendments published in the February 6, 2002, Iowa Administrative Bulletin as **ARC 1365B**.

[6] Effective date of October 1, 2002, delayed 70 days by the Administrative Rules Review Committee at its meeting held September 10, 2002. At its meeting held November 19, 2002, the Committee voted to delay the effective date until adjournment of the 2003 Session of the General Assembly.

[7] July 1, 2009, effective date of amendments to 79.1(1)*"d,"* 79.1(2), and 79.1(24)*"a"*(1) delayed 70 days by the Administrative Rules Review Committee at a special meeting held June 25, 2009.

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.

"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]

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) 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]

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 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.

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.

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.

[**ARC 8500B**, IAB 2/10/10, effective 3/1/10; **ARC 9135B**, IAB 10/6/10, effective 10/1/10]

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. Effective for applications and recertifications received on or after October 1, 2010, 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	$47
170% of federal poverty level	$50
180% of federal poverty level	$53
190% of federal poverty level	$56
200% of federal poverty level	$60

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	$63
170% of federal poverty level	$68
180% of federal poverty level	$72
190% of federal poverty level	$76
200% of federal poverty level	$80

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."* If the statement is not postmarked by the premium due date, the member or household shall be obligated to pay the premium.

a. A partial payment submitted with a written statement indicating that full payment of the monthly premium will be a financial hardship that is postmarked or received on or before the end of the month for which the premium is due shall be considered a request for a hardship exemption. The exemption shall be granted for the balance owed for that month.

b. If the postmark is illegible, the date that the hardship declaration is initially received by the department or the department's designee shall be considered the date of the request.

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]

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(6), 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).

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.

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) 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 enroll the member with that provider. A member who is enrolled with a medical home provider:

(1) Shall utilize the medical home provider for covered services available from that provider, and

(2) Must receive a referral from the medical home provider to another IowaCare provider for any services not available from the medical home provider.

92.8(7) *Emergency 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) The treating nonparticipating provider has consulted with the IowaCare provider network hospital and the providers jointly agree that the conditions for payment are met.

(6) 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 and documentation of the consultation with the IowaCare network provider.

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.

[**ARC 9135B**, IAB 10/6/10, effective 10/1/10]

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 July 1, 2010, IowaCare network providers shall be paid for nonhospital services at the Medicaid fee schedule amounts in effect on November 30, 2009, 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. Physician services provided to IowaCare members in a federally qualified health center shall 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.

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]

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.* 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.

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.

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 6/11/08after 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]

NATURAL RESOURCE COMMISSION[571]

[Prior to 12/31/86, see Conservation Commission [290], renamed Natural Resource Commission[571] under the "umbrella" of Department of Natural Resources by 1986 Iowa Acts, chapter 1245]

TITLE I
GENERAL

CHAPTER 10
FORFEITED PROPERTY

CHAPTER 11
WAIVERS OR VARIANCES FROM ADMINISTRATIVE RULES

CHAPTER 12
CONSERVATION EDUCATION

DIVISION I
RESOURCE ENHANCEMENT AND
PROTECTION CONSERVATION EDUCATION PROGRAM (REAP)

DIVISION II
RECREATION EDUCATION COURSES
PART I
VOLUNTEER INSTRUCTOR CERTIFICATION AND
DECERTIFICATION PROCEDURES

TITLE II
LICENSES, PERMITS AND CONCESSION CONTRACTS

CHAPTER 14
CONCESSIONS

CHAPTER 15
GENERAL LICENSE REGULATIONS

DIVISION I
LICENSE SALES, REFUNDS AND ADMINISTRATION

DIVISION II
MULTIPLE OFFENDER AND WILDLIFE VIOLATOR COMPACT

DIVISION III
SPECIAL LICENSES

DIVISION IV
EDUCATION AND CERTIFICATION PROGRAMS

15.41(483A) Hunter safety and ethics education program
15.42(483A) Testing procedures
15.43(321G,462A,483A) Volunteer bow and fur harvester education instructors, snowmobile and all-terrain vehicle (ATV) safety instructors, boating safety instructors and hunter education instructors
15.44 to 15.50 Reserved

DIVISION V
LICENSE REVOCATION, SUSPENSION, AND MODIFICATION DUE TO LIABILITIES OWED TO THE STATE

15.51(272D) Purpose and use
15.52(272D) Definitions
15.53(272D) Requirements of the department
15.54(272D) No administrative appeal of the department's action
15.55(272D) District court hearing

CHAPTER 16
DOCKS AND OTHER STRUCTURES ON PUBLIC WATERS

16.1(461A,462A) Definitions

DIVISION I
PRIVATE, COMMERCIAL AND PUBLIC DOCKS

16.2(461A,462A) Scope of division and classes of permits
16.3(461A,462A) Standard requirements for all docks
16.4(461A,462A) Class I permits for standard private docks
16.5(461A,462A) Class I permits for docks permitted by Corps of Engineers
16.6(461A,462A) Class II permits for docks authorized by cities and counties that own or otherwise control shoreline property
16.7(461A,462A) Class III permits for nonstandard private docks
16.8(461A,462A) Class IV permits for commercial docks
16.9(461A,462A) Exceptions for renewal of Class III and Class IV permits for existing docks
16.10(461A,462A) Exceptions to Class III and Class IV permits for new structures
16.11 Reserved
16.12(461A,462A) Initial decision and right of appeal
16.13(461A,462A) Application forms and administrative fees
16.14 to 16.16 Reserved
16.17(461A,462A) Duration and transferability of permits; refund of application fees; suspension, modification, or revocation of permits; complaint investigation; property line location
16.18(461A,462A) Exemptions from winter removal requirement
16.19(461A,462A) General conditions of all dock permits
16.20(461A,462A) Permit criteria for rafts, platforms, or other structures
16.21 to 16.24 Reserved

DIVISION II
DOCK MANAGEMENT AREAS

16.25(461A) Designation or modification of dock management areas
16.26(461A) Procedures and policies for dock site permits and hoist or slip assignments in dock management areas
16.27(461A) Standard requirements for dock management area docks
16.28(461A) Dock management area permit restrictions and conditions
16.29(461A) Fees for docks in dock management areas
16.30(461A) Suspension, modification or revocation of dock management area permits
16.31(461A) Persons affected by DMA permit—hearing request

CHAPTER 17
BARGE FLEETING REGULATIONS

CHAPTER 18
RENTAL FEE SCHEDULE FOR STATE-OWNED PROPERTY,
RIVERBED, LAKEBED, AND WATERFRONT LANDS

CHAPTER 19
SAND AND GRAVEL PERMITS

CHAPTER 20
MANUFACTURER'S CERTIFICATE OF ORIGIN

TITLE III
ASSISTANCE PROGRAMS

CHAPTER 21
AGRICULTURAL LEASE PROGRAM

CHAPTER 26
RELOCATION ASSISTANCE

CHAPTER 27
LANDS AND WATERS CONSERVATION FUND PROGRAM

CHAPTER 28
SNOWMOBILE AND ALL-TERRAIN VEHICLE REGISTRATION
REVENUE COST-SHARE PROGRAM

CHAPTER 29
LOCAL RECREATION INFRASTRUCTURE GRANTS PROGRAM

CHAPTER 30
WATERS COST-SHARE AND GRANT PROGRAMS

DIVISION I
WATER RECREATION ACCESS COST-SHARE PROGRAM

DIVISION II
WATER TRAILS DEVELOPMENT PROGRAM AND LOW-HEAD DAM PUBLIC HAZARD PROGRAM

CHAPTER 31
PUBLICLY OWNED LAKES PROGRAM

CHAPTER 32
PRIVATE OPEN SPACE LANDS

CHAPTER 33
RESOURCE ENHANCEMENT AND PROTECTION PROGRAM:
COUNTY, CITY AND PRIVATE OPEN SPACES GRANT PROGRAMS

Part 1
GENERAL PROVISIONS

Part 2
COUNTY GRANTS

Part 3
CITY GRANTS

Part 4
PRIVATE GRANTS

CHAPTER 34
COMMUNITY FORESTRY GRANT PROGRAM (CFGP)

CHAPTER 35
FISH HABITAT PROMOTION FOR COUNTY CONSERVATION BOARDS

TITLE IV
RECREATIONAL VESSEL AND VEHICLE REGISTRATION AND SAFETY

CHAPTER 36
GREEN VALLEY LAKE SPECIAL WATER ACTIVITY RULES

40.5(462A)	Rathbun Lake, Appanoose County—zoned areas
40.6(462A)	Red Rock Lake, Marion County—zoned areas
40.7(462A)	Coralville Lake, Johnson County—zoned areas
40.8(462A)	Saylorville Lake, Polk County—zoned areas
40.9(462A)	Lake Odessa in Louisa County
40.10(462A)	Mississippi River lock and dam safety zone
40.11(462A)	Joyce Slough Area
40.12(462A)	Swan Slough, Camanche, Iowa
40.13(462A)	Massey Slough
40.14(462A)	Black Hawk County waters
40.15(462A)	Mitchell County waters
40.16(462A)	Maquoketa River
40.17(462A)	Zoning of off-channel waters of the Wapsipinicon River in Pinicon Ridge Park in Linn County
40.18(462A)	Speed restrictions on Lake Manawa
40.19(462A)	Zoning of Little Wall Lake
40.20(462A)	Lake Icaria, Adams County—watercraft use
40.21(462A)	Zoning of the Des Moines River
40.22(462A)	Upper Gar Lake, Dickinson County
40.23(462A)	Zoning of the Mississippi River, Guttenberg river mile 616, Clayton County
40.24(462A)	Mt. Ayr City Lake (Loch Ayr)
40.25(462A)	Iowa River in Iowa City, Johnson County
40.26(462A)	Zoning of the Mississippi River, Dubuque, Dubuque County
40.27(462A)	Zoning Harpers Slough, Harpers Ferry, Allamakee County
40.28(462A)	Black Hawk Lake, Sac County—zoned areas
40.29(462A)	Speed and other restrictions on Brown's Lake, Woodbury County
40.30(462A)	Speed and other restrictions on Snyder Bend Lake, Woodbury County
40.31(462A)	Speed restrictions on East Okoboji and West Okoboji Lakes in Dickinson County
40.32(462A)	Spirit Lake, Dickinson County—zoned areas
40.33(462A)	Speed restrictions on the Mississippi River, Jackson County, at Spruce Creek County Park
40.34(462A)	Speed restrictions on the Mississippi River, Jackson County, at the city of Sabula
40.35(462A)	Speed restrictions on the Greene Impoundment of the Shell Rock River
40.36(462A)	Zoning of the Iowa River, Iowa Falls, Hardin County
40.37(462A)	Zoning of Crystal Lake
40.38(462A)	Five Island Lake, Palo Alto County
40.39(462A)	Lost Island Lake, Palo Alto and Clay Counties
40.40(462A)	Ingham Lake, Emmet County
40.41(462A)	Storm Lake, Buena Vista County
40.42(462A)	Raccoon River Regional Park Lake, Polk County
40.43(462A)	Zoning of the Mississippi River, Bellevue, Jackson County
40.44(462A)	Three Mile Lake, Union County—watercraft use
40.45(462A)	Zoning of the Cedar River
40.46(462A)	Zoning of Carter Lake, Pottawattamie County
40.47(462A)	Zoning of the Mississippi River, McGregor, Clayton County
40.48(462A)	Zoning of the Mississippi River, Marquette, Clayton County
40.49(462A)	Zoning of Green Island, Jackson County
40.50(462A)	Mooring of vessels on riparian property of the state of Iowa
40.51(462A)	Little River Lake, Decatur County
40.52(462A)	Zoning of the Mississippi River, Johnson Slough, Clayton County
40.53(462A)	Zoning of the Mississippi River, Mud Lake, Dubuque County
40.54(462A)	Nighttime speed limit, Dickinson County

DIVISION II
ALL-TERRAIN VEHICLE DEALERS

DIVISION III
REGULATION OF DESIGNATED RIDING AREAS

CHAPTER 47
SNOWMOBILES

DIVISION I
REGISTRATION, RENEWAL, TITLING, DECAL PLACEMENT
AND ACCIDENT REPORTS

CHAPTER 62
STATE FOREST CAMPING

CHAPTER 63
KEG BEER RULES

CHAPTER 64
METAL DETECTORS USE IN STATE AREAS

CHAPTER 65
FIREWORKS DISPLAYS—
STATE PARKS AND RECREATION AREAS

CHAPTER 66
SAYLORVILLE MULTIUSE TRAIL

CHAPTER 67
DEVELOPMENT AND MANAGEMENT OF RECREATION TRAILS
ON STATE FORESTS, PARKS, PRESERVES AND RECREATION AREAS

67.1(456A,461A) Applicability
67.2(456A,461A) Definitions
67.3(456A,461A) Purpose
67.4(456A,461A) Establishment of trails
67.5(456A,461A) Designation of recreation trails
67.6(456A,461A) Guidelines for trail location
67.7(456A,461A) Control of trail use
67.8(456A,461A) Use of designated trails

CHAPTERS 68 to 70
Reserved

TITLE VII
FORESTRY

CHAPTER 71
NURSERY STOCK SALE TO THE PUBLIC

71.1(456A,461A) Purpose
71.2(456A,461A) Procedures
71.3(456A,461A) Nursery stock prices

CHAPTER 72
TIMBER BUYERS

72.1(456A) Definitions
72.2(456A) Applicability of rules
72.3(456A) Forms

CHAPTER 73
FOREST AND FRUIT-TREE RESERVATIONS

73.1(427C,456A) Criteria for establishing and maintaining forest and fruit-tree reservations
73.2(427C,456A) County assessor's annual report on forest and fruit-tree reservations to the department of natural resources

CHAPTER 74
FOREST LAND ENHANCEMENT PROGRAM (FLEP)

74.1(461A) Purpose
74.2(461A) Definitions
74.3(461A) Project scope
74.4(461A) Availability of funds
74.5(461A) Forest land enhancement program areas
74.6(461A) Cost reimbursement

CHAPTER 75
Reserved

TITLE VIII
SEASONS, LIMITS, METHODS OF TAKE

CHAPTER 76
UNPROTECTED NONGAME

CHAPTER 77
ENDANGERED AND THREATENED PLANT AND ANIMAL SPECIES

CHAPTER 78
GINSENG HARVESTING AND SALE

CHAPTER 79
FISH STOCKING PROCEDURES AND FEES FOR PRIVATE WATERS

CHAPTER 80
SALVAGE OF FISH AND GAME

CHAPTER 81
FISHING REGULATIONS

CHAPTER 82
COMMERCIAL FISHING

INLAND WATERS

82.1(482) Contract policy

MISSISSIPPI AND MISSOURI RIVERS

82.2(482) Commercial taking

CHAPTER 83
SCUBA AND SKIN SPEARING OF ROUGH FISH

83.1(481A) When permitted
83.2(481A) Prohibited areas
83.3(481A) Permitted equipment
83.4(481A) Prohibited equipment
83.5(481A) Diver's flag
83.6(481A) Employees exempt

CHAPTER 84
PROMISCUOUS FISHING

84.1(481A) General

CHAPTER 85
TROTLINES

85.1(481A) Trotlines

CHAPTER 86
TURTLES

86.1(481A,482) Taking

CHAPTER 87
MUSSEL REGULATIONS

87.1(481A) Seasons, areas, methods, species, limits

CHAPTER 88
FISHING TOURNAMENTS

88.1(462A,481A) Definition
88.2(462A,481A) Permit required
88.3(462A,481A) Application procedures
88.4(462A,481A) Permit conditions

CHAPTER 89
AQUACULTURE

89.1(481A) Approved aquaculture species
89.2(481A) Importation permit
89.3(481A) Disease-free certification

CHAPTER 90
AQUATIC INVASIVE SPECIES

90.1(456A) Definitions
90.2(456A) Aquatic invasive species
90.3(456A) Restrictions
90.4(456A) Infested waters

CHAPTER 91
WATERFOWL AND COOT HUNTING SEASONS

CHAPTER 92
MIGRATORY GAME BIRDS

CHAPTER 93
COMMERCIAL USE OF CAPTIVE-REARED WATERFOWL

CHAPTER 94
NONRESIDENT DEER HUNTING

CHAPTER 95
GAME HARVEST REPORTING AND LANDOWNER-TENANT REGISTRATION

CHAPTER 96
PHEASANT, QUAIL AND GRAY (HUNGARIAN)
PARTRIDGE HUNTING SEASONS

CHAPTER 97
COMMON SNIPE, VIRGINIA RAIL AND SORA, WOODCOCK AND RUFFED GROUSE HUNTING SEASONS

CHAPTER 98
WILD TURKEY SPRING HUNTING

RESIDENT WILD TURKEY SPRING HUNTING

NONRESIDENT WILD TURKEY SPRING HUNTING

CHAPTER 99
WILD TURKEY FALL HUNTING

CHAPTER 100
CROW AND PIGEON REGULATIONS

CHAPTER 101
FALCONRY REGULATIONS

CHAPTER 111
SCIENTIFIC COLLECTING AND WILDLIFE REHABILITATION

CHAPTER 112
HUNTING PRESERVES

CHAPTER 113
RESTITUTION FOR POLLUTION CAUSING INJURY TO WILD ANIMALS

CHAPTER 114
NUISANCE WILDLIFE CONTROL

CHAPTER 115
WHITETAIL HUNTING PRESERVES

CHAPTER 116
HELP US STOP HUNGER PROGRAM ADMINISTRATION

CHAPTER 44
BOATING, SPECIAL EVENTS
[Prior to 12/31/86, Conservation Commission[290] Ch 35]

571—44.1(462A) Registration exemption. Vessels entered in special events as defined in Iowa Code section 462A.16 shall not be required to be registered as stated in 462A.4 and 462A.5, subject to the following regulations.

44.1(1) *Vessel and participant list.* Sponsors of the special event shall maintain a list of the names and addresses of all persons participating in the event and a description of each vessel in the event.

44.1(2) *Vessels identified.* Each vessel in the special event will be labeled with an identifying number or letter, clearly visible, and such will be recorded with the names and addresses of vessel passengers on the list as provided for in 44.1(1).

44.1(3) *Exemption period.* Any vessel entered into a special event may be exempted from state registration requirements for the full 24-hour period of each day covered by the permit to conduct such event and as issued under Iowa Code section 462A.16.
[**ARC 9114B**, IAB 10/6/10, effective 9/10/10]

571—44.2(462A) Sponsoring organizations. The individuals or organizations responsible for sponsoring a special event are responsible to assure regulations of this chapter are fully complied with.
[**ARC 9114B**, IAB 10/6/10, effective 9/10/10]

These rules are intended to implement Iowa Code section 462A.16.

[Filed 11/2/84, Notice 9/26/84—published 11/21/84, effective 1/1/85]
[Filed without Notice 12/12/86—published 12/31/86, effective 2/4/87]
[Filed ARC 8815B (Notice ARC 8462B, IAB 1/13/10), IAB 6/2/10, effective 7/7/10][1]
[Editorial change: IAC Supplement 6/30/10]
[Filed Emergency ARC 9114B, IAB 10/6/10, effective 9/10/10]

[1] July 7, 2010, effective date of ARC 8815B delayed for 70 days by the Administrative Rules Review Committee at its meeting held June 8, 2010.

CHAPTER 9
IOWA COMPREHENSIVE PLAN

[Prior to 4/18/90, Public Defense Department[650], Ch 6]
[Prior to 5/12/93, Disaster Services Division[607], Ch 6]
[Prior to 8/9/00, see 605—Chapter 6]

605—9.1(29C) Description. Iowa Code section 29C.8 requires the administrator of the homeland security and emergency management division to prepare a comprehensive plan for homeland security, disaster response, recovery, mitigation, and emergency resource management for the state. This comprehensive plan is comprised of the following parts:

Part A: Iowa Emergency Response Plan

Part B: Iowa Hazard Mitigation Plan

Part C: Iowa Disaster Recovery Plan

Part D: Iowa Critical Asset Protection Plan (confidential per Iowa Code section 22.7, Confidential records)

605—9.2(29C) Part A: Iowa Emergency Response Plan. The Part A: Iowa Emergency Response Plan is developed in accordance with Iowa Code section 29C.8, and has been adopted, published, and maintained by the division. Part A details the state government response to a wide range of natural, technological or human-caused disasters.

1. A copy of Part A will be placed in the state library located in the Ola Babcock Miller Building, 1112 East Grand Avenue, Des Moines, Iowa.
2. Part A shall be distributed to state agencies and departments that have been assigned emergency functions and to all county emergency management agencies.
3. The Iowa Emergency Response Plan serves as the state disaster emergency response document.
4. The division updates the plan by amendments promulgated by rule in accordance with Iowa Code chapter 17A and distributes amendments to all plan holders on the division distribution list.
5. Part A shall be available for public view at the Homeland Security and Emergency Management Division, Hoover State Office Building, Level A, Des Moines, Iowa.

605—9.3(29C) Part B: Iowa Hazard Mitigation Plan. The Part B: Iowa Hazard Mitigation Plan is developed in accordance with Iowa Code section 29C.8, and has been adopted on September 17, 2010, published, and maintained by the division. Part B details the state government goals, objectives, and strategies to mitigate a wide range of natural, technological or human-caused disasters in accordance with Section 322 of the Stafford Act, 42 U.S.C. 5165.

1. A copy of Part B will be placed in the state library located in the Ola Babcock Miller Building, 1112 East Grand Avenue, Des Moines, Iowa.
2. Part B shall be distributed to state agencies and departments that have participated in the writing of the plan or are assigned hazard mitigation functions and to all county emergency management agencies.
3. The Iowa Hazard Mitigation Plan serves as the state hazard mitigation document and demonstrates the state's commitment to reduce risks from natural, technological, and human-caused hazards and serves as a guide for the commitment of resources to reducing the effects of natural, technological, and human-caused hazards.
4. The division updates the plan by amendments promulgated by rule in accordance with Iowa Code chapter 17A and distributes amendments to all plan holders on the division distribution list. Part B shall be reviewed and amended as appropriate at a minimum of every three years.
5. Part B shall be available for public view at the Homeland Security and Emergency Management Division, Hoover State Office Building, Level A, Des Moines, Iowa.

[**ARC 9149B**, IAB 10/6/10, effective 9/17/10]

605—9.4(29C) Part C: Iowa Disaster Recovery Plan. The Part C: Iowa Disaster Recovery Plan is developed in accordance with Iowa Code section 29C.8, and has been adopted on March 20, 2008,

published, and maintained by the division. Part C details the state government goals, objectives, and strategies to recover from a wide range of natural, technological, or human-caused disasters.

1. A copy of Part C will be placed in the state library located in the Ola Babcock Miller Building, 1112 East Grand Avenue, Des Moines, Iowa.

2. Part C shall be distributed to state agencies and departments that have been assigned recovery functions and to all county emergency management agencies.

3. The Iowa Disaster Recovery Plan serves as the state disaster recovery document.

4. The division updates the plan by amendments promulgated by rule in accordance with Iowa Code chapter 17A and distributes amendments to all plan holders on the division distribution list. Part C shall be reviewed and amended as appropriate at a minimum of every three years.

5. Part C shall be available for public view at the Homeland Security and Emergency Management Division, Hoover State Office Building, Level A, Des Moines, Iowa.

These rules are intended to implement Iowa Code section 29C.8.

[Filed 4/29/77, Notice 1/12/77—published 5/18/77, effective 6/22/77[1]]
[Filed without Notice 12/8/78—published 12/27/78, effective 2/1/79]
[Filed emergency 6/5/81—published 6/24/81, effective 6/5/81]
[Filed emergency 1/28/82—published 2/17/82, effective 1/29/82]
[Filed 3/20/90, Notice 2/7/90—published 4/18/90, effective 5/23/90]
[Filed 4/22/93, Notice 3/17/93—published 5/12/93, effective 6/16/93]
[Filed 7/18/00, Notice 5/17/00—published 8/9/00, effective 9/13/00]
[Filed emergency 3/28/03—published 4/16/03, effective 3/28/03]
[Filed 5/28/03, Notice 4/16/03—published 6/25/03, effective 7/30/03]
[Filed emergency 9/10/04—published 9/29/04, effective 9/10/04]
[Filed 11/3/04, Notice 9/29/04—published 11/24/04, effective 12/29/04]
[Filed emergency 9/17/07—published 10/10/07, effective 9/17/07]
[Filed 11/14/07, Notice 10/10/07—published 12/5/07, effective 1/9/08]
[Filed 6/25/08, Notice 4/23/08—published 7/16/08, effective 8/20/08]
[Filed Emergency ARC 9149B, IAB 10/6/10, effective 9/17/10]

[1] Effective date of Chapter 6 delayed by the Administrative Rules Review Committee for 70 days pursuant to Iowa Code section 17A.4.

PUBLIC HEALTH DEPARTMENT[641]

Rules of divisions under this department "umbrella" include Substance Abuse[643], Professional Licensure[645], Dental Examiners[650], Medical Examiners[653], Nursing Board[655] and Pharmacy Examiners[657]

CHAPTER 1
REPORTABLE DISEASES, POISONINGS AND CONDITIONS, AND QUARANTINE AND ISOLATION

CHAPTER 2
HEPATITIS PROGRAMS

CHAPTER 3
EARLY HEARING DETECTION AND INTERVENTION

EARLY HEARING DETECTION AND INTERVENTION (EHDI) PROGRAM

HEARING AIDS AND AUDIOLOGIC SERVICES FUNDING PROGRAM

CHAPTER 4
CENTER FOR CONGENITAL AND INHERITED DISORDERS

CHAPTER 5
MATERNAL DEATHS

CHAPTER 6
Reserved

CHAPTER 7
IMMUNIZATION AND IMMUNIZATION EDUCATION: PERSONS ATTENDING ELEMENTARY OR SECONDARY SCHOOLS, LICENSED CHILD CARE CENTERS OR INSTITUTIONS OF HIGHER EDUCATION

CHAPTER 8
Reserved

CHAPTER 9
OUTPATIENT DIABETES EDUCATION PROGRAMS

CHAPTER 10
Reserved

CHAPTER 11
ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS)

FINANCIAL ASSISTANCE
TO ELIGIBLE HIV-INFECTED PATIENTS

CERTIFICATION OF LABORATORIES
FOR HIV TESTING

CHAPTER 12
APPROVAL OF CONFIRMATORY LABORATORIES FOR
PRIVATE SECTOR DRUG-FREE WORKPLACE TESTING

CHAPTER 13
Reserved

CHAPTER 14
WATER TREATMENT SYSTEMS

CHAPTER 15
SWIMMING POOLS AND SPAS

CHAPTER 27
PLUMBING AND MECHANICAL SYSTEMS BOARD—ADMINISTRATIVE AND REGULATORY AUTHORITY

CHAPTER 28
PLUMBING AND MECHANICAL SYSTEMS BOARD—LICENSURE FEES

CHAPTER 29
PLUMBING AND MECHANICAL SYSTEMS BOARD—APPLICATION, LICENSURE, AND EXAMINATION

CHAPTER 30
CONTINUING EDUCATION FOR PLUMBING AND MECHANICAL SYSTEMS PROFESSIONALS

CHAPTER 31
PLUMBING AND MECHANICAL SYSTEMS BOARD—WAIVERS OR VARIANCES FROM ADMINISTRATIVE RULES

CHAPTER 32
PLUMBING AND MECHANICAL SYSTEMS BOARD—LICENSEE DISCIPLINE

CHAPTER 33
PLUMBING AND MECHANICAL SYSTEMS BOARD—CONTESTED CASES

CHAPTER 39
REGISTRATION OF RADIATION MACHINE FACILITIES, LICENSURE OF RADIOACTIVE MATERIALS AND TRANSPORTATION OF RADIOACTIVE MATERIALS

CHAPTER 40
STANDARDS FOR PROTECTION AGAINST RADIATION

GENERAL PROVISIONS

RADIATION PROTECTION PROGRAMS

OCCUPATIONAL DOSE LIMITS

RADIATION DOSE LIMITS FOR INDIVIDUAL MEMBERS OF THE PUBLIC

RADIOLOGICAL CRITERIA FOR LICENSE TERMINATION

TESTING FOR LEAKAGE OR CONTAMINATION OF SEALED SOURCES

SURVEYS AND MONITORING

CONTROL OF EXPOSURE FROM EXTERNAL SOURCES IN RESTRICTED AREAS

CHAPTERS 52 to 54
Reserved

CHAPTER 55
ADVISORY COUNCIL ON HEAD INJURIES

CHAPTER 56
BRAIN INJURY SERVICES PROGRAM

CHAPTERS 57 to 66
Reserved

CHAPTER 67
BLOOD LEAD TESTING

CHAPTER 68
CONTROL OF LEAD-BASED PAINT HAZARDS

CHAPTER 69
RENOVATION, REMODELING, AND REPAINTING—
LEAD HAZARD NOTIFICATION PROCESS

CHAPTER 70
LEAD-BASED PAINT ACTIVITIES

CHAPTER 71
EMERGENCY INFORMATION SYSTEM ON PESTICIDES FOR USE BY HEALTH CARE PROVIDERS DURING MEDICAL EMERGENCIES

CHAPTER 72
CHILDHOOD LEAD POISONING PREVENTION PROGRAM

CHAPTER 73
SPECIAL SUPPLEMENTAL NUTRITION PROGRAM FOR WOMEN, INFANTS, AND CHILDREN (WIC)

CHAPTER 74
FAMILY PLANNING SERVICES

CHAPTER 79
Reserved

CHAPTER 80
LOCAL PUBLIC HEALTH SERVICES

CHAPTER 81
GENERAL RULES FOR MIGRATORY LABOR CAMPS

CHAPTER 82
OFFICE OF MULTICULTURAL HEALTH

CHAPTERS 83 and 84
Reserved

CHAPTER 85
LOCAL SUBSTITUTE MEDICAL DECISION-MAKING BOARDS

CHAPTER 86
PLACES WHERE DEAD HUMAN BODIES ARE PREPARED
FOR BURIAL OR ENTOMBMENT

CHAPTER 87
HEALTHY FAMILIES IOWA (HFI)

CHAPTER 88
VOLUNTEER HEALTH CARE PROVIDER PROGRAM

CHAPTER 89
DECISION-MAKING ASSISTANCE PROGRAM
AND PARENTAL NOTIFICATION OF INTENT
TO TERMINATE A PREGNANCY THROUGH ABORTION

CHAPTER 99
DELAYED BIRTH, DEATH AND MARRIAGE REGISTRATION

CHAPTER 100
ESTABLISHMENT OF NEW CERTIFICATES OF BIRTH

CHAPTER 101
DEATH CERTIFICATION, AUTOPSY AND DISINTERMENT

CHAPTER 102
CORRECTION AND AMENDMENT OF VITAL RECORDS

CHAPTER 103
CONFIDENTIALITY OF RECORDS

CHAPTER 104
COPIES OF VITAL RECORDS

CHAPTER 105
DECLARATION OF PATERNITY REGISTRY

CHAPTER 106
REPORTING OF TERMINATION OF PREGNANCY

CHAPTER 107
MUTUAL CONSENT VOLUNTARY ADOPTION REGISTRY

CHAPTER 108
Reserved

CHAPTER 109
PRESCRIPTION DRUG DONATION REPOSITORY PROGRAM

CHAPTERS 115 to 123
Reserved

CHAPTER 124
INTERAGENCY COORDINATING COUNCIL
FOR THE STATE MEDICAL EXAMINER

CHAPTER 125
ADVISORY COUNCIL FOR THE STATE MEDICAL EXAMINER

CHAPTER 126
STATE MEDICAL EXAMINER

CHAPTER 127
COUNTY MEDICAL EXAMINERS

CHAPTERS 128 and 129
Reserved

CHAPTER 130
EMERGENCY MEDICAL SERVICES ADVISORY COUNCIL

CHAPTER 131
EMERGENCY MEDICAL SERVICES
PROVIDER EDUCATION/TRAINING/CERTIFICATION

CHAPTER 132
EMERGENCY MEDICAL SERVICES—SERVICE PROGRAM AUTHORIZATION

CHAPTER 133
WHITE FLASHING LIGHT AUTHORIZATION

CHAPTER 141
LOVE OUR KIDS GRANT

CHAPTER 142
OUT-OF-HOSPITAL DO-NOT-RESUSCITATE ORDERS

CHAPTER 143
AUTOMATED EXTERNAL DEFIBRILLATOR PROGRAM

AUTOMATED EXTERNAL DEFIBRILLATOR GRANT PROGRAM

AUTOMATED EXTERNAL DEFIBRILLATOR MAINTENANCE

CHAPTER 144
EMERGENCY MEDICAL SERVICES—AIR MEDICAL SERVICE PROGRAM AUTHORIZATION

CHAPTERS 145 to 149
Reserved

CHAPTER 150
IOWA REGIONALIZED SYSTEM OF PERINATAL HEALTH CARE

CHAPTER 151
TOBACCO USE PREVENTION AND CONTROL
COMMUNITY PARTNERSHIP INITIATIVE

CHAPTER 152
TOBACCO USE PREVENTION AND CONTROL FUNDING PROCESS

CHAPTER 153
SMOKEFREE AIR

CHAPTER 154
Reserved

CHAPTER 155
LICENSURE STANDARDS FOR SUBSTANCE ABUSE AND PROBLEM GAMBLING TREATMENT PROGRAMS

CHAPTER 156
LICENSURE STANDARDS FOR SUBSTANCE ABUSE TREATMENT PROGRAMS IN CORRECTIONAL FACILITIES

CHAPTER 157
STANDARDS FOR SUBSTANCE ABUSE TREATMENT AND ASSESSMENT PROGRAMS AND THE OPERATING A MOTOR VEHICLE WHILE INTOXICATED (OWI) LAW

CHAPTER 158
REGIONS FOR SUBSTANCE ABUSE PREVENTION AND TREATMENT

CHAPTERS 159 to 169
Reserved

CHAPTER 170
ORGANIZATION OF THE DEPARTMENT

CHAPTER 171
PETITIONS FOR RULE MAKING

CHAPTER 172
DECLARATORY ORDERS

CHAPTER 173
CONTESTED CASES

CHAPTER 174
AGENCY PROCEDURE FOR RULE MAKING
(Uniform Rules)

CHAPTER 175
FAIR INFORMATION PRACTICES AND PUBLIC RECORDS

CHAPTER 204
UNIFORM REPORTING REQUIREMENTS

CHAPTER 91
IOWA DOMESTIC ABUSE DEATH REVIEW TEAM

641—91.1(135) Purpose. The purpose of the domestic abuse death review team is to aid in the reduction of the incidence of domestic abuse deaths by accurately identifying the cause and manner of deaths occurring from domestic violence and by making recommendations for changes in policy and practice to improve community interventions for preventing domestic abuse deaths.
[**ARC 9110B**, IAB 10/6/10, effective 11/10/10]

641—91.2(135) Definitions.

"Team" means the Iowa domestic abuse death review team.

"Unexcused absence" means failure by a team member to notify the chairperson of an anticipated absence from a team meeting.
[**ARC 9110B**, IAB 10/6/10, effective 11/10/10]

641—91.3(135) Agency. The Iowa domestic abuse death review team is established as an independent agency of state government. The Iowa department of public health shall provide staffing and administrative support to the team.
[**ARC 9110B**, IAB 10/6/10, effective 11/10/10]

641—91.4(135) Membership. The membership of the team is subject to the provisions of Iowa Code sections 69.16 and 69.16A, relating to political affiliation and gender balance. Team members who are not designated by another appointing authority shall be appointed by the director of public health, in consultation with the attorney general. At least one member shall also be a member of the Iowa child death review team. Membership terms shall be for three years. One-third of the initial members shall serve for three years, one-third of the initial members shall serve for two years, and one-third of the initial members shall serve for one year, as designated by the appointing authority.

91.4(1) The team shall include the following:

a. The state medical examiner or the state medical examiner's designee.

b. A licensed physician or nurse who is knowledgeable concerning domestic abuse injuries and deaths, including suicides.

c. A licensed mental health professional who is knowledgeable concerning domestic abuse.

d. A representative or designee of the Iowa coalition against domestic violence.

e. A certified or licensed professional who is knowledgeable concerning substance abuse.

f. A law enforcement official who is knowledgeable about domestic abuse and is a member of a state law enforcement association.

g. A law enforcement investigator experienced in domestic abuse investigation.

h. A prosecuting attorney experienced in prosecuting domestic abuse cases.

i. A member of the judiciary appointed by the chief justice of the supreme court.

j. A clerk of the district court appointed by the chief justice of the supreme court.

k. A department of correctional services' employee or subcontractor who is assigned batterers' treatment program responsibilities and is knowledgeable about risk level assessment.

l. An attorney licensed in this state who provides criminal defense assistance or child custody representation and who is experienced in dissolution of marriage proceedings.

m. Both a female and a male victim of domestic abuse.

n. A family member of a decedent whose death resulted from domestic abuse.

91.4(2) Vacancies shall be filled in the same manner in which the original appointments were made. An appointee shall complete the original member's term.

91.4(3) Three consecutive unexcused absences shall be grounds for the director to consider dismissal of the team member and the appointment of another. The chairperson of the team is charged with providing notification of absences.

91.4(4) The department may temporarily appoint other members to serve as experts, as needed, on a case-by-case basis.

91.4(5) Members of the team who are currently practicing attorneys or current employees of the judicial branch shall not participate in the following:

a. A case review involving a case in which the team member is presently involved by professional capacity.

b. Development of protocols for domestic abuse death investigations and team review.

c. Development of regulatory changes related to domestic abuse deaths.

[**ARC 9110B**, IAB 10/6/10, effective 11/10/10]

641—91.5(135) Officers. Officers of the team shall be a chairperson and a vice chairperson and shall be elected at the first meeting of each fiscal year unless designated at the time of appointment. Vacancy in the office of chairperson shall be filled by elevation of the vice chairperson. Vacancy in the office of vice chairperson shall be filled by election at the next meeting after the vacancy occurs. The chairperson shall preside at all meetings of the team, appoint such subcommittees as deemed necessary, and designate the chairperson of each subcommittee. If the chairperson is absent or unable to act, the vice chairperson shall perform the duties of the chairperson. When so acting, the vice chairperson shall have all the powers of and be subject to all restrictions upon the chairperson. The vice chairperson shall also perform such other duties as may be assigned by the chairperson.

[**ARC 9110B**, IAB 10/6/10, effective 11/10/10]

641—91.6(135) Meetings. The team shall meet upon the call of the chairperson, upon the request of a state agency, or as determined by the team. Robert's Rules of Order shall govern all meetings.

[**ARC 9110B**, IAB 10/6/10, effective 11/10/10]

641—91.7(135) Expenses of team members. The members of the team are eligible for reimbursement of actual and necessary expenses incurred in the performance of their official duties.

[**ARC 9110B**, IAB 10/6/10, effective 11/10/10]

641—91.8(135) Team duties and responsibilities.

91.8(1) The team shall perform the following duties:

a. Prepare a biennial report to the governor, supreme court, attorney general, and the general assembly concerning the following subjects:

(1) The causes and manner of domestic abuse deaths, including an analysis of factual information obtained through review of domestic abuse death certificates and domestic abuse death data, including patient records and other pertinent confidential and public information concerning domestic abuse deaths.

(2) The contributing factors of domestic abuse deaths.

(3) Recommendations regarding the prevention of future domestic abuse deaths, including actions to be taken by communities, based on an analysis of the contributing factors.

b. Advise and consult the agencies represented on the team and other state agencies regarding program and regulatory changes that may prevent domestic abuse deaths.

c. Develop protocols for domestic abuse death investigations and team review.

91.8(2) In performing duties pursuant to subrule 91.8(1), the review team shall:

a. Review information concerning the relationship between the decedent victim and the alleged or convicted perpetrator from the point when the abuse began until the death occurred in order to identify any correlation between events in the relationship and the escalation of the abuse.

b. Review documents such as orders of protection, dissolution, custody, and support or related court records.

c. Determine whether patterns regarding these events can be established in relation to domestic abuse deaths in general, and consider such conclusions in making recommendations for the biennial report.

91.8(3) The team may establish committees or panels to which the team may assign some or all of the team's responsibilities set out in this rule.

[**ARC 9110B**, IAB 10/6/10, effective 11/10/10]

641—91.9(135) Liaisons. The following individuals shall each designate a liaison to assist the team in fulfilling its responsibilities:

1. Director of public health.
2. Director of human services.
3. Commissioner of public safety.
4. Director of corrections.
5. Attorney general.
6. Director of education.
7. State court administrator.
8. Director of the law enforcement academy.
9. Director of human rights.
10. Administrator of the bureau of vital records of the department of public health.

[**ARC 9110B**, IAB 10/6/10, effective 11/10/10]

641—91.10(135) Confidentiality and disclosure of information. The team and liaisons shall maintain the confidentiality of all information and records used in the review and analysis of domestic abuse deaths, including disclosure of information which is confidential under Iowa Code chapter 22 or any other provisions of state law.

91.10(1) No information on individual deaths contained in the records described in this rule shall be disclosed except for the purposes of the team, committee or subcommittee meeting, and no confidential information received in preparation for or during the course of such meeting shall be removed from the meeting room except for further review as authorized by the team chairperson.

91.10(2) In preparation for review of an individual death by the team or its authorized committee or subcommittee, the chairperson of the team or the chairperson's designee is authorized to gather all information pertinent to the review. This information may include, but is not limited to:

a. Hospital records;
b. Physician's records;
c. School and child care records;
d. Autopsy records;
e. Child abuse registry, investigation or assessment records;
f. State public assistance records;
g. Traffic and public safety records;
h. Law enforcement records;
i. Fire marshal's records;
j. Birth and death records; and
k. Other relevant records necessary to conduct a complete review.

91.10(3) A person in possession or control of medical, investigative or other information pertaining to a domestic abuse death and related incidents and events preceding the domestic abuse death shall allow the inspection and reproduction of the information by the department upon the request of the department to be used only in the administration and for the duties of the Iowa domestic abuse death review team.

91.10(4) Information and records which are confidential under Iowa Code section 22.7 and Iowa Code chapter 235A, and information or records received from the confidential records, remain confidential under this rule.

91.10(5) A person does not incur legal liability by reason of releasing information to the department as required under and in compliance with this rule.

91.10(6) A person who releases or discloses confidential data, records, or any other type of information in violation of this rule is guilty of a serious misdemeanor.

[**ARC 9110B**, IAB 10/6/10, effective 11/10/10]

641—91.11(135) Immunity and liability.

91.11(1) Review team members and their agents are immune from any liability, civil or criminal, which might otherwise be incurred or imposed as a result of any act, omission, proceeding, decision, or determination undertaken or performed, or recommendation made as a review team member or agent

provided that the review team members or agents acted in good faith and without malice in carrying out their official duties in their official capacity.

91.11(2) A complainant bears the burden of proof in establishing malice or lack of good faith in an action brought against review team members involving the performance of their duties and powers.
[**ARC 9110B**, IAB 10/6/10, effective 11/10/10]

These rules are intended to implement Iowa Code sections 135.108 to 135.112.

[Filed 11/10/98, Notice 9/9/98—published 12/2/98, effective 1/6/99]
[Filed ARC 9110B (Notice ARC 8974B, IAB 7/28/10), IAB 10/6/10, effective 11/10/10]

CHIROPRACTIC

CHAPTER 41
LICENSURE OF CHIROPRACTIC PHYSICIANS

[Prior to 7/24/02, see 645—40.10(151) to 645—40.13(151), 645—40.15(151) and 645—40.16(151)]

645—41.1(151) Definitions. The following definitions shall be applicable to the rules of the Iowa board of chiropractic:

"Active license" means a license that is current and has not expired.

"Board" means the Iowa board of chiropractic.

"Council on Chiropractic Education" or *"CCE"* means the organization that establishes the Educational Standards of Chiropractic Colleges and Bylaws. A copy of the standards may be requested from the Council on Chiropractic Education. CCE's address and Web site may be obtained from the board's Web site at http://www.idph.state.ia.us/licensure.

"Department" means the Iowa department of public health.

"Grace period" means the 30-day period following expiration of a license when the license is still considered to be active. In order to renew a license during the grace period, a licensee is required to pay a late fee.

"Inactive license" means a license that has expired because it was not renewed by the end of the grace period. The category of "inactive license" may include licenses formerly known as lapsed, inactive, delinquent, closed, or retired.

"License" means license to practice chiropractic in Iowa.

"Licensee" means any person licensed to practice as a chiropractic physician in Iowa.

"License expiration date" means June 30 of even-numbered years.

"Licensure by endorsement" means the issuance of an Iowa license to practice chiropractic to an applicant who is or has been licensed in another state and meets the criteria for licensure in this state.

"Mandatory training" means training on identifying and reporting child abuse or dependent adult abuse required of chiropractic physicians who are mandatory reporters. The full requirements on mandatory reporting of child abuse and the training requirements are found in Iowa Code section 232.69. The full requirements on mandatory reporting of dependent adult abuse and the training requirements are found in Iowa Code section 235B.16.

"NBCE" means the National Board of Chiropractic Examiners. The mailing address and Web site address may be obtained from the board's Web site at http://www.idph.state.ia.us/licensure.

"Reactivate" or *"reactivation"* means the process as outlined in rule 41.14(17A,147,272C) by which an inactive license is restored to active status.

"Reciprocal license" means the issuance of an Iowa license to practice chiropractic to an applicant who is currently licensed in another state that has a mutual agreement with the Iowa board of chiropractic to license persons who have the same or similar qualifications to those required in Iowa.

"Reinstatement" means the process as outlined in 645—11.31(272C) by which a licensee who has had a license suspended or revoked or who has voluntarily surrendered a license may apply to have the license reinstated, with or without conditions. Once the license is reinstated, the licensee may apply for active status.

"SPEC" means Special Purposes Examination for Chiropractic, which is an examination provided by the NBCE that is designed specifically for utilization by state or foreign licensing agencies.

645—41.2(151) Requirements for licensure.

41.2(1) The following criteria shall apply to licensure:

a. An applicant shall complete a board-approved application form. Application forms may be obtained from the board's Web site (http://www.idph.state.ia.us/licensure) or directly from the Board of Chiropractic, Professional Licensure Division, Fifth Floor, Lucas State Office Building, Des Moines, Iowa 50319-0075.

b. An applicant shall complete the application form according to the instructions contained in the application. If the application is not completed according to the instructions, the application will not be reviewed by the board.

c. An applicant shall submit the appropriate fee to the Iowa Board of Chiropractic. The fee is nonrefundable.

d. No applicant shall be considered for licensure until official copies of academic transcripts are received by the board directly from a chiropractic school accredited by the CCE and approved by the board. The transcript must display the date of graduation and the degree conferred.

e. An applicant shall submit an official certificate of completion of 120 hours of physiotherapy from a board-approved chiropractic college. The physiotherapy course must include a practicum component.

f. An applicant shall pass all parts of the NBCE examination as outlined in 645—41.3(151).

g. An applicant shall submit a copy of the chiropractic diploma (no larger than 8½″ × 11″) from a chiropractic school accredited by the CCE and approved by the board.

41.2(2) Licensees who were issued their licenses within six months prior to the renewal date shall not be required to renew their licenses until the renewal date two years later.

41.2(3) Incomplete applications that have been on file in the board office for more than two years shall be:

a. Considered invalid and shall be destroyed; or

b. Maintained upon written request of the candidate. The candidate is responsible for requesting that the file be maintained.

41.2(4) Persons licensed to practice chiropractic shall keep their license publicly displayed in the primary place of practice.

41.2(5) Licensees are required to notify the board of chiropractic of changes in residence or place of practice within 30 days after the change of address occurs.

[**ARC 9109B**, IAB 10/6/10, effective 11/10/10]

645—41.3(151) Examination requirements.

41.3(1) Applicants shall submit the application for the NBCE examination and the fee directly to the NBCE.

41.3(2) The following criteria shall apply for the NBCE:

a. Prior to July 1, 1973, applicants shall provide proof of being issued a basic science certificate.

b. After July 1, 1973, applicants shall provide proof of successful completion of the required examination from the National Board of Chiropractic Examiners. The required examination shall meet the following criteria:

(1) Examinations completed after July 1, 1973, shall be defined as the successful completion of Parts I and II of the NBCE examination.

(2) Examinations completed after August 1, 1976, shall be defined as the successful completion of Parts I, II and Physiotherapy of the NBCE examination.

(3) Examinations completed after January 1, 1987, shall be defined as the successful completion of Parts I, II, III and Physiotherapy of the NBCE examination.

(4) Examinations completed after January 1, 1996, shall be defined as satisfactory completion of Parts I, II, III, IV and Physiotherapy of the NBCE examination.

645—41.4(151) Educational qualifications.

41.4(1) An applicant for licensure to practice as a chiropractic physician shall present an official transcript verifying graduation from a board-approved college of chiropractic.

41.4(2) Foreign-trained chiropractic physicians shall:

a. Provide an equivalency evaluation of their educational credentials by the International Educational Research Foundations, Inc., Credentials Evaluation Service, P.O. Box 3665, Culver City, California 90231-3665, telephone (310)258-9451,Web site www.ierf.org or E-mail at info@ierf.org. The professional curriculum must be equivalent to that stated in these rules. A candidate shall bear the expense of the curriculum evaluation.

b. Provide a notarized copy of the certificate or diploma awarded to the applicant from a chiropractic program in the country in which the applicant was educated.

c. Receive a final determination from the board regarding the application for licensure.

645—41.5(151) Temporary certificate.

41.5(1) The board may issue a temporary certificate to practice chiropractic if the issuance is in the public interest. A temporary certificate may be issued at the discretion of the board to an applicant who demonstrates a need for the temporary certificate and meets the professional qualifications for licensure.

41.5(2) Demonstrated need. An applicant must establish that a need exists for the issuance of a temporary license and that the need serves the public interest. An applicant may only meet the demonstrated need requirement by proving that the need meets one of the following conditions:

a. The applicant will provide chiropractic services in connection with a special activity, event or program conducted in this state;

b. The applicant will provide chiropractic services in connection with a state emergency as proclaimed by the governor; or

c. The applicant previously held an unrestricted license to practice chiropractic in this state and will provide gratuitous chiropractic services as a voluntary public service.

41.5(3) Professional qualifications. The applicant shall:

a. Submit the board-approved application form. Applications may be obtained from the board's Web site (http://www.idph.state.ia.us/licensure) or directly from the Board of Chiropractic, Professional Licensure Division, Fifth Floor, Lucas State Office Building, Des Moines, Iowa 50319-0075.

b. Provide verification of current active licensure in the United States sent directly to the board office from the state in which the applicant is licensed.

c. Submit proof of two years of full-time chiropractic practice within the immediately preceding two years.

d. Provide a copy of a chiropractic diploma (no larger than 8½″ × 11″) from a chiropractic school accredited by the CCE and approved by the board and submit an official certificate of completion of 120 hours of physiotherapy from a board-approved chiropractic college. The physiotherapy course must include a practicum component.

e. Submit the temporary certificate fee.

f. Submit information explaining the demonstrated need, the scope of practice requested by the applicant, and why a temporary certificate should be granted.

41.5(4) If the application is approved by the board, a temporary certificate shall be issued authorizing the applicant to practice chiropractic for one year to fulfill the demonstrated need for temporary licensure, as stated on the application and described in subrule 41.5(2).

41.5(5) An applicant or temporary certificate holder who has been denied a temporary certificate may appeal the denial pursuant to rule 41.11(17A,151,272C). A temporary certificate holder is subject to discipline for any grounds for which licensee discipline may be imposed.

41.5(6) A temporary license holder who meets all licensure conditions as specified in rule 645—41.2(151) may obtain a permanent license in lieu of the temporary certificate. To obtain a permanent license, the applicant shall submit any additional documentation required for permanent licensure that was not submitted as a part of the temporary certificate application. The applicant may receive fee credit toward the permanent licensure fee equivalent to the fee paid for the temporary permit

if the application for the permanent license and all required documentation are received by the board prior to the expiration of the temporary permit.

645—41.6(151) Licensure by endorsement.

41.6(1) An applicant who has been licensed to practice chiropractic under the laws of another jurisdiction shall file an application for licensure by endorsement with the board office.

41.6(2) The board may receive by endorsement any applicant from the District of Columbia or another state, territory, province or foreign country who:

a. Submits to the board a completed application;

b. Pays the licensure fee;

c. Provides a notarized copy of the diploma (no larger than 8½″ × 11″) along with an official copy of the transcript from a board-approved chiropractic school sent directly from the school to the board office;

d. Shows evidence of successful completion of the examination of the National Board of Chiropractic Examiners as outlined in 645—41.3(151);

e. Provides verification of license(s) from every jurisdiction in which the applicant has been licensed, sent directly from the jurisdiction(s) to the board office. Web-based verification may be substituted for verification direct from the jurisdiction's board office if the verification provides:

(1) Licensee's name;

(2) Date of initial licensure;

(3) Current licensure status; and

(4) Any disciplinary action taken against the license; and

f. Holds or has held a current license and provides evidence of one of the following requirements:

(1) Completion of 60 hours of board-approved continuing education during the immediately preceding two-year period as long as the applicant had an active practice within the last five years; or

(2) Practice as a licensed chiropractic physician for a minimum of one year during the immediately preceding two-year period; or

(3) The equivalent of one year as a full-time faculty member teaching chiropractic in an accredited chiropractic college for at least one of the immediately preceding two years; or

(4) Graduation from a board-approved chiropractic college within the immediately preceding two years from the date the application is received in the board office.

g. If the applicant does not meet the requirements of paragraph 41.6(2)*"f,"* the applicant shall submit the following:

(1) Evidence of satisfactory completion of 60 hours of board-approved continuing education during the immediately preceding two-year period; and

(2) Evidence of successful completion of the SPEC examination within one year prior to receipt of the application in the board office.

645—41.7(151) Licensure by reciprocal agreement. Rescinded IAB 8/13/08, effective 9/17/08.

645—41.8(151) License renewal.

41.8(1) The biennial license renewal period for a license to practice as a chiropractic physician shall begin on July 1 of an even-numbered year and end on June 30 of the next even-numbered year. The board shall send a renewal notice by regular mail to each licensee at the address on record at least 60 days prior to the expiration of the license. The licensee is responsible for renewing the license prior to its expiration. Failure of the licensee to receive the notice does not relieve the licensee of the responsibility for renewing the license.

41.8(2) An individual who was issued a license within six months of the license renewal date will not be required to renew the license until the subsequent renewal two years later.

41.8(3) A licensee seeking renewal shall:

a. Meet the continuing education requirements of rule 645—44.2(272C) and the mandatory reporting requirements of subrule 41.8(4). A licensee whose license was reactivated during the current

renewal compliance period may use continuing education credit earned during the compliance period for the first renewal following reactivation; and

b. Submit the completed renewal application, continuing education report form and renewal fee before the license expiration date.

41.8(4) Mandatory reporter training requirements.

a. A licensee who, in the scope of professional practice or in the licensee's employment responsibilities, examines, attends, counsels or treats children in Iowa shall indicate on the renewal application completion of two hours of training in child abuse identification and reporting in the previous five years or condition(s) for waiver of this requirement as identified in paragraph *"e."*

b. A licensee who, in the course of employment, examines, attends, counsels or treats adults in Iowa shall indicate on the renewal application completion of two hours of training in dependent adult abuse identification and reporting in the previous five years or condition(s) for waiver of this requirement as identified in paragraph *"e."*

c. A licensee who, in the scope of professional practice or in the course of employment, examines, attends, counsels, or treats both adults and children in Iowa shall indicate on the renewal application completion of training in abuse identification and reporting for dependent adults and children in the previous five years of condition(s) for waiver of this requirement as identified in paragraph *"e."*

Training may be completed through separate courses as identified in paragraphs *"a"* and *"b"* or in one combined two-hour course that includes curricula for identifying and reporting child abuse and dependent adult abuse. The course shall be a curriculum approved by the Iowa department of public health abuse education review panel.

d. The licensee shall maintain written documentation for five years after mandatory training as identified in paragraphs *"a"* to *"c,"* including program date(s), content, duration, and proof of participation.

e. The requirement for mandatory training for identifying and reporting child and dependent adult abuse shall be suspended if the board determines that suspension is in the public interest or that a person at the time of license renewal:

(1) Is engaged in active duty in the military service of this state or the United States.

(2) Holds a current waiver by the board based on evidence of significant hardship in complying with training requirements, including an exemption of continuing education requirements or extension of time in which to fulfill requirements due to a physical or mental disability or illness as identified in 645—Chapter 44.

f. The board may select licensees for audit of compliance with the requirements in paragraphs *"a"* to *"e."*

41.8(5) Upon receiving the information required by this rule and the required fee, board staff shall administratively issue a two-year license and shall send the licensee a wallet card by regular mail. In the event the board receives adverse information on the renewal application, the board shall issue the renewal license but may refer the adverse information for further consideration or disciplinary investigation.

41.8(6) A person licensed to practice as a chiropractic physician shall keep the license certificate and wallet card(s) displayed in a conspicuous public place at the primary site of practice.

41.8(7) Late renewal. The license shall become late when the license has not been renewed by the expiration date on the wallet card. The licensee shall be assessed a late fee as specified in 645—subrule 46.1(4). To renew a late license, the licensee shall complete the renewal requirements and submit the late fee within the grace period.

41.8(8) Inactive license. A licensee who fails to renew the license by the end of the grace period has an inactive license. A licensee whose license is inactive continues to hold the privilege of licensure in Iowa, but may not practice as a chiropractor in Iowa until the license is reactivated. A licensee who practices as a chiropractor in the state of Iowa with an inactive license may be subject to disciplinary action by the board, injunctive action pursuant to Iowa Code section 147.83, criminal sanctions pursuant to Iowa Code section 147.86, and other available legal remedies.

645—41.9(272C) Exemptions for inactive practitioners. Rescinded IAB 8/3/05, effective 9/7/05.

645—41.10(272C) Lapsed licenses. Rescinded IAB 8/3/05, effective 9/7/05.

645—41.11(147) Duplicate certificate or wallet card. Rescinded IAB 8/13/08, effective 9/17/08.

645—41.12(147) Reissued certificate or wallet card. Rescinded IAB 8/13/08, effective 9/17/08.

645—41.13(17A,151,272C) License denial. Rescinded IAB 8/13/08, effective 9/17/08.

645—41.14(17A,147,272C) License reactivation. To apply for reactivation of an inactive license, a licensee shall:

41.14(1) Submit a reactivation application on a form provided by the board.

41.14(2) Pay the reactivation fee that is due as specified in 645—Chapter 46.

41.14(3) Provide verification of current competence to practice as a chiropractic physician by satisfying one of the following criteria:

a. If the license has been on inactive status for five years or less, an applicant must provide the following:

(1) Verification of the license(s) from every jurisdiction in which the applicant is or has been licensed and is or has been practicing during the time period the Iowa license was inactive, sent directly from the jurisdiction(s) to the board office. Web-based verification may be substituted for verification from a jurisdiction's board office if the verification includes:

1. Licensee's name;
2. Date of initial licensure;
3. Current licensure status; and
4. Any disciplinary action taken against the license; and

(2) Verification of completion of 60 hours of continuing education that comply with standards defined in 645—44.3(151,272C) within two years of the application for reactivation.

b. If the license has been on inactive status for more than five years, an applicant must provide the following:

(1) Verification of the license(s) from every jurisdiction in which the applicant is or has been licensed and is or has been practicing during the time period the Iowa license was inactive, sent directly from the jurisdiction(s) to the board office. Web-based verification may be substituted for verification from a jurisdiction's board office if the verification includes:

1. Licensee's name;
2. Date of initial licensure;
3. Current licensure status; and
4. Any disciplinary action taken against the license; and

(2) Verification of completion of 60 hours of continuing education that comply with standards defined in 645—44.3(151,272C) within two years of application for reactivation; and

(3) Verification of passing the Special Purpose Examination for Chiropractic (SPEC) if the applicant does not have a current license and has not been in active practice in the United States during the past five years.

645—41.15(17A,147,272C) License reinstatement. A licensee whose license has been revoked, suspended, or voluntarily surrendered must apply for and receive reinstatement of the license in accordance with 645—11.31(272C) and must apply for and be granted reactivation of the license in accordance with 41.14(17A,147,272C) prior to practicing as a chiropractic physician in this state.

These rules are intended to implement Iowa Code chapters 17A, 147, 151 and 272C.

[Filed 7/3/02, Notice 5/1/02—published 7/24/02, effective 8/28/02]
[Filed 3/24/04, Notice 2/4/04—published 4/14/04, effective 5/19/04]
[Filed 7/14/05, Notice 5/25/05—published 8/3/05, effective 9/7/05]◊
[Filed 1/27/06, Notice 11/9/05—published 2/15/06, effective 3/22/06]
[Filed 1/28/08, Notice 11/7/07—published 2/27/08, effective 4/2/08]
[Filed 7/17/08, Notice 5/7/08—published 8/13/08, effective 9/17/08]◊

[Filed ARC 9109B (Notice ARC 8782B, IAB 6/2/10), IAB 10/6/10, effective 11/10/10]

◊ Two or more ARCs

CHAPTER 43
PRACTICE OF CHIROPRACTIC PHYSICIANS

[Prior to 7/24/02, see 645—40.1(151) and 645—40.17(151) to 645—40.24(147,272C)]

645—43.1(151) Definitions. The following definitions shall be applicable to the rules of the Iowa board of chiropractic.

"Active chiropractic physiotherapy" means therapeutic treatment performed by the patient with the assistance and guidance of the chiropractic assistant including, but not limited to, exercises and functional activities that promote strength, endurance, flexibility, and coordination.

"Acupuncture," pursuant to Iowa Code section 148E.1, means a form of health care developed from traditional and modern oriental medical concepts that employs oriental medical diagnosis and treatment, and adjunctive therapies and diagnostic techniques, for the promotion, maintenance, and restoration of health and the prevention of disease.

"Adjustment/manipulation of neuromusculoskeletal structures" means the use by a doctor of chiropractic of a skillful treatment based upon differential diagnosis of neuromusculoskeletal structures and procedures related thereto by the use of passive movements with the chiropractic physician's hands or instruments in a manipulation of a joint by thrust so the patient's volitional resistance cannot prevent the motion. The manipulation is directed toward the goal of restoring joints to their proper physiological relationship of motion and related function. Movement of the joint is by force beyond its active limit of motion, but within physiologic integrity. Adjustment or manipulation commences where mobilization ends and specifically begins when the elastic barrier of resistance is encountered by the doctor of chiropractic and ends at the limit of anatomical integrity. Adjustment or manipulation as described in this definition is directed to the goal of the restoration of joints to their proper physiological relationship of motion and related function, release of adhesions or stimulation of joint receptors. Adjustment or manipulation as described in this definition is by hand or instrument. The primary emphasis of this adjustment or manipulation is upon specific joint element adjustment or manipulation and treatment of the articulation and adjacent tissues of the neuromusculoskeletal structures of the body and nervous system, using one or more of the following:

1. Impulse adjusting or the use of sudden, high velocity, short amplitude thrust of a nature that patient volitional resistance is overcome, commencing where the motion encounters the elastic barrier of resistance and ending at the limit of anatomical integrity.
2. Instrument adjusting, utilizing instruments specifically designed to deliver sudden, high velocity, short amplitude thrust.
3. Light force adjusting, utilizing sustained joint traction or applied directional pressure, or both, which may be combined with passive motion to restore joint mobility.
4. Long distance lever adjusting, utilizing forces delivered at some distance from the dysfunctional site and aimed at transmission through connected structures to accomplish joint mobility.

"Anatomic barrier" means the limit of motion imposed by anatomic structure, the limit of passive motion.

"Chiropractic assistant" means a person who has satisfactorily completed a chiropractic assistant training program to perform selected chiropractic health care services under the supervision of a chiropractic physician.

"Chiropractic insurance consultant" means an Iowa-licensed chiropractic physician registered with the board who serves as a liaison and advisor to an insurance company.

"Chiropractic manipulation" means care of an articular dysfunction or neuromusculoskeletal disorder by manual or mechanical adjustment of any skeletal articulation and contiguous articulations.

"Differential diagnosis" means to examine the body systems and structures of a human subject to determine the source, nature, kind or extent of a disease, vertebral subluxation, neuromusculoskeletal disorder or other physical condition, and to make a determination of the source, nature, kind, or extent of a disease or other physical condition.

"Elastic barrier" means the range between the physiologic and anatomic barrier of motion in which passive ligamentous stretching occurs before tissue disruption.

"Extremity manipulation" means a corrective thrust or maneuver by a doctor of chiropractic by hand or instrument based upon differential diagnosis of neuromusculoskeletal structures applied to a joint of the appendicular skeleton.

"Malpractice" means any error or omission, unreasonable lack of skill, or failure to maintain a reasonable standard of care by a chiropractic physician in the practice of the profession.

"Mobilization" means movement applied singularly or repetitively within or at the physiological range of joint motion, without imparting a thrust or impulse, with the goal of restoring joint mobility.

"Passive chiropractic physiotherapy" means therapeutic treatment administered by the chiropractic assistant and received by the patient including, but not limited to, mechanical, electrical, thermal, or manual methods.

"Physiologic barrier" means the limit of active motion, which can be altered to increase range of active motion by warm-up activity.

"Practice of acupuncture," pursuant to Iowa Code section 148E.1, means the insertion of acupuncture needles and the application of moxibustion to specific areas of the human body based upon oriental medical diagnosis as a primary mode of therapy. Adjunctive therapies within the scope of acupuncture may include manual, mechanical, thermal, electrical, and electromagnetic treatment, and the recommendation of dietary guidelines and therapeutic exercise based on traditional oriental medicine concepts.

"Supervising chiropractic physician" means the Iowa-licensed chiropractor responsible for supervision of services provided to a patient by a chiropractic assistant.

"Supervision" means the physical presence and direction of the supervising chiropractic physician at the location where services are rendered.

645—43.2(147,272C) Principles of chiropractic ethics. The following principles of chiropractic ethics are hereby adopted by the board relative to the practice of chiropractic in this state.

43.2(1) These principles are intended to aid chiropractic physicians individually and collectively in maintaining a high level of ethical conduct. These are standards by which a chiropractic physician may determine the propriety of the chiropractic physician's conduct in the chiropractic physician's relationship with patients, with colleagues, with members of allied professions, and with the public.

43.2(2) The principal objective of the chiropractic profession is to render service to humanity with full respect for the dignity of the person. Chiropractic physicians should merit the confidence of patients entrusted to their care, rendering to each a full measure of service and devotion.

43.2(3) Chiropractic physicians should strive continually to improve chiropractic knowledge and skill, and should make available to their patients and colleagues the benefits of their professional attainments.

43.2(4) A chiropractic physician should practice a method of healing founded on a scientific basis, and should not voluntarily associate professionally with anyone who violates this principle.

43.2(5) The chiropractic profession should safeguard the public and itself against chiropractic physicians deficient in moral character or professional competence. Chiropractic physicians should observe all laws, uphold the dignity and honor of the profession and accept its self-imposed disciplines. They should expose, without hesitation, illegal or unethical conduct of fellow members of the profession.

43.2(6) A chiropractic physician may choose whom to serve. In an emergency, however, services should be rendered to the best of the chiropractic physician's ability. Having undertaken the case of a patient, the chiropractic physician may not neglect the patient; and, unless the patient has been discharged, the chiropractic physician may discontinue services only after giving adequate notice.

43.2(7) A chiropractic physician should not dispose of services under terms or conditions which tend to interfere with or impair the free and complete exercise of professional judgment and skill or tend to cause a deterioration of the quality of chiropractic care.

43.2(8) A chiropractic physician should seek consultation upon request, in doubtful or difficult cases, or whenever it appears that the quality of chiropractic service may be enhanced thereby.

43.2(9) A chiropractic physician may not reveal the confidences entrusted in the course of chiropractic attendance, or the deficiencies observed in the character of patients, unless required to do so by law or unless it becomes necessary in order to protect the welfare of the individual or of the community.

43.2(10) The honored ideals of the chiropractic profession imply that the responsibilities of the chiropractic physician extend not only to the individual, but also to society where these responsibilities deserve interest and participation in activities which have the purpose of improving both the health and well-being of the individual and the community.

645—43.3(514F) Utilization and cost control review.

43.3(1) The board shall establish utilization and cost control review (UCCR) committee(s). A UCCR committee shall be established by approval of the board upon a showing that the committee meets the requirements of this rule. The name of each committee and a list of committee members shall be on file with the board and available to the public. As a condition of board approval, each committee shall agree to submit to the board an annual report which meets the requirements of this rule.

43.3(2) Each member of a UCCR committee shall:

a. Hold a current license in Iowa.

b. Have practiced chiropractic in the state of Iowa for a minimum of five years prior to appointment.

c. Be actively involved in a chiropractic practice during the term of appointment as a UCCR committee member.

d. Have no pending disciplinary action, no disciplinary action taken during the three years prior to appointment, and no disciplinary action pending or taken during the period of appointment.

e. Have no malpractice judgment awarded or settlement paid during the three years prior to appointment or during the period of appointment.

f. Not assist in the review or adjudication of claims in which the committee member may reasonably be presumed to have a conflict of interest.

g. Rescinded IAB 5/10/06, effective 6/14/06.

43.3(3) Procedures for utilization and cost control review. A request for review may be made to the UCCR committee by any person governed by the various chapters of Title XIII, subtitle 1, of the Iowa Code, self-insurers for health care benefits to employees, other third-party payers, chiropractic patients or licensees.

a. There shall be a reasonable fee, as established by the UCCR committee and approved by the board, for services rendered, which will be made payable directly to the UCCR committee that conducts the review. Each UCCR committee approved by the board shall make a yearly accounting to the board.

b. A request for service shall be submitted to the executive director of the UCCR committee on a submission form approved by the board, and shall be accompanied by the number of copies required by the UCCR committee.

c. The UCCR committee shall respond in writing to the parties involved with its findings and recommendations within 90 days of the date the request for review was submitted. The committee shall review the appropriateness of levels of treatment and give an opinion as to the reasonableness of charges for diagnostic or treatment services rendered as requested.

43.3(4) Types of cases reviewed shall include:

a. Utilization.

(1) Frequency of treatment;

(2) Amount of treatment;

(3) Necessity of service;

(4) Appropriateness of treatment.

b. Usual and customary service.

43.3(5) Criteria for review may include but are not limited to:

a. Was diagnosis compatible and consistent with information?

b. Were X-ray and other examination procedures adequate, or were they insufficient or unrelated to history or diagnosis?

c. Were clinical records adequate, complete, and of sufficient frequency?

d. Was treatment consistent with diagnosis?

e. Was treatment program consistent with scientific knowledge and with academic and clinical training provided in accredited chiropractic colleges?

f. Were charges reasonable and customary for the service?

43.3(6) Confidentiality. Members of the UCCR committee shall observe the requirements of confidentiality imposed by Iowa Code chapter 272C.

43.3(7) Annual report. Each UCCR committee shall annually submit a report to the board, and shall meet to review that report with the board chairperson or designee upon the board's request. The annual report shall include the following information:

a. The fee to be charged the party requesting UCCR review.

b. A report regarding the activities of the committee for the past year, including a report regarding each review conducted, the conclusions reached regarding that review, and any recommendations made following the review.

43.3(8) A conclusion or recommendation, or both, made by a UCCR committee does not constitute a decision of the board.

645—43.4(151) Chiropractic insurance consultant.

43.4(1) A chiropractic insurance consultant advises insurance companies, third-party administrators and other similar entities of Iowa standards of (a) recognized and accepted chiropractic services and procedures permitted by the Iowa Code and administrative rules and (b) the propriety of chiropractic diagnosis and care.

43.4(2) All licensees who review chiropractic records for the purposes of determining the adequacy or sufficiency of chiropractic treatments, or the clinical indication for those treatments, shall notify the board annually that they are engaged in those activities and of the location where those activities are performed.

43.4(3) Licensed chiropractic physicians shall not hold themselves out as chiropractic insurance consultants unless they meet the following requirements:

a. Hold a current license in Iowa.

b. Have practiced chiropractic in the state of Iowa during the immediately preceding five years.

c. Are actively involved in a chiropractic practice during the term of appointment as a chiropractic insurance consultant. Active practice includes but is not limited to maintaining an office location and providing clinical care to patients.

645—43.5(151) Acupuncture. A chiropractic physician who engages in the practice of acupuncture shall maintain documentation that shows the chiropractic physician has successfully completed a course in acupuncture consisting of at least 100 hours of traditional, in-person classroom instruction with the instructor on site. The licensee shall maintain a transcript or certification of completion showing the licensee's name, school or course sponsor's name, date of course completion or graduation, grade or other evidence of successful completion, and number of course hours. The licensee shall provide the transcript or certification of completion to the board upon request.

[**ARC 9109B**, IAB 10/6/10, effective 11/10/10]

645—43.6(151) Nonprofit nutritional product sales. Rescinded IAB 11/26/03, effective 12/31/03.

645—43.7(151) Adjunctive procedures.

43.7(1) Adjunctive procedures are defined as procedures related to differential diagnosis.

43.7(2) For any applicant for licensure to practice chiropractic in the state of Iowa who chooses to be tested in limited adjunctive procedures, those limited procedures must be adequate for the applicant to come to a differential diagnosis in order to pass the examination.

43.7(3) Applicants for licenses to practice chiropractic who refuse to utilize any of the adjunctive procedures which they have been taught in approved colleges of chiropractic must adequately show the board that they can come to an adequate differential diagnosis without the use of adjunctive procedures.

645—43.8(151) Physical examination. The chiropractic physician is to perform physical examinations to determine human ailments, or the absence thereof, utilizing principles taught by chiropractic colleges. Physical examination procedures shall not include prescription drugs or operative surgery.

645—43.9(151) Gonad shielding. Gonad shielding of not less than 0.25 millimeter lead equivalent shall be used for chiropractic patients who have not passed the reproductive age during radiographic procedures in which the gonads are in the useful beam, except for cases in which this would interfere with the diagnostic procedures.

645—43.10(151) Record keeping.

43.10(1) Chiropractic physicians shall maintain clinical records in a manner consistent with the protection of the welfare of the patient. Records shall be timely, dated, chronological, accurate, signed or initialed, legible, and easily understandable. Record-keeping rules apply to all patient records whether handwritten, typed or maintained electronically. Electronic signatures are acceptable when the record has been reviewed by the physician whose signature appears on the record.

43.10(2) Chiropractic physicians shall maintain clinical records for each patient. The clinical records shall, at a minimum, include all of the following:

a. Personal data.

(1) Name;

(2) Date of birth;

(3) Address; and

(4) Name of parent or guardian if a patient is a minor.

b. Health history. Records shall include information from the patient or the patient's parent or guardian regarding the patient's health history.

c. Patient's reason for visit. When a patient presents with a chief complaint, clinical records shall include the patient's stated health concerns.

d. Clinical examination progress notes. Records shall include chronological dates and descriptions of the following:

(1) Clinical examination findings, tests conducted, a summary of all pertinent diagnoses, and updated health assessments;

(2) Plan of intended treatment, including description of treatment, frequency and duration;

(3) Services rendered and any treatment complications;

(4) All testing ordered or performed;

(5) Diagnostic imaging report if imaging procedure is ordered or performed;

(6) Sufficient data to support the recommended treatment plan.

e. Clinical record. Each page of the clinical record shall include the patient's name, the date information was recorded and the doctor's name or facility's name.

43.10(3) Retention of records. A chiropractic physician shall maintain a patient's record(s) for a minimum of six years after the date of last examination or treatment. Records for minors shall be maintained for one year after the patient reaches the age of majority (18) or six years after the date of last examination or treatment, whichever is longer. Proper safeguards shall be maintained to ensure the safety of records from destructive elements. This provision includes both clinical and fiscal records.

43.10(4) Electronic record keeping. When electronic records are utilized, a chiropractic physician shall maintain either a duplicate hard-copy record or a backup electronic record.

43.10(5) Correction of written records. Notations shall be legible, written in ink, and contain no erasures or whiteouts. If incorrect information is placed in the record, it must be crossed out with a single nondeleting line. Entries recorded at a time other than the date of the patient encounter must include the date of the entry and the initials of the author.

43.10(6) Correction of electronic records. Any alterations made after the date of service shall be visibly recorded. All alterations shall include a notation setting forth the date of alteration and identification of the author. Entries recorded at a time other than the date of the patient encounter must include the date of the entry and the initials of the author.

43.10(7) Abbreviations shall be standard and common to all health care disciplines. Nonstandard abbreviations shall be referenced with a key that is included in the record when the record is requested.

43.10(8) Confidentiality and transfer of records. Chiropractic physicians shall preserve the confidentiality of patient records. Upon signed request of the patient, the chiropractic physician shall furnish such records or copies of the records as directed by the patient within 30 days. A notation indicating the items transferred, date and method of transfer shall be maintained in the patient record. The chiropractic physician may charge a reasonable fee for duplication of records, but may not refuse to transfer records for nonpayment of any fees. In certain instances a summary of the record may be more beneficial for the future treatment of the patient; however, if a third party requests copies of the original documentation, that request must be honored.

43.10(9) Retirement or discontinuance of practice. A licensee, upon retirement, discontinuation of the practice of chiropractic, leaving a practice, or moving from a community, shall:

a. Notify all active patients, in writing and by publication, once a week for three consecutive weeks in a newspaper of general circulation in the community. The notification shall include the following information:

(1) That the licensee intends to discontinue the practice of chiropractic in the community and that patients are encouraged to seek the services of another licensee; and

(2) How patients can obtain their records, including the name and contact information of the records custodian.

b. Make reasonable arrangements with active patients for the transfer of patient records, or copies of those records, to the succeeding licensee.

c. For the purposes of this subrule, "active patient" means a person whom the licensee has examined, treated, cared for, or otherwise consulted with during the one-year period prior to retirement, discontinuation of the practice of chiropractic, leaving a practice, or moving from a community.

43.10(10) Record-keeping procedures and standards shall be utilized for all individuals who receive treatment from a chiropractic physician in all sites where care is provided.

43.10(11) A chiropractic physician who offers a prepayment plan for chiropractic services shall:

a. Have a written prepayment policy statement that is maintained in the office and available to patients upon request. The policy statement, at a minimum, shall include provisions that:

(1) Prepaid funds will not be expended until services are provided; and

(2) The patient shall receive a prompt refund of any unused funds upon request. The refund shall be calculated based on a defined method, which shall be clearly set forth in the written prepayment policy statement.

b. Require the patient to sign and date a prepayment document that incorporates the conditions and descriptions of the written prepayment policy statement.

c. Maintain the signed and dated written prepayment policy statement in the patient's record.

[**ARC 9109B**, IAB 10/6/10, effective 11/10/10]

645—43.11(151) Billing procedures.

43.11(1) Chiropractic physicians shall maintain accurate billing records for each patient. Records may be stored on paper or electronically. The records shall contain all of the following:

a. Name, date of birth and address.

b. Diagnosis indicated with description or ICD code.

c. Services provided with description or CPT code.

d. Dates of services provided.

e. Charges for each service provided.

f. Payments made for each service and indication of the party providing payment.

g. Dates payments are made.

h. Balance due for any outstanding charges.

43.11(2) Chiropractic physicians shall preserve the confidentiality of billing records.

43.11(3) Upon signed request of the patient, the chiropractic physician shall furnish billing records or copies of the records as directed by the patient within 30 days. The chiropractic physician may charge a reasonable fee for duplication of records, but may not refuse to transfer records for nonpayment of any fees.

43.11(4) Each chiropractic physician is responsible for the accuracy and validity of billings submitted under the chiropractic physician's name.

43.11(5) Chiropractic physicians:

a. Who are owners, operators, members, partners, shareholders, officers, directors, or managers of a chiropractic clinic will be responsible for the policies, procedures and billings generated by the clinic.

b. Who provide clinical services are required to familiarize themselves with the clinic's billing practices to ensure that the services rendered are accurately reflected in the billings generated. In the event an error occurs which results in an overbilling, the licensee must promptly make reimbursement of the overbilling whether or not the licensee is in any way compensated for such reimbursement by an employer, agent or any other individual or business entity responsible for such error.

43.11(6) A chiropractic physician has a right to review and correct all billings submitted under the chiropractic physician's name or identifying number(s). Signature stamps or electronically generated signatures shall be utilized only with the authorization of the chiropractic physician whose name or signature is designated. Such authorization may be revoked at any time in writing by the chiropractic physician.

43.11(7) Chiropractic physicians shall not knowingly:

a. Increase charges when a patient utilizes a third-party payment program.

b. Report incorrect dates or types of service on any billing documents.

c. Submit charges for services not rendered.

d. Submit charges for services rendered which are not documented in a patient's record.

e. Bill patients or make claims under a third-party payer contract for chiropractic services that have not been performed.

f. Bill patients or make claims under a third-party payer contract in a manner which misrepresents the nature of the chiropractic services that have been performed.

43.11(8) For cases not involving third-party payers, nothing in this rule shall prevent a chiropractic physician from providing a fee reduction for reasonable time of service or substantiated hardship cases. The chiropractic physician shall document time of service or hardship case fee reduction provisions in the patient record.

43.11(9) The chiropractic physician shall not enter into an agreement to waive, abrogate, or rebate the deductible or copayment amounts of any third-party payer contract by forgiving any or all of any patient's obligation for payment thereunder, except in substantiated hardship cases, unless the third-party payer is notified in writing of the fact of such waiver, abrogation, rebate, or forgiveness in accordance with the third-party payer contract. The chiropractic physician shall document any hardship case fee reduction provisions in the patient record.

645—43.12(151) Chiropractic assistants. The requirements of this rule shall become effective on July 1, 2009.

43.12(1) *Supervisory responsibilities of the chiropractic physician.*

a. The supervising chiropractic physician shall ensure at all times that the chiropractic assistant has the necessary training and skills as required by these rules to competently perform the delegated services.

b. The supervising chiropractic physician may delegate services to a chiropractic assistant that are within the scope of practice of the chiropractic physician in a manner consistent with these rules. Violation of these rules shall be grounds for discipline under 645—Chapter 45.

c. A chiropractic physician shall not delegate to the chiropractic assistant the following:

(1) Services outside the chiropractic physician's scope of practice;

(2) Initiation, alteration, or termination of chiropractic treatment programs;

(3) Chiropractic manipulation and adjustments;

(4) Diagnosis of a condition.

d. A supervising chiropractic physician shall ensure that a chiropractic assistant is informed of the supervisor and chiropractic assistant relationship and is responsible for all services performed by the chiropractic assistant.

43.12(2) *Education requirements for chiropractic assistants.*

a. The supervising chiropractic physician shall ensure that a chiropractic assistant has completed a chiropractic assistant training program. A chiropractic assistant training program shall include training and instruction on the use of chiropractic physiotherapy procedures related to services to be provided by the chiropractic assistant. Any chiropractic assistant training program shall be provided by an approved CCE-accredited chiropractic college.

b. Chiropractic assistants performing active chiropractic physiotherapy procedures are required to complete 12 hours of instruction, of which 6 hours shall be clinical experience under the supervision of the chiropractic physician.

c. Chiropractic assistants performing passive chiropractic physiotherapy procedures are required to complete 12 hours of instruction, of which 6 hours shall be clinical experience under the supervision of the chiropractic physician.

d. If both paragraphs *"b"* and *"c"* apply, then 12 hours of instruction for active chiropractic physiotherapy procedures and 12 hours of instruction for passive chiropractic physiotherapy procedures shall be required for a total of 24 hours of instruction.

e. The supervising chiropractic physician shall provide a written attestation to the chiropractic college that the chiropractic assistant has completed the clinical experience. The college shall issue a separate certificate of completion for the active or passive chiropractic training program as defined in paragraphs *"b,""c"* and *"d"* of this subrule.

f. The chiropractic physician shall maintain in the chiropractic physician's primary place of business proof of the chiropractic assistant's completion of the training program. Copies of such documents shall be provided to the board upon request.

These rules are intended to implement Iowa Code chapter 151.

[Filed 7/3/02, Notice 5/1/02—published 7/24/02, effective 8/28/02]
[Filed 11/6/03, Notice 7/23/03—published 11/26/03, effective 12/31/03]
[Filed 4/13/06, Notice 2/15/06—published 5/10/06, effective 6/14/06]
[Filed 1/28/08, Notice 11/7/07—published 2/27/08, effective 4/2/08]
[Filed 7/17/08, Notice 5/7/08—published 8/13/08, effective 9/17/08]
[Filed ARC 9109B (Notice ARC 8782B, IAB 6/2/10), IAB 10/6/10, effective 11/10/10]

CHAPTER 44
CONTINUING EDUCATION FOR CHIROPRACTIC PHYSICIANS
[Prior to 7/24/02, see 645—Ch 43]

645—44.1(151) Definitions. For the purpose of these rules, the following definitions shall apply:

"Active license" means a license that is current and has not expired.

"Approved program/activity" means a continuing education program/activity meeting the standards set forth in these rules.

"Audit" means the selection of licensees for verification of satisfactory completion of continuing education requirements during a specified time period.

"Board" means the board of chiropractic.

"Continuing education" means planned, organized learning acts acquired during licensure designed to maintain, improve, or expand a licensee's knowledge and skills in order for the licensee to develop new knowledge and skills relevant to the enhancement of practice, education, or theory development to improve the safety and welfare of the public.

"Hour of continuing education" means at least 50 minutes spent by a licensee in actual attendance at and completion of an approved continuing education activity.

"Inactive license" means a license that has expired because it was not renewed by the end of the grace period. The category of "inactive license" may include licenses formerly known as lapsed, inactive, delinquent, closed, or retired.

"Independent study" means a subject/program/activity that a person pursues autonomously that meets standards for approval criteria in the rules and includes a posttest and certificate of completion.

"License" means license to practice.

"Licensee" means any person licensed to practice as a chiropractic physician in the state of Iowa.

[**ARC 9109B**, IAB 10/6/10, effective 11/10/10]

645—44.2(272C) Continuing education requirements.

44.2(1) The biennial continuing education compliance period shall extend for a two-year period beginning on July 1 of each even-numbered year and ending on June 30 of each even-numbered year two years later. Each biennium, each person who is licensed to practice as a licensee in this state shall be required to complete a minimum of 60 hours of continuing education approved by the board.

44.2(2) Rescinded IAB 8/3/05, effective 9/7/05.

44.2(3) Requirements of new licensees. Those persons licensed for the first time shall not be required to complete continuing education as a prerequisite for the first renewal of their licenses with the exception of two hours in the content areas of Iowa Administrative Code, 645—Chapters 40 through 46 and Iowa Code chapter 151. Continuing education hours acquired anytime from the initial licensing until the second license renewal with the exception of two hours in the content areas of Iowa Administrative Code, 645—Chapters 40 through 46 and Iowa Code chapter 151 may be used. The new licensee will be required to complete a minimum of 60 hours of continuing education per biennium for each subsequent license renewal.

44.2(4) Hours of continuing education credit may be obtained by attending and participating in a continuing education activity. These hours must be in accordance with these rules.

44.2(5) No hours of continuing education shall be carried over into the next biennium except as stated in 44.2(3) and 44.3(2)*"a"*(3). A licensee whose license is reactivated during the current renewal compliance period may use continuing education earned during the compliance period for the first renewal following reactivation.

44.2(6) It is the responsibility of each licensee to finance the cost of continuing education.

645—44.3(151,272C) Standards.

44.3(1) *General criteria.* A continuing education activity which meets all of the following criteria is appropriate for continuing education credit if the continuing education activity:

a. Constitutes an organized program of learning which contributes directly to the professional competency of the licensee;

b. Pertains to subject matters which integrally relate to the practice of the profession;

c. Is conducted by individuals who have specialized education, training and experience by reason of which said individuals should be considered qualified concerning the subject matter of the program. At the time of audit, the board may request the qualifications of presenters;

d. Fulfills stated program goals, objectives, or both; and

e. Provides proof of attendance to licensees in attendance including:

(1) Date(s), location, course title, presenter(s);

(2) Number of program clock hours; and

(3) Certificate of completion or evidence of successful completion of the course provided by the course sponsor.

44.3(2) *Specific criteria.*

a. Continuing education hours of credit shall be obtained by completing:

(1) At least 36 hours of continuing education credit obtained from a program that directly relates to clinical case management of chiropractic patients. Beginning with the July 1, 2008, to June 30, 2010, renewal cycle, at least 24 of these hours shall be earned by completing a program in which an instructor conducts the class employing either a traditional in-person classroom-type presentation or a live presentation through the Iowa Communications Network (ICN). The remaining 12 hours may be obtained by independent study, including on-line instruction.

(2) A minimum of two hours per biennium in professional boundaries regarding ethical issues related to professional conduct that may include but are not limited to sexual harassment, sensitivity training and ethics.

(3) Starting with the 2006 renewal cycle, a minimum of 12 hours per biennium of continuing education in the field of acupuncture if the chiropractic physician is engaged in the practice of acupuncture. Continuing education hours in the field of acupuncture earned between December 31, 2003, and June 30, 2004, up to a maximum of 12 hours may be used to satisfy licensure renewal requirements for either the 2004 or 2006 renewal cycle. The licensee may use the earned continuing education credit hours only once. Credit can not be duplicated for both the 2004 and 2006 compliance periods.

(4) Classes on child abuse and dependent adult abuse that meet the criteria in subrule 44.3(1).

(5) Two hours of continuing education credit at the time of the first biennial renewal period and one hour every biennial renewal period after that in the content areas of Iowa Administrative Code, 645—Chapters 40 through 46 and Iowa Code chapter 151.

b. Continuing education hours of credit may be obtained by:

(1) Teaching at a Council on Chiropractic Education (CCE)-approved program or board of chiropractic-approved institution. A maximum of 15 hours per biennium may be obtained for each course taught.

(2) Completing electronically transmitted programs/activities or independent study programs/activities that have a certificate of completion that meets criteria in 645—44.3(151,272C).

(3) A licensee who is a presenter of a continuing education program that meets criteria in 645—44.3(151,272C) may receive credit once per biennium for the initial presentation of the program.

(4) Completing continuing education that meets criteria in 645—44.3(151,272C) or a program provided by a CCE-accredited chiropractic college in the United States, the Iowa Chiropractic Society, American Chiropractic Association or International Chiropractors Association.

(5) Completing continuing education courses/programs that are certified by the Providers of Approved Continuing Education (PACE) through the Federation of Chiropractic Licensing Boards (FCLB).

(6) Proctoring at the NBCE examination. Fifteen hours of continuing education hours per NBCE examination event may be claimed up to a maximum of 30 hours of continuing education credit per biennium. The proctoring hours may apply toward the clinical requirement.

c. Continuing education may not be obtained by completing or teaching classes in basic anatomy and physiology or undergraduate level coursework.

44.3(3) *Specific criteria for presenters.* All instructors/presenters of a continuing education activity must include, as part of the continuing education activity, verbal and written statements to the participants regarding any affiliations or employment relationships with any entity promoting, developing or marketing products, services, procedures or treatment methods.
[**ARC 9109B**, IAB 10/6/10, effective 11/10/10]

645—44.4(151,272C) Audit of continuing education report. Rescinded IAB 8/13/08, effective 9/17/08.

645—44.5(151,272C) Automatic exemption. Rescinded IAB 8/13/08, effective 9/17/08.

645—44.6(272C) Continuing education exemption for disability or illness. Rescinded IAB 8/13/08, effective 9/17/08.

645—44.7(151,272C) Grounds for disciplinary action. Rescinded IAB 8/13/08, effective 9/17/08.

645—44.8(272C) Continuing education exemption for inactive practitioners. Rescinded IAB 8/3/05, effective 9/7/05.

645—44.9(272C) Continuing education exemption for disability or illness. Rescinded IAB 8/3/05, effective 9/7/05.

645—44.10(272C) Reinstatement of inactive practitioners. Rescinded IAB 8/3/05, effective 9/7/05.

645—44.11(272C) Hearings. Rescinded IAB 8/3/05, effective 9/7/05.

These rules are intended to implement Iowa Code section 272C.2 and chapter 151.

[Filed 12/8/00, Notice 10/18/00—published 12/27/00, effective 1/31/01[1]]
[Filed 7/3/02, Notice 5/1/02—published 7/24/02, effective 8/28/02]
[Filed 11/6/03, Notice 7/23/03—published 11/26/03, effective 12/31/03]
[Filed emergency 5/14/04—published 6/9/04, effective 5/14/04]
[Filed 7/14/05, Notice 5/25/05—published 8/3/05, effective 9/7/05]◊
[Filed 1/27/06, Notice 11/9/05—published 2/15/06, effective 3/22/06]
[Filed 4/13/06, Notice 2/15/06—published 5/10/06, effective 6/14/06]
[Filed 1/28/08, Notice 11/7/07—published 2/27/08, effective 4/2/08]
[Filed 7/17/08, Notice 5/7/08—published 8/13/08, effective 9/17/08]◊
[Filed ARC 9109B (Notice ARC 8782B, IAB 6/2/10), IAB 10/6/10, effective 11/10/10]

◊ Two or more ARCs

1 Effective date delayed 70 days by the Administrative Rules Review Committee at its meeting held January 29, 2001; delay lifted by the committee at its meeting held February 9, 2001, effective 2/10/01.

CHAPTER 45
DISCIPLINE FOR CHIROPRACTIC PHYSICIANS
[Prior to 7/24/02, see 645—Ch 44]

645—45.1(151) Definitions.

"Board" means the board of chiropractic.

"Discipline" means any sanction the board may impose upon licensees.

"Licensee" means a person licensed to practice as a chiropractic physician in Iowa.

645—45.2(151,272C) Grounds for discipline. The board may impose any of the disciplinary sanctions provided in rule 645—45.3(147,272C) when the board determines that the licensee is guilty of any of the following acts or offenses:

45.2(1) Fraud in procuring a license. Fraud in procuring a license includes, but is not limited to, an intentional perversion of the truth in making application for a license to practice in this state, which includes the following:

a. False representations of a material fact, whether by word or by conduct, by false or misleading allegations, or by concealment of that which should have been disclosed when making application for a license in this state, or

b. Attempting to file or filing with the board or the department of public health any false or forged diploma or certificate or affidavit or identification or qualification in making an application for a license in this state.

45.2(2) Professional incompetency. Professional incompetency includes, but is not limited to:

a. A substantial lack of knowledge or ability to discharge professional obligations within the scope of practice.

b. A substantial deviation from the standards of learning or skill ordinarily possessed and applied by other chiropractic physicians in the state of Iowa acting in the same or similar circumstances.

c. A failure to exercise the degree of care which is ordinarily exercised by the average chiropractic physician acting in the same or similar circumstances.

d. Failure to conform to the minimal standard of acceptable and prevailing practice of a chiropractic physician in this state.

e. Inability to practice with reasonable skill and safety by reason of illness, drunkenness, excessive use of drugs, narcotics, chemicals, or other type of material or as a result of a mental or physical condition.

f. Being adjudged mentally incompetent by a court of competent jurisdiction.

g. Failure to maintain a patient's record(s) for a minimum of six years after the date of last examination or treatment. Records for minors shall be maintained for one year after the patient reaches the age of majority (18) or six years after the date of last examination or treatment, whichever is longer. Proper safeguards shall be maintained to ensure the safety of records from destructive elements. This provision includes both clinical and fiscal records.

45.2(3) Knowingly making misleading, deceptive, untrue or fraudulent representations in the practice of the profession or engaging in unethical conduct or practice harmful or detrimental to the public. This includes representations utilizing the term "physical therapy" when informing the public of the services offered by the chiropractic physician unless a licensed physical therapist is performing such services. Nothing herein shall be construed as prohibiting a chiropractic physician from making representations regarding physiotherapy that may be the same as, or similar to, physical therapy or physical medicine as long as treatment is appropriate as authorized in Iowa Code chapter 151. Proof of actual injury need not be established.

45.2(4) Practice outside the scope of the profession.

45.2(5) Use of untruthful or improbable statements in advertisements. Use of untruthful or improbable statements in advertisements includes, but is not limited to, an action by a licensee in making information or intention known to the public which is false, deceptive, misleading or promoted through fraud or misrepresentation or representations that are likely to cause the average person to misunderstand.

45.2(6) Habitual intoxication or addiction to the use of drugs.

45.2(7) Obtaining, possessing, attempting to obtain or possess, or administering controlled substances without lawful authority.

45.2(8) Falsification of client records.

45.2(9) Acceptance of any fee by fraud or misrepresentation.

45.2(10) Negligence by the licensee in the practice of the profession. Negligence by the licensee in the practice of the profession includes a failure to exercise due care including negligent delegation of duties or supervision of employees or other individuals, whether or not injury results; or any conduct, practice or conditions which impair the ability to safely and skillfully practice the profession.

45.2(11) Conviction of a crime related to the profession or occupation of the licensee or the conviction of any crime that would affect the licensee's ability to practice within the profession. A copy of the record of conviction or plea of guilty shall be conclusive evidence.

45.2(12) Violation of a regulation or law of this state, another state, or the United States, which relates to the practice of the profession.

45.2(13) Revocation, suspension, or other disciplinary action taken by a licensing authority of this state, another state, territory, or country; or failure by the licensee to report in writing to the board revocation, suspension, or other disciplinary action taken by a licensing authority within 30 days of the final action. A stay by an appellate court shall not negate this requirement; however, if such disciplinary action is overturned or reversed by a court of last resort, the report shall be expunged from the records of the board.

45.2(14) Failure of a licensee or an applicant for licensure in this state to report any voluntary agreements restricting the practice of the profession in another state, district, territory or country.

45.2(15) Failure to notify the board of a criminal conviction within 30 days of the action, regardless of the jurisdiction where it occurred.

45.2(16) Failure to notify the board within 30 days after occurrence of any judgment or settlement of a malpractice claim or action.

45.2(17) Engaging in any conduct that subverts or attempts to subvert a board investigation.

45.2(18) Failure to comply with a subpoena issued by the board, or otherwise fail to cooperate with an investigation of the board.

45.2(19) Failure to comply with the terms of a board order or the terms of a settlement agreement or consent order.

45.2(20) Failure to pay costs assessed in any disciplinary action.

45.2(21) Submission of a false report of continuing education or failure to submit the biennial report of continuing education.

45.2(22) Failure to report another licensee to the board for any violations listed in these rules, pursuant to Iowa Code section 272C.9.

45.2(23) Knowingly aiding, assisting, procuring, or advising a person to unlawfully practice as a chiropractic physician.

45.2(24) Failure to report a change of name or address within 30 days after it occurs.

45.2(25) Representing oneself as a chiropractic physician when one's license has been suspended or revoked, or when one's license is on inactive status.

45.2(26) Permitting another person to use the licensee's license for any purposes.

45.2(27) Permitting an unlicensed employee or person under the licensee's control to perform activities requiring a license.

45.2(28) Unethical conduct. In accordance with Iowa Code section 147.55(3), behavior (i.e., acts, knowledge, and practices) which constitutes unethical conduct may include, but need not be limited to, the following:

a. Verbally or physically abusing a patient, client or coworker.

b. Improper sexual contact with, or making suggestive, lewd, lascivious or improper remarks or advances to a patient, client or coworker.

c. Betrayal of a professional confidence.

d. Engaging in a professional conflict of interest.

45.2(29) Failure to comply with universal precautions for preventing transmission of infectious diseases as issued by the Centers for Disease Control and Prevention of the United States Department of Health and Human Services.

45.2(30) Violation of the terms of an initial agreement with the impaired practitioner review committee or violation of the terms of an impaired practitioner recovery contract with the impaired practitioner review committee.

[**ARC 8625B**, IAB 3/24/10, effective 4/28/10; **ARC 9109B**, IAB 10/6/10, effective 11/10/10]

645—45.3(147,272C) Method of discipline. The board has the authority to impose the following disciplinary sanctions:

1. Revocation of license.
2. Suspension of license until further order of the board or for a specific period.
3. Prohibit permanently, until further order of the board, or for a specific period the licensee's engaging in specified procedures, methods, or acts.
4. Probation.
5. Require additional education or training.
6. Require a reexamination.
7. Order a physical or mental evaluation, or order alcohol and drug screening within a time specified by the board.
8. Impose civil penalties not to exceed $1000.
9. Issue a citation and warning.
10. Such other sanctions allowed by law as may be appropriate.

645—45.4(272C) Discretion of board. The following factors may be considered by the board in determining the nature and severity of the disciplinary sanction to be imposed:

1. The relative serious nature of the violation as it relates to ensuring a high standard of professional care to the citizens of this state;
2. The facts of the particular violation;
3. Any extenuating facts or other countervailing considerations;
4. The number of prior violations or complaints;
5. The seriousness of prior violations or complaints;
6. Whether remedial action has been taken; and
7. Such other factors as may reflect upon the competency, ethical standards, and professional conduct of the licensee.

645—45.5(151) Order for mental, physical, or clinical competency examination or alcohol or drug screening. Rescinded IAB 8/13/08, effective 9/17/08.

These rules are intended to implement Iowa Code chapters 147, 151 and 272C.

[Filed 12/8/00, Notice 10/18/00—published 12/27/00, effective 1/31/01[1]]
[Filed 9/27/01, Notice 6/13/01—published 10/17/01, effective 11/21/01]
[Filed 7/3/02, Notice 5/1/02—published 7/24/02, effective 8/28/02]
[Filed 3/24/04, Notice 2/4/04—published 4/14/04, effective 5/19/04]
[Filed 7/14/05, Notice 5/25/05—published 8/3/05, effective 9/7/05]
[Filed 1/27/06, Notice 11/9/05—published 2/15/06, effective 3/22/06]
[Filed 4/13/06, Notice 2/15/06—published 5/10/06, effective 6/14/06]
[Filed 1/28/08, Notice 11/7/07—published 2/27/08, effective 4/2/08]
[Filed 7/17/08, Notice 5/7/08—published 8/13/08, effective 9/17/08]◊
[Filed ARC 8625B (Notice ARC 8278B, IAB 11/18/09), IAB 3/24/10, effective 4/28/10]
[Filed ARC 9109B (Notice ARC 8782B, IAB 6/2/10), IAB 10/6/10, effective 11/10/10]

◊ Two or more ARCs

1 Effective date delayed 70 days by the Administrative Rules Review Committee at its meeting held January 29, 2001; delay lifted by the committee at its meeting held February 9, 2001, effective 2/10/01.

CHAPTER 3
PHARMACY TECHNICIANS
[Prior to 9/4/02, see 657—Ch 22]

657—3.1(155A) Definitions. For the purposes of this chapter, the following definitions shall apply:

"Board" means the Iowa board of pharmacy.

"Cashier" means a person whose duties within the pharmacy are limited to accessing finished, packaged prescription orders and processing payments for and delivering such orders to the patient or the patient's representative.

"Certified pharmacy technician" or *"certified technician"* means an individual who holds a valid current national certification and who has registered with the board as a certified pharmacy technician. The term includes an individual registered with the board who voluntarily acquired certification as provided in subrule 3.5(2).

"Delivery" means the transport and conveyance of a finished, securely packaged prescription order to the patient or the patient's caregiver.

"Nationally accredited program" means a program and examination for the certification of pharmacy technicians that is accredited by the NCCA.

"NCCA" means the National Commission for Certifying Agencies.

"Pharmacy support person" means a person, other than a licensed pharmacist, a registered pharmacist-intern, or a registered pharmacy technician, who may perform nontechnical duties assigned by the pharmacist under the pharmacist's responsibility and supervision pursuant to 657—Chapter 5.

"Pharmacy technician" or *"technician"* means a person who is employed in Iowa by a licensed pharmacy under the responsibility of an Iowa-licensed pharmacist to assist in the technical functions of the practice of pharmacy, as provided in rules 657—3.22(155A) through 657—3.24(155A), and includes a certified pharmacy technician, a pharmacy technician trainee, and an uncertified pharmacy technician.

"Pharmacy technician certification" or *"national certification"* means a certificate issued by a national pharmacy technician certification authority accredited by the NCCA attesting that the technician has successfully completed the requirements of the certification program. The term includes evidence of renewal of the national certification.

"Pharmacy technician trainee" or *"technician trainee"* means an individual who is in training to become a pharmacy technician and who is in the process of acquiring national certification as a pharmacy technician as provided in rule 657—3.5(155A).

"Pharmacy technician training" or *"technician training"* means education or experience acquired for the purpose of qualifying for and preparing for national certification.

"Supervising pharmacist" means an Iowa-licensed pharmacist who is on duty in an Iowa-licensed pharmacy and who is responsible for the actions of a pharmacy technician or other supportive personnel.

"Uncertified pharmacy technician" or *"uncertified technician"* means a pharmacy technician who has not attained national certification and who qualifies for the time extension to attain national certification as provided in rule 657—3.6(155A).

[**ARC 8673B**, IAB 4/7/10, effective 6/1/10; **ARC 9009B**, IAB 8/11/10, effective 7/23/10]

657—3.2(155A) Purpose of registration. A registration program for pharmacy technicians is established for the purposes of determining the competency of a pharmacy technician or of an applicant for registration as a certified pharmacy technician, pharmacy technician trainee, or uncertified pharmacy technician and for the purposes of identification, tracking, and disciplinary action for violations of federal or state pharmacy or drug laws or regulations.

[**ARC 9009B**, IAB 8/11/10, effective 7/23/10]

657—3.3(155A) Registration required. Any person employed in Iowa as a pharmacy technician, except a pharmacist-intern whose pharmacist-intern registration is in good standing with the board, shall obtain and maintain during such employment a current registration as a certified pharmacy technician, pharmacy technician trainee, or uncertified pharmacy technician pursuant to these rules. An individual accepting employment as a pharmacy technician in Iowa who fails to register as a certified pharmacy

technician, technician trainee, or uncertified technician as provided by these rules may be subject to disciplinary sanctions.

3.3(1) *Licensed health care provider.* Except as provided in this rule, a licensed health care provider whose registration or license is in good standing with and not subject to current disciplinary sanctions or practice restrictions imposed by the licensee's professional licensing board and who assists in the technical functions of the practice of pharmacy shall be required to register as a certified pharmacy technician, technician trainee, or uncertified technician pursuant to these rules.

3.3(2) *Original application required.* Any person not currently registered with the board as a pharmacy technician shall complete the appropriate application for registration within 30 days of accepting employment in an Iowa pharmacy as a pharmacy technician. Such application shall be received in the board office before the expiration of this 30-day period.

3.3(3) *Technician training.* A person who is enrolled in a college-based or American Society of Health-System Pharmacists (ASHP)-accredited technician training program shall obtain a pharmacy technician trainee registration prior to beginning on-site practical experience. A person who is employed in a pharmacy and who is receiving pharmacy technician training through work experience shall obtain a pharmacy technician trainee registration within 30 days of the commencement of pharmacy technician training.

3.3(4) *Registration number.* Each pharmacy technician registered with the board will be assigned a unique registration number.

[**ARC 9009B**, IAB 8/11/10, effective 7/23/10]

657—3.4 Reserved.

657—3.5(155A) Certification of pharmacy technicians. Except as provided in rule 657—3.6(155A) or subrule 3.5(3), effective July 1, 2010, all pharmacy technicians shall be required to be nationally certified as provided by this rule. National certification does not replace the need for licensed pharmacist control over the performance of delegated functions, nor does national certification exempt the pharmacy technician from registration pursuant to these rules.

3.5(1) *Certification prior to July 1, 2010.* An individual who holds a valid current national certification from the Institute for the Certification of Pharmacy Technicians (ICPT) or the Pharmacy Technician Certification Board (PTCB) and who acquired such certification prior to July 1, 2010, shall be deemed to have met the requirement for national certification beginning July 1, 2010, provided the certification is maintained in current standing.

3.5(2) *Required certification effective July 1, 2010.* Beginning July 1, 2010, national certification acquired through successful completion of any NCCA-accredited pharmacy technician certification program and examination fulfills the requirement for national certification.

3.5(3) *Pharmacy technician trainee.* Except as provided in rule 657—3.6(155A), effective July 1, 2009, a person who is in the process of acquiring national certification as a pharmacy technician shall register with the board as a pharmacy technician trainee. The registration shall be issued for a period of one year and shall not be renewed.

3.5(4) *Certified pharmacy technician.* Beginning July 1, 2010, all applicants for a new pharmacy technician registration except as provided by subrule 3.5(3), and all applicants for renewal of a pharmacy technician registration except as provided in rule 657—3.6(155A), shall provide proof of current national pharmacy technician certification and shall complete the application for certified pharmacy technician registration.

[**ARC 8673B**, IAB 4/7/10, effective 6/1/10; **ARC 9009B**, IAB 8/11/10, effective 7/23/10]

657—3.6(155A) Extension of deadline for national certification. A pharmacy technician who meets all of the criteria identified in this rule shall not be required to acquire national certification prior to December 31, 2013. The pharmacy technician shall register with the board as an uncertified pharmacy technician and shall maintain that registration during all periods of employment as a pharmacy technician. To qualify for this extension, the uncertified pharmacy technician shall meet all of the following criteria:

3.6(1) *Prior registration.* The pharmacy technician shall have registered as a pharmacy technician prior to January 1, 2010;

3.6(2) *Minimum prior employment.* The pharmacy technician shall have worked as a pharmacy technician for at least 2,000 hours in the 18-month period immediately before submission of the application for renewal of the pharmacy technician's registration as evidenced by one or more affidavits as provided in paragraph 3.8(5)*"d"*; and

3.6(3) *Minimum continued employment.* The pharmacy technician shall continue to work as a pharmacy technician for at least 2,000 hours during any 18-month period between January 1, 2010, and December 31, 2013, or until the pharmacy technician attains national certification.

[**ARC 9009B**, IAB 8/11/10, effective 7/23/10]

657—3.7 Reserved.

657—3.8(155A) Application form.

3.8(1) *Required information.* The application for a certified pharmacy technician registration, pharmacy technician trainee registration, or uncertified pharmacy technician registration shall include the following:

a. Information sufficient to identify the applicant including, but not limited to, name, address, date of birth, gender, and social security number;

b. Educational background;

c. Work experience;

d. Current place or places of employment;

e. Any other information deemed necessary by the board and as provided by this rule.

3.8(2) *Declaration of current impairment or limitations.* The applicant shall declare any current use of drugs, alcohol, or other chemical substances that in any way impairs or limits the applicant's ability to perform the duties of a pharmacy technician with reasonable skill and safety.

3.8(3) *History of felony or misdemeanor crimes.* The applicant shall declare any history of being charged, convicted, found guilty of, or entering a plea of guilty or no contest to a felony or misdemeanor crime (other than minor traffic violations with fines under $100).

3.8(4) *History of disciplinary actions.* The applicant shall declare any history of disciplinary actions or practice restrictions imposed by a state health care professional or technician licensure or registration authority.

3.8(5) *Additional information.* The following additional information shall be required from an applicant for the specified registration.

a. Technician trainee. The applicant for technician trainee registration shall identify the source of technician training, the anticipated date of completion of training, and the anticipated date of national certification.

b. Certified pharmacy technician. The applicant for certified technician registration shall provide proof of current pharmacy technician certification. The applicant shall also identify all current pharmacy employers including pharmacy name, license number, address, and average hours worked per week.

c. Licensed health care provider. In addition to the additional information required by paragraph *"a," "b"* or *"d"* as applicable, a licensed health care provider shall provide evidence that the licensee's professional license or registration is current and in good standing and is not subject to current disciplinary sanctions or practice restrictions imposed by the licensee's professional licensing authority.

d. Uncertified pharmacy technician. The applicant for uncertified pharmacy technician registration shall submit with the application for registration renewal one or more affidavits signed by the pharmacists in charge of one or more Iowa pharmacies where the applicant practiced as a pharmacy technician during the 18 months prior to submission of the application for registration. Affidavits shall be on a form provided by the board office.

3.8(6) *Sworn signature.* The applicant shall sign the application under penalty of perjury and shall submit the application to the board with the appropriate fees pursuant to rule 657—3.10(155A).

[**ARC 9009B**, IAB 8/11/10, effective 7/23/10]

657—3.9(155A) Registration term and renewal. A pharmacy technician registration shall expire as provided in this rule for the specified registration. The board shall not require continuing education for renewal of a pharmacy technician registration.

3.9(1) *Certified pharmacy technician registration.* A certified pharmacy technician registration shall expire on the second last day of the birth month following initial registration, with the exception that a new certified pharmacy technician registration issued within the two months immediately preceding the applicant's birth month shall expire on the third last day of the birth month following initial registration.

3.9(2) *Pharmacy technician trainee registration.* Beginning July 1, 2009, a registration for a pharmacy technician who is in the process of acquiring national certification (technician trainee) shall expire on the last day of the registration month 12 months following the date of registration or 12 months following the date registration was required pursuant to subrule 3.3(3).

a. National certification completed. When the registered technician trainee completes national certification, and no later than the date of expiration of the technician trainee registration, the pharmacy technician trainee shall complete and submit an application for certified pharmacy technician registration. A successful application shall result in issuance of a new certified pharmacy technician registration as provided in subrule 3.9(1).

b. Voluntary cancellation of registration. A registered technician trainee who fails to complete national certification prior to expiration of the technician trainee registration shall notify the board that the pharmacy technician trainee registration should be canceled and that the individual has ceased practice as a pharmacy technician.

c. Failure to notify the board. If a pharmacy technician trainee fails to notify the board prior to the expiration date of the technician trainee registration regarding the individual's intentions as provided in paragraph *"a"* or *"b,"* the technician trainee registration shall be canceled and the individual shall cease practice as a pharmacy technician.

3.9(3) *Uncertified pharmacy technician registration.* Beginning June 1, 2010, a registration for a pharmacy technician who qualifies for the time extension for certification as provided by rule 657—3.6(155A) shall expire the second last day of the birth month following the latest scheduled registration renewal. In no case shall a registration for an uncertified pharmacy technician expire later than December 31, 2013, unless the pharmacy technician attains national certification as provided in subrule 3.5(2) and is reclassified as a certified pharmacy technician.
[**ARC 9009B**, IAB 8/11/10, effective 7/23/10]

657—3.10(155A) Registration fee. The following fees for initial registration and registration renewal shall apply to the specified registration applications filed within the following time frames. The appropriate fee shall be submitted with the registration application in the form of a personal check, certified check or cashier's check, or a money order payable to the Iowa Board of Pharmacy.

3.10(1) *Certified or uncertified pharmacy technician registration.* The fee for obtaining an initial certified pharmacy technician registration or for biennial renewal of a certified pharmacy technician registration or an uncertified pharmacy technician registration shall be $50 plus applicable surcharge pursuant to rule 657—30.8(155A).

3.10(2) *Technician trainee registration.* The fee for a one-year pharmacy technician trainee registration shall be $20 plus applicable surcharge pursuant to rule 657—30.8(155A).
[**ARC 9009B**, IAB 8/11/10, effective 7/23/10]

657—3.11(155A) Late applications and fees.

3.11(1) *Initial registration.* An application for initial registration that is not received within the applicable period specified in subrule 3.3(2) or 3.3(3) shall be delinquent, and the applicant shall be assessed a late payment fee. The late payment fee shall be equal to the amount of the fee for initial registration. A delinquent initial registration shall include payment of the initial registration fee, applicable surcharge pursuant to rule 657—30.8(155A), and late payment fee.

3.11(2) *Registration renewal.* A technician registration that is not renewed before its expiration date shall be delinquent, and the registrant shall not continue employment as a pharmacy technician until the registration is reactivated. An individual who continues employment as a pharmacy technician without

a current registration, in addition to the pharmacy and the pharmacist in charge that allow the individual to continue practice as a pharmacy technician, may be subject to disciplinary sanctions.

a. A person who is required to renew a registration pursuant to these rules and who fails to renew the registration before the first day of the month following expiration shall pay the renewal fee, a penalty fee equal to the amount of the renewal fee, plus the applicable surcharge pursuant to rule 657—30.8(155A).

b. A person who is required to renew a registration pursuant to these rules and who fails to renew the registration before the first day of the second month following expiration shall pay the renewal fee, a penalty fee equal to the amount of the renewal fee, the applicable surcharge pursuant to rule 657—30.8(155A), plus an additional penalty fee of $10 for each additional month, not to exceed three additional months, that the registration is delinquent. The maximum combined fee payment for reactivation of a delinquent registration shall not exceed an amount equal to twice the renewal fee plus $30 plus the applicable surcharge pursuant to rule 657—30.8(155A).

657—3.12(155A) Registration certificates. The certificate of technician registration issued by the board to a certified pharmacy technician, pharmacy technician trainee, or uncertified pharmacy technician is the property of and shall be maintained by the registered technician. The certificate or a copy of the certificate shall be maintained in each pharmacy where the pharmacy technician works. Each pharmacy utilizing pharmacy technicians shall be responsible for verifying that all pharmacy technicians working in the pharmacy are registered and that technician registrations remain current and active.
[**ARC 9009B**, IAB 8/11/10, effective 7/23/10]

657—3.13(155A) Notifications to the board. A pharmacy technician shall report to the board within ten days a change of the technician's name, address, or pharmacy employment status.
[**ARC 9009B**, IAB 8/11/10, effective 7/23/10]

657—3.14 to **3.16** Reserved.

657—3.17(155A) Training and utilization of pharmacy technicians. All Iowa-licensed pharmacies utilizing pharmacy technicians shall develop, implement, and periodically review written policies and procedures for the training and utilization of pharmacy technicians appropriate to the practice of pharmacy. Pharmacy policies shall specify the frequency of review. Technician training shall be documented and maintained by the pharmacy for the duration of employment. Policies and procedures and documentation of technician training shall be available for inspection and copying by the board or an agent of the board.

657—3.18(147,155A) Identification of pharmacy technician.

3.18(1) *Identification badge.* A pharmacy technician shall wear a visible identification badge while on duty that clearly identifies the person as a pharmacy technician and that includes at least the technician's first name.

3.18(2) *Misrepresentation prohibited.* A pharmacy technician shall not represent himself or herself in any manner as a pharmacist or pharmacist-intern. A pharmacy technician shall not represent himself or herself in any manner as a certified pharmacy technician unless the technician has attained national pharmacy technician certification.
[**ARC 9009B**, IAB 8/11/10, effective 7/23/10]

657—3.19 Reserved.

657—3.20(155A) Responsibility of supervising pharmacist. The ultimate responsibility for the actions of a pharmacy technician shall remain with the supervising pharmacist.
[**ARC 9009B**, IAB 8/11/10, effective 7/23/10]

657—3.21(155A) Delegation of functions.

3.21(1) *Technical dispensing functions.* A pharmacist may delegate technical dispensing functions to an appropriately trained and registered pharmacy technician, but only if the pharmacist is on site and available to supervise the pharmacy technician when delegated functions are performed, except as provided in 657—subrule 6.7(2) or 657—subrule 7.6(2), as appropriate, or as provided for telepharmacy in 657—Chapter 9. The pharmacist shall provide and document the final verification for the accuracy, validity, completeness, and appropriateness of the patient's prescription or medication order prior to the delivery of the medication to the patient or the patient's representative. A pharmacy technician shall not delegate technical functions to a pharmacy support person.

3.21(2) *Nontechnical functions.* A pharmacist may delegate nontechnical functions to a pharmacy technician or a pharmacy support person only if the pharmacist is present to supervise the pharmacy technician or pharmacy support person when delegated nontechnical functions are performed, except as provided in 657—subrule 6.7(2) or 657—subrule 7.6(2), as appropriate, or as provided for telepharmacy in 657—Chapter 9.

[**ARC 8673B**, IAB 4/7/10, effective 6/1/10]

657—3.22(155A) Technical functions. At the discretion of the supervising pharmacist, the following technical functions may be delegated to a pharmacy technician as specified in the following subrules.

3.22(1) *Certified pharmacy technician.* Under the supervision of a pharmacist, a certified pharmacy technician may perform technical functions delegated by the supervising pharmacist including, but not limited to, the following:

a. Perform packaging, manipulative, or repetitive tasks relating to the processing of a prescription or medication order in a licensed pharmacy.

b. Accept prescription refill authorizations communicated to a pharmacy by a prescriber or by the prescriber's office.

c. Contact prescribers to obtain prescription refill authorizations.

d. Process pertinent patient information, including information regarding allergies and disease state.

e. Enter prescription and patient information into the pharmacy computer system.

f. Inspect drug supplies provided and controlled by an Iowa-licensed pharmacy but located or maintained outside the pharmacy department, including but not limited to drug supplies maintained in an ambulance or other emergency medical service vehicle, a long-term care facility, a hospital patient care unit, or a hospice facility.

g. Affix required prescription labels upon any container of drugs sold or dispensed pursuant to the prescription of an authorized prescriber.

h. Prepackage or label multidose and single-dose packages of drugs, including dose picks for unit dose cart or AMDS fills for hospital or long-term care facility patients.

i. Perform drug compounding processes for nonsterile compounding as provided in 657—Chapter 20.

j. Perform drug compounding processes for sterile compounding as provided in 657—Chapter 13.

k. As provided in rule 657—3.24(155A), accept new prescription drug orders or medication orders communicated to the pharmacy by a prescriber or by the prescriber's agent.

3.22(2) *Pharmacy technician trainee.* Under the supervision of a pharmacist, a pharmacy technician trainee may perform only the following technical functions delegated by the supervising pharmacist:

a. Perform packaging, manipulative, or repetitive tasks relating to the processing of a prescription or medication order in a licensed pharmacy.

b. Accept prescription refill authorizations communicated to a pharmacy by a prescriber or by the prescriber's office.

c. Contact prescribers to obtain prescription refill authorizations.

d. Process pertinent patient information, including information regarding allergies and disease state.

e. Enter prescription and patient information into the pharmacy computer system.

f. Affix required prescription labels upon any container of drugs sold or dispensed pursuant to the prescription of an authorized prescriber.

g. Prepackage or label multidose and single-dose packages of drugs, including dose picks for unit dose cart or AMDS fills for hospital or long-term care facility patients.

h. Under the supervision of a pharmacist who provides training and evaluates and monitors trainee competence in the compounding processes, perform drug compounding processes for nonsterile compounding as provided in 657—Chapter 20.

i. Under the supervision of a pharmacist who provides training and evaluates and monitors trainees, and contingent on successful completion of appropriate media fill testing processes, perform drug compounding processes for sterile compounding as provided in 657—Chapter 13.

3.22(3) **[See Objection at end of chapter]** *Uncertified pharmacy technician.* Under the supervision of a pharmacist, an uncertified pharmacy technician may perform technical functions delegated by the supervising pharmacist limited to the following:

a. Select the appropriate stock supply of a prescription drug from the pharmacy drug supply shelves to process a prescription drug order.

b. Count dosage forms of prescription drugs into appropriate prescription vials or containers pursuant to prescription drug orders. Uncertified pharmacy technicians shall not prepackage or label multidose and single-dose packages of drugs, including dose picks for unit dose cart or AMDS fills for hospital or long-term care facility patients.

c. Affix required prescription labels upon any container of drugs sold or dispensed pursuant to the prescription of an authorized prescriber.

d. Return or place stock supplies of prescription drugs in the appropriate locations on the pharmacy drug supply shelves.

[**ARC 8673B**, IAB 4/7/10, effective 6/1/10; **ARC 9009B**, IAB 8/11/10, effective 7/23/10]

657—3.23(155A) Tasks a pharmacy technician shall not perform. A pharmacy technician shall not be authorized to perform any of the following judgmental tasks:

1. Provide the final verification for the accuracy, validity, completeness, or appropriateness of a filled prescription or medication order;
2. Conduct prospective drug use review or evaluate a patient's medication record for purposes identified in rule 657—8.21(155A);
3. Provide patient counseling, consultation, or patient-specific drug information, tender an offer of patient counseling on behalf of a pharmacist, or accept a refusal of patient counseling from a patient or patient's agent;
4. Make decisions that require a pharmacist's professional judgment, such as interpreting prescription drug orders or applying information;
5. Transfer a prescription drug order to another pharmacy or receive the transfer of a prescription drug order from another pharmacy;
6. Delegate technical functions to a pharmacy support person.

[**ARC 8673B**, IAB 4/7/10, effective 6/1/10; **ARC 9009B**, IAB 8/11/10, effective 7/23/10]

657—3.24(155A) New prescription drug orders or medication orders. At the discretion of the supervising pharmacist, a certified pharmacy technician may be allowed to accept new prescription drug orders or medication orders communicated to the pharmacy by a prescriber or by the prescriber's agent if the certified pharmacy technician has received appropriate training pursuant to the pharmacy's policies and procedures. The supervising pharmacist shall remain responsible for ensuring the accuracy, validity, and completeness of the information received by the certified pharmacy technician. The pharmacist shall contact the prescriber to resolve any questions, inconsistencies, or other issues relating to the information received by the certified pharmacy technician that involve a pharmacist's professional judgment.

[**ARC 9009B**, IAB 8/11/10, effective 7/23/10]

657—3.25(155A) Delegation of nontechnical functions. Rescinded IAB 4/7/10, effective 6/1/10.

657—3.26 and **3.27** Reserved.

657—3.28(147,155A) Unethical conduct or practice. Violation by a pharmacy technician of any of the provisions of this rule shall constitute unethical conduct or practice and may be grounds for disciplinary action as provided in rule 657—3.30(155A).

3.28(1) *Misrepresentative deeds.* A pharmacy technician shall not make any statement tending to deceive, misrepresent, or mislead anyone, or be a party to or an accessory to any fraudulent or deceitful practice or transaction in pharmacy or in the operation or conduct of a pharmacy.

3.28(2) *Confidentiality.* In the absence of express written authorization from the patient or written order or direction of a court, except where the best interests of the patient require, a pharmacy technician shall not divulge or reveal to any person other than the patient or the patient's authorized representative, the prescriber or other licensed practitioner then caring for the patient, a licensed pharmacist, a person duly authorized by law to receive such information, or as otherwise provided in rule 657—8.16(124,155A), any of the following:

a. A patient's name, address, social security number, or any information that could be used to identify a patient;

b. The contents of any prescription drug order or medication order or the therapeutic effect thereof, or the nature of professional pharmaceutical services rendered to a patient;

c. The nature, extent, or degree of illness suffered by any patient; or

d. Any medical information furnished by the prescriber or the patient.

3.28(3) *Discrimination.* It is unethical to unlawfully discriminate between patients or groups of patients for reasons of religion, race, creed, color, gender, gender identity, sexual orientation, marital status, age, national origin, physical or mental disability, or disease state when providing pharmaceutical services.

3.28(4) *Unethical conduct or behavior.* A pharmacy technician shall not exhibit unethical behavior in connection with the technician's pharmacy employment. Unethical behavior shall include, but is not limited to, the following acts: verbal or physical abuse, coercion, intimidation, harassment, sexual advances, threats, degradation of character, indecent or obscene conduct, and theft.

[**ARC 9009B**, IAB 8/11/10, effective 7/23/10]

657—3.29(155A) Denial of registration. The executive director or designee may deny an application for registration as a certified pharmacy technician, pharmacy technician trainee, or uncertified pharmacy technician for any violation of the laws of this state, another state, or the United States relating to prescription drugs, controlled substances, or nonprescription drugs or for any violation of Iowa Code chapter 124, 124A, 124B, 126, 147, 155A, or 205 or any rule of the board.

An individual whose application for registration as a certified pharmacy technician, pharmacy technician trainee, or uncertified pharmacy technician is denied pursuant to this rule may, within 30 days after issuance of the notice of denial, appeal to the board for reconsideration of the application.

[**ARC 9009B**, IAB 8/11/10, effective 7/23/10]

657—3.30(155A) Discipline of pharmacy technicians.

3.30(1) *Violations.* The board may impose discipline for any violation of the laws of this state, another state, or the United States relating to prescription drugs, controlled substances, or nonprescription drugs, or for any violation of Iowa Code chapter 124, 124A, 124B, 126, 147, 155A, or 205 or any rule of the board.

3.30(2) *Sanctions.* The board may impose the following disciplinary sanctions:

a. Revocation of a certified pharmacy technician, pharmacy technician trainee, or uncertified pharmacy technician registration.

b. Suspension of a certified pharmacy technician, pharmacy technician trainee, or uncertified pharmacy technician registration until further order of the board or for a specified period.

c. Nonrenewal of a certified pharmacy technician or uncertified pharmacy technician registration.

d. Prohibition, permanently, until further order of the board, or for a specified period, from engaging in specified procedures, methods, or acts.

e. Probation.

f. The ordering of a physical or mental examination.

g. The imposition of civil penalties not to exceed $25,000.

h. Issuance of a citation and warning.

i. Such other sanctions allowed by law as may be appropriate.

[**ARC 9009B**, IAB 8/11/10, effective 7/23/10]

These rules are intended to implement Iowa Code sections 147.72, 155A.23, 155A.33, and 155A.39 and Iowa Code section 155A.6A as amended by 2010 Iowa Acts, House File 2531, section 112.

[Filed 2/27/97, Notice 1/1/97—published 3/26/97, effective 4/30/97]
[Filed 4/24/98, Notice 3/11/98—published 5/20/98, effective 6/24/98]
[Filed 2/22/99, Notice 10/21/98—published 3/10/99, effective 4/14/99]
[Filed 9/8/99, Notice 6/2/99—published 10/6/99, effective 11/10/99]
[Filed 8/14/02, Notice 6/12/02—published 9/4/02, effective 10/9/02]
[Filed 3/11/04, Notice 8/6/03—published 3/31/04, effective 5/5/04]
[Filed emergency 7/16/04 after Notice 6/9/04—published 8/4/04, effective 7/16/04]
[Filed 10/22/04, Notice 3/31/04—published 11/10/04, effective 12/15/04]
[Filed emergency 6/30/05 after Notice 5/11/05—published 7/20/05, effective 7/1/05]
[Filed 3/22/06, Notice 1/18/06—published 4/12/06, effective 5/17/06]
[Filed 5/17/06, Notice 4/12/06—published 6/7/06, effective 7/12/06]
[Filed 2/7/07, Notice 10/25/06—published 2/28/07, effective 4/4/07]
[Filed emergency 11/13/07 after Notice 8/29/07—published 12/5/07, effective 11/13/07]
[Filed 3/5/08, Notice 12/19/07—published 3/26/08, effective 4/30/08[1]]
[Filed emergency 6/9/08—published 7/2/08, effective 7/9/08]
[Filed ARC 8673B (Notice ARC 8380B, IAB 12/16/09), IAB 4/7/10, effective 6/1/10]
[Filed Emergency ARC 9009B, IAB 8/11/10, effective 7/23/10]
[Editorial change: IAC Supplement 10/6/10]

[1] April 30, 2008, effective date delayed 70 days by the Administrative Rules Review Committee at its meeting held April 4, 2008.

OBJECTION

At its September 14, 2010 meeting the Administrative Rules Review Committee voted to object to a specific provision of **ARC 9009B**: subrule 3.22(3) relating to the functions that may be performed by an uncertified pharmacy technician. The filing appears in IAB Vol. XXXIII, No. 03 (08/11/10). The committee takes this action pursuant to the authority of §17A.4(5).

The committee objects to subrule 3.22(3) on the grounds that it is beyond the authority delegated to the agency. The head note to **ARC 9009B** cites 2010 Iowa Acts, House File 2531, section 112, as the authority for the filing. That provision relates only to extending the timeframe for certain pharmacy technicians or pharmacy technician trainees to obtain national certification. The provisions of subrule 3.22(3) do not relate to national certification and exceed the scope of **ARC 9009B**.

Objection filed September 21, 2010

CHAPTER 276
LICENSING OF FIRE PROTECTION SYSTEM INSTALLERS AND MAINTENANCE WORKERS

661—276.1(100D) Establishment of program. There is established within the fire marshal division a fire protection system installer and maintenance worker licensing program. The program is established pursuant to 2009 Iowa Code Supplement chapter 100D as amended by 2010 Iowa Acts, Senate File 2355.

276.1(1) *Licensing required.* A person shall not act as a fire protection system installer and maintenance worker without being currently licensed as a fire protection system installer and maintenance worker by the fire marshal, except for the following as provided in 2009 Iowa Code Supplement section 100D.11 as amended by 2010 Iowa Acts, Senate File 2355:

a. A person licensed as a professional engineer pursuant to Iowa Code chapter 542B who is providing consultation or develops plans or other work concerning the installation or design of fire protection systems shall not be required to be licensed pursuant to this chapter.

b. A person whose work on fire protection systems is limited to routine maintenance shall not be required to be licensed pursuant to this chapter.

c. A person who is licensed as a plumber pursuant to Iowa Code chapter 105 and whose work is within the scope of that license shall not be required to be licensed pursuant to this chapter.

d. A person who is working as an apprentice fire protection system installer and maintenance worker under the direct supervision of a responsible managing employee or under the direct supervision of a licensed fire sprinkler installer and maintenance worker who is on site while the work is being performed shall not be required to be licensed pursuant to this chapter. For purposes of this rule, "direct supervision" means that the person supervising the person performing the work shall be on the job site while the work being supervised is performed.

e. A person who demolishes fire protection system components shall not be required to be licensed pursuant to this chapter when the work involves the demolition of a complete fire protection system or if the work results in a fire protection system's being placed out of service. If a fire protection system has been placed out of service, work required to place it into service must be performed by a person licensed to perform such work pursuant to this chapter. A person who demolishes a fire protection system or components thereof shall comply with any local ordinance, statute or administrative rule which requires notification to a local fire authority or the state fire marshal.

f. A person who is a responsible managing employee of a fire extinguishing system contractor certified pursuant to Iowa Code chapter 100C shall not be required to be licensed pursuant to this chapter, provided that the work performed which is subject to the provisions of this chapter is within the scope of the endorsement or endorsements of the certification of the certified contractor employing the responsible managing employee.

276.1(2) *Endorsement.* Any person acting as a fire protection system installer and maintenance worker shall do so only in relation to systems and work covered by the endorsements on the person's license. The license of each installer and maintenance worker shall carry an endorsement for one or more of the following:

a. Automatic sprinkler system installation and maintenance;

b. Special hazards fire suppression system installation and maintenance;

c. Installation of preengineered dry chemical or wet agent fire protection systems;

d. Maintenance of preengineered dry chemical or wet agent fire protection systems;

e. Installation of preengineered water-based fire protection systems in one- and two-family dwellings;

f. Maintenance of preengineered water-based fire protection systems in one- and two-family dwellings;

g. Any combination thereof.

276.1(3) *Length of licensure.* Licensure shall normally be for two years and shall expire on December 31 of the year following the issuance of the license. A license which is effective on a date other than January 1 shall be effective on the date on which the license is issued and shall expire on

December 31 of the year following the year in which the license is issued. The fee for licenses issued for less than a full two-year period shall be prorated on the basis of the number of quarters for which the license shall be in effect.

EXCEPTION: Any license issued before January 1, 2011, shall expire on December 31, 2012.

276.1(4) *Inquiries.* Inquiries regarding the fire protection system installer and maintenance worker licensing program may be addressed to:

Fire Protection System Installer and Maintenance Worker Licensing Program
Fire Marshal Division
Iowa Department of Public Safety
215 East 7th Street
Des Moines, Iowa 50319

Inquiries may be addressed by electronic mail to fesccp@dps.state.ia.us; by telephone to (515)725-6145; or by facsimile to (515)725-6172.

[**ARC 9032B**, IAB 8/25/10, effective 10/1/10]

661—276.2(100D) Definitions. The following definitions apply to rules 661—276.1(100D) through 661—276.6(100D):

"Apprentice fire protection system installer and maintenance worker" means a person, other than a trainee, who is registered in an apprenticeship program approved by the United States Department of Labor and who is engaged in learning the fire protection system industry trade under the direct supervision of a responsible managing employee of a certified fire extinguishing system contractor or licensed fire protection system installer and maintenance worker.

"Department" means the department of public safety.

"Fire extinguishing system contractor" means a person(s) engaging in or representing oneself to the public as engaging in the activity or business of layout, installation, repair, service, alteration, addition, testing, maintenance, or maintenance inspection of automatic fire extinguishing systems in this state, as defined in Iowa Code section 100C.1, and who is certified pursuant to Iowa Code chapter 100C.

"Fire protection system" means a sprinkler, standpipe, hose system, special hazard system, dry system, foam system, or any water-based fire protection system, whether engineered or preengineered and whether manually or automatically activated, used for fire protection purposes which may include an integrated system of underground and overhead piping and which may be connected to a water source.

"Fire protection system installation" means to set up or establish a fire protection system for use in an indicated space.

"Fire protection system installer and maintenance worker" means a person who, having the necessary qualifications, training, experience, and technical knowledge, conducts fire protection system installation and maintenance and who is licensed by the department to install or maintain the types of fire protection systems endorsed on the person's license.

"Fire protection system maintenance" means to provide repairs, including all inspections and tests, required to keep a fire protection system and its component parts in an operative condition at all times and the replacement of the system or its component parts when they become undependable or inoperable.

"Listed" means equipment, materials, or services included in a list published by a nationally recognized independent testing organization concerned with evaluation of products or services that maintains periodic inspection of the production of listed equipment or materials or periodic evaluation of services and whose listing states that either the equipment, material, or service meets appropriate designated standards or has been tested and found suitable for a specified purpose.

"Preengineered fire protection system" means a fire protection system that has a predetermined flow rate, nozzle pressure, and quantity of extinguishing agent.

"Responsible managing employee" means a person who is an owner, partner, officer, or manager employed full-time by a fire extinguishing system contractor and who meets the requirements for a responsible managing employee established in Iowa Code chapter 100C and 661—Chapter 275.

"Routine maintenance" means the repair or replacement of existing fire protection system components of the same size and type, for which no changes in configuration are made. "Routine

maintenance" does not mean any new installation or any expansion or extension of any existing fire protection system, nor does it mean inspection and testing.

"Temporary license" means a license issued to a fire protection system installer and maintenance worker who is licensed or certified in another state and who will perform work in Iowa only within areas covered by a disaster emergency proclamation issued by the governor pursuant to Iowa Code section 29C.6.

"Trainee" means a person who is engaged in learning the fire protection system industry trade under the direct supervision of a responsible managing employee or a licensed fire protection system installer and maintenance worker who is not a trainee. "Trainee" does not mean a person who is an apprentice fire protection system installer and maintenance worker.

[**ARC 9032B**, IAB 8/25/10, effective 10/1/10]

661—276.3(100D) Licensing requirements. A fire protection system installer and maintenance worker shall meet all of the following requirements in order to receive a license from the fire marshal and shall continue to meet all requirements throughout the period of licensure. A licensee shall notify the fire marshal, in writing on a form designated by the fire marshal, within 30 calendar days if the licensee fails to meet any requirement for licensure.

276.3(1) *Liability insurance.* Each licensee, other than a trainee, shall maintain general and complete operations liability insurance covering any work that the licensee is authorized to perform pursuant to any endorsements on the license in the following amounts: $500,000 per person, $1,000,000 per occurrence, and $1,000,000 property damage.

a. The carrier of any insurance coverage maintained to meet this requirement shall notify the fire marshal 30 days prior to the effective date of cancellation or reduction of the coverage.

b. The licensee shall cease work immediately if the insurance coverage required by this subrule is no longer in force and other insurance coverage meeting the requirements of this subrule is not in force. A licensee shall not initiate any work which requires licensure pursuant to this chapter or to 2009 Iowa Code Supplement chapter 100D as amended by 2010 Iowa Acts, Senate File 2355, which cannot reasonably be expected to be completed prior to the effective date of the cancellation of the insurance coverage required by this subrule and of which the licensee has received notice, unless new insurance coverage meeting the requirements of this subrule has been obtained and will be in force upon cancellation of the prior coverage.

EXCEPTION: A licensee is not required to maintain insurance coverage provided that the licensee's employer maintains insurance coverage equivalent to the requirements of this subrule.

276.3(2) *Compliance.* Each licensee shall maintain compliance with all other applicable provisions of law related to operation in the state of Iowa and in any political subdivision in which the licensee is performing work.

276.3(3) *Training and experience requirements.* An applicant for a license shall meet the following training and experience requirements:

a. For endorsement for automatic sprinkler system installation and maintenance, the applicant shall show evidence of the following:

(1) Satisfactory completion of an apprenticeship program in fire sprinkler installation and maintenance approved by the United States Department of Labor, including four years of employment as an apprentice fire protection system installer and maintenance worker, and

(2) A passing score on either the United Association Star Fire Sprinkler Mastery Exam or on another examination administered by a nationally recognized third-party testing organization and approved as equivalent by the state fire marshal.

EXCEPTION: Prior to August 1, 2012, an applicant who was employed as a fire protection system installer as of July 1, 2008, may receive endorsement for automatic sprinkler system installation and maintenance upon submission of evidence of completion of 8500 hours of employment as a fire protection system installer and maintenance worker and any of the following:

1. Satisfactory completion of an apprenticeship program in fire sprinkler installation and maintenance of four or more years in duration, approved by the United States Department of Labor.

2. Passing the United Association Star Fire Sprinkler Mastery Exam or another examination administered by a nationally recognized third-party testing organization and approved as equivalent by the state fire marshal.

3. Certification by the National Institute for Certification in Engineering Technologies in Automatic Sprinkler System Layout at Level I, or another form of certification or testing administered by a nationally recognized organization and approved as equivalent by the state fire marshal. An applicant for licensure or the applicant's employer may request approval from the state fire marshal of a form of certification or testing as equivalent to that required by this paragraph by contacting the program as indicated in subrule 276.1(4) and following the instructions given to request such approval. For any training which commences on or after January 1, 2011, or testing which occurs on or after July 1, 2011, such approval shall be obtained in advance.

b. For endorsement for special hazards fire protection system installation and maintenance, the applicant shall show evidence of the following:

(1) Satisfactory completion of an apprenticeship program in installation and maintenance of special hazards fire protection systems approved by the United States Department of Labor, and

(2) Certification by the National Institute for Certification in Engineering Technologies in Special Hazards Protection Systems at Level I, or another form of certification or testing by a nationally recognized organization approved as equivalent by the state fire marshal. An applicant for licensure or the applicant's employer may request approval from the state fire marshal of a form of certification or testing as equivalent to that required by this subparagraph by contacting the program as indicated in subrule 276.1(4) and following the instructions given to request such approval. For any training which commences on or after January 1, 2011, or testing which occurs on or after July 1, 2011, such approval shall be obtained in advance.

EXCEPTION 1: If the state fire marshal determines that no appropriate apprenticeship program is readily available, the fire marshal may allow the substitution of documentation of 8500 hours or more of employment in installation and maintenance of special hazards systems in lieu of meeting the apprenticeship requirement. Credit for such work experience obtained on or after October 1, 2010, shall be awarded only for work performed as an apprentice fire protection system installer and maintenance worker or as a licensed fire protection system installer and maintenance worker trainee. An applicant for a license, a certified contractor, or another employer of an applicant for a license may request determination by the state fire marshal that no appropriate apprenticeship is readily available to the applicant. In order to make such a request, the person making the request shall contact the program as specified in subrule 276.1(4) for instructions regarding information to be submitted.

EXCEPTION 2: Prior to August 1, 2012, an applicant who was employed as a fire protection system installer as of July 1, 2008, may receive endorsement for special hazards fire protection system installation and maintenance upon submission of evidence of completion of 8500 hours of employment as a fire protection system installer and maintenance worker and either of the following:

1. Satisfactory completion of an apprenticeship program in installation and maintenance of special hazards fire protection systems of four or more years in duration, approved by the United States Department of Labor.

2. Certification by the National Institute for Certification in Engineering Technologies in Special Hazards Systems Installation and Maintenance at Level I, or another form of certification or testing administered by a nationally recognized organization and approved as equivalent by the state fire marshal. An applicant for licensure or the applicant's employer may request approval from the state fire marshal of a form of certification or testing as equivalent to that required by this paragraph by contacting the program as indicated in subrule 276.1(4) and following the instructions given to request such approval. For any training which commences on or after January 1, 2011, or testing which occurs on or after July 1, 2011, such approval shall be obtained in advance.

c. For endorsement for installation or maintenance of preengineered dry chemical or wet agent fire protection systems, the applicant shall show evidence of the following:

(1) To be endorsed as a preengineered kitchen fire extinguishing system installer, the applicant shall have successfully completed training and an examination verified by a preengineered system

manufacturer, an agent of a preengineered system manufacturer, or an organization that is approved by the state fire marshal. Completion of training and examination which would qualify the applicant for equivalent endorsement as a responsible managing employee of a certified fire extinguishing system contractor shall be deemed to meet the requirement of this subparagraph. An organization which wishes to be approved pursuant to this subparagraph shall contact the program as specified in subrule 276.1(4) and shall follow the instructions received from the program. For any training which commences on or after January 1, 2011, or testing which occurs on or after July 1, 2011, such approval shall be obtained in advance.

(2) To be endorsed as a preengineered kitchen fire extinguishing system maintenance worker, the applicant shall have successfully completed training by the applicant's employer or the system's manufacturer and passed a written or online examination for preengineered kitchen fire extinguishing system maintenance that is approved by the state fire marshal. Completion of training and examination which would qualify the applicant for equivalent endorsement as a responsible managing employee of a certified fire extinguishing system contractor shall be deemed to meet the requirement of this subparagraph. An organization which wishes to be approved pursuant to this subparagraph shall contact the program as specified in subrule 276.1(4) and shall follow the instructions received from the program. For any testing which occurs on or after January 1, 2011, such approval shall be obtained in advance.

(3) To be endorsed as a preengineered industrial fire extinguishing system installer, the applicant shall possess a training and examination certification from a preengineered system manufacturer, an agent of a preengineered system manufacturer, or an organization that is approved by the state fire marshal. Completion of training and examination which would qualify the applicant for equivalent endorsement as a responsible managing employee of a certified fire extinguishing system contractor shall be deemed to meet the requirement of this subparagraph. An organization which wishes to be approved pursuant to this subparagraph shall contact the program as specified in subrule 276.1(4) and shall follow the instructions received from the program. For any training which commences on or after January 1, 2011, or testing which occurs on or after July 1, 2011, such approval shall be obtained in advance.

(4) To be endorsed as a preengineered industrial fire extinguishing system maintenance worker, the applicant shall have been trained by the applicant's employer and shall have passed a written or online examination for preengineered industrial fire extinguishing system maintenance that is approved by the state fire marshal. Completion of training and examination which would qualify the applicant for equivalent endorsement as a responsible managing employee of a certified fire extinguishing system contractor shall be deemed to meet the requirement of this subparagraph. An organization which wishes to be approved pursuant to this subparagraph shall contact the program as specified in subrule 276.1(4) and shall follow the instructions received from the program. For any training which commences on or after January 1, 2011, or testing which occurs on or after July 1, 2011, such approval shall be obtained in advance.

d. For endorsement for installation of preengineered water-based fire protection systems in one- and two-family dwellings, the applicant shall show evidence of satisfactory completion of any training required by the manufacturer for installation of any system that the applicant will install. Completion of training and examination which would qualify the person for equivalent endorsement as a responsible managing employee of a certified fire extinguishing system contractor shall be deemed to meet the requirement of this paragraph.

276.3(4) *Continuing education.* A license may be renewed only if the licensee has completed 16 or more hours of continuing education in subjects related to the license and its endorsements during the two years preceding the date on which the new license will become effective if it is issued. The continuing education must consist of courses approved by the fire marshal and must have been completed by the licensee during the two years prior to the effective date of the renewal. Any person or organization which wishes to obtain approval for continuing education courses to satisfy the provisions of this subrule shall contact the program as specified in subrule 276.1(4) and shall follow the instructions received from the program. After January 1, 2011, prior approval must be obtained before a licensee may take a course for which credit toward the requirements of this subrule will be sought.

276.3(5) *Temporary license requirements.* A person may be issued a temporary license upon submission of an application to the state fire marshal with proof of equivalent licensure or certification in another state, accompanied by the applicable fee. The state fire marshal may require the submission of any documentation of licensure or certification in another state that the state fire marshal deems necessary. A temporary license may be used only in an area which is or has been within the past 180 days subject to a disaster emergency proclamation issued by the governor pursuant to Iowa Code section 29C.6. A temporary license shall be in effect for 90 days from the date of issuance and may be renewed once for an additional 90 days.
[**ARC 9032B**, IAB 8/25/10, effective 10/1/10 (See Delay note at the end of chapter)]

661—276.4(100D) Application and fees.

276.4(1) *Application.* Any person seeking licensure as a fire protection system installer and maintenance worker shall submit a completed application form to the fire marshal. The application shall be filed no later than 30 days prior to the date on which licensure is required or on which an existing license expires. An application form may be obtained from the fire marshal or from the Web site of the fire protection system installer and maintenance worker licensing program. The application form shall be submitted with all required attachments and the required license fee established in subrule 276.4(2). An application shall not be considered complete unless all required information is submitted, including required attachments and fees, and shall not be processed until it is complete.

NOTE: The Web site for the fire protection system installer and maintenance worker licensing program is http://www.dps.state.ia.us/fm/building/fesccp/index.shtml.

276.4(2) *License fee.*

a. The fee for a permanent or provisional license, except for a trainee license, shall be $200. If an application is denied, all except $25 of the fee may be refunded if the applicant applies to the fire marshal for a refund. No refund of the license fee shall be made if the license is revoked or if the denial of the license is based on the applicant's knowingly including false or misleading information on the application. If an application for a license provides for more than one endorsement as provided in subrule 276.1(2), there shall be an additional fee of $25 for each endorsement beyond the first.

b. The fee for a trainee license shall be $100.

c. The fee for a temporary license shall be $50. A temporary license may be renewed once; the renewal fee shall be $50.

276.4(3) *Payment.* The license fee shall be submitted by draft, check, or money order in the applicable amount payable to the Iowa Department of Public Safety. The memo portion of the check should have the following notation: "Fire Protection System Installer and Maintenance Worker Licensing Program."

276.4(4) *Amended license.*

a. The fee for issuance of an amended license is $25. The fee shall be submitted with a request for an amended license. A licensee shall request and the fire marshal shall issue an amended license for any of the following reasons:

(1) A change in employer;

(2) A change in insurance coverage; or

(3) A change in any other material information included in or with the initial or renewal application.

A change of address is a material change. However, if the request for an amended license is solely for a change of business address, the former address of the business is in an area subject to a disaster emergency proclamation issued by the governor pursuant to Iowa Code section 29C.6, and the relocation occurs as a result of flooding or storm damage or other conditions which form a basis for the issuance of the disaster emergency proclamation, the fee shall not apply, although an amended license shall be issued.

b. Other changes in the information required in the application form, including renewal of insurance coverage with a new expiration date, shall be reported to the fire marshal but shall not require issuance of an amended license or payment of the amended license fee.

276.4(5) *Attachments.* Required attachments to the application for a license include, but are not limited to, the following:

a. Documentation verifying that the applicant has in force the insurance coverage required by subrule 276.3(1). The documentation shall include an acknowledgment that the applicant's or employer's insurance coverage extends to any work performed by the licensee within the scope of licensure pursuant to this chapter. The documentation may consist of a letter from the insurance carrier, a copy of the insurance certificate with an endorsement showing the required information, or a signed statement from the applicant's employer attesting that the employer has insurance coverage in effect equivalent to the coverage required by subrule 276.3(1).

b. If the application requests licensure based on work experience, the applicant shall attach a notarized affidavit attesting that the applicant has the required experience.

NOTE: An applicant may contact the fire protection system installer and maintenance worker licensing program for assistance with the wording of the affidavit.

[**ARC 9032B**, IAB 8/25/10, effective 10/1/10]

661—276.5(100D) Complaints.

276.5(1) Complaints regarding the performance of any licensed fire protection system installer and maintenance worker; failure of a licensee to meet any of the requirements established in 2009 Iowa Code Supplement chapter 100D as amended by 2010 Iowa Acts, Senate File 2355, or this chapter or any other provision of law; or persons operating as fire protection system installers and maintenance workers without licensure may be filed with the fire marshal. Complaints should be addressed as follows:

Fire Protection System Installer and Maintenance Worker Licensing Program
Fire Marshal Division
Iowa Department of Public Safety
215 East 7th Street
Des Moines, Iowa 50319

276.5(2) Complaints may be submitted by electronic mail to fesccp@dps.state.ia.us or by facsimile to (515)725-6172.

276.5(3) Complaints should be as specific as possible and shall clearly identify the licensee or other person against whom the complaint is filed. Complaints shall be submitted in writing. A complaint may be submitted anonymously, but if the name and contact information of the complainant are provided, the complainant will be notified of the disposition of the complaint.

[**ARC 9032B**, IAB 8/25/10, effective 10/1/10]

661—276.6(100D) Denial, suspension, or revocation of licensure; civil penalties; appeals. If a licensee or person who performs work requiring a license violates any provision of these rules or any other provision of law related to work requiring licensure pursuant to this chapter, the fire marshal may deny, suspend or revoke a license or assess a civil penalty to a licensee or to a person who performs work requiring licensure pursuant to this chapter and who is not licensed.

276.6(1) *Denial.* The fire marshal may deny an application for licensure:

a. If the applicant makes a false statement on the application form or in any other submission of information required for licensure. "False statement" means providing false information or failing to include material information, such as a previous criminal conviction or action taken by another jurisdiction, when requested on the application form or otherwise in the application process.

b. If the applicant fails to meet all of the requirements for licensure established in this chapter.

c. If the applicant is currently barred for cause from licensure equivalent to that provided for in this chapter in another jurisdiction.

d. If an applicant has previously been barred for cause from operating in another jurisdiction as a fire protection system installer and maintenance worker and if the basis of that action reflects upon the integrity of the applicant in operating as a fire protection system installer and maintenance worker. If an applicant is found to have been previously barred for cause from operating as a fire protection system installer and maintenance worker in another jurisdiction and is no longer barred from doing so, the fire marshal shall evaluate the record of that action with regard to the likelihood that the applicant

would operate with integrity as a licensee. If an applicant is denied licensure under this paragraph, the applicant shall be notified of the specific reasons for the denial.

e. If the applicant has been convicted of a crime which reflects upon the integrity of the applicant in operating as a fire protection system installer and maintenance worker. If an applicant is found to have a criminal record, the fire marshal shall evaluate that record with regard to the likelihood that the applicant would operate with integrity as a licensee. If an applicant is denied licensure under this paragraph, the applicant shall be notified of the specific reasons for the denial.

276.6(2) *Suspension.* A suspension of a license may be imposed by the fire marshal for any violation of these rules or 2009 Iowa Code Supplement chapter 100D as amended by 2010 Iowa Acts, Senate File 2355, or for a failure to meet any legal requirement to operate as a fire protection system installer and maintenance worker in this state. Failure to provide any notice to the fire marshal as required by these rules shall be grounds for suspension. An order of suspension shall specify the length of the suspension and shall specify that correction of all conditions which were a basis for the suspension is a condition of reinstatement of the license even after the period of the suspension.

276.6(3) *Revocation.*

a. A revocation is a termination of a license. A license may be revoked by the fire marshal for repeated violations or for a violation which creates an imminent danger to the safety or health of individuals protected by a fire protection system incorrectly installed by a licensee or when information comes to the attention of the fire marshal which, if known to the fire marshal when the application was being considered, would have resulted in denial of the license.

b. A new application for a license from an applicant whose license has previously been revoked shall not be considered for a period of one year after the effective date of the revocation and, in any event, until every condition which was a basis for the revocation has been corrected. The fire marshal may specify in the revocation order a period longer than one year before a new application for a license may be considered. When a new application for a license from a person whose license was previously revoked is being considered, the applicant may be denied a license based upon the same information which was the basis for revocation even after any such period established by the fire marshal has expired.

276.6(4) *Civil penalties.* The fire marshal may impose a civil penalty of up to $500 per day during which a violation has occurred and for every day until the violation is corrected. A civil penalty may be imposed in lieu of or in addition to a suspension or may be imposed in addition to a revocation. A civil penalty shall not be imposed in lieu of a revocation.

276.6(5) *Suspension or revocation for nonpayment of child support.* The following procedures shall apply to actions taken by the fire marshal on a certificate of noncompliance received from the Iowa department of human services pursuant to Iowa Code chapter 252J:

a. The notice required by Iowa Code section 252J.8 shall be served upon the licensee by restricted certified mail, return receipt requested, or personal service in accordance with Iowa Rule of Civil Procedure 1.305. Alternatively, the licensee may accept service personally or through authorized counsel.

b. The effective date of revocation or suspension of a license, as specified in the notice required by Iowa Code section 252J.8, shall be 60 days following service upon the licensee.

c. Licensees shall keep the fire marshal informed of all court actions and all child support recovery unit actions taken under or in connection with Iowa Code chapter 252J and shall provide the fire marshal with copies, within 7 days of filing or issuance, of all applications filed with the district court pursuant to Iowa Code section 252J.9, all court orders entered in such actions, and withdrawals of certificates of noncompliance by the child support recovery unit.

d. All applicable fees for an application or reinstatement must be paid by the licensee before a license will be issued, renewed, or reinstated after the fire marshal has denied the issuance or renewal of a license or has suspended or revoked a license pursuant to Iowa Code chapter 252J.

e. In the event the licensee files a timely district court action following service of a notice pursuant to Iowa Code sections 252J.8 and 252J.9, the fire marshal shall continue with the intended action described in the notice upon the receipt of a court order lifting the stay, dismissing the action, or otherwise directing the fire marshal to proceed. For the purpose of determining the effective date

of revocation or suspension of the license, the fire marshal shall count the number of days before the action was filed and the number of days after the action was disposed of by the court.

f. Suspensions or revocations imposed pursuant to this subrule may not be appealed administratively to the fire marshal or within the department of public safety.

NOTE: The procedures established in subrule 276.6(5) implement the requirements of Iowa Code chapter 252J. The provisions of Iowa Code chapter 252J establish mandatory requirements for an agency which administers a licensing program, such as the one established in this chapter, and provide that actions brought under these provisions are not subject to contested case procedures established in Iowa Code chapter 17A but must be appealed directly to district court.

276.6(6) *Suspension or revocation for nonpayment of debts owed state or local government.* The following procedures shall apply to actions taken by the fire marshal on a certificate of noncompliance received from the Iowa department of revenue pursuant to Iowa Code chapter 272D:

a. The notice required by Iowa Code section 272D.3 shall be served upon the licensee by regular mail.

b. The effective date of revocation or suspension of a license, as specified in the notice required by Iowa Code section 272D.3, shall be 20 days following service upon the licensee.

c. Licensees shall keep the fire marshal informed of all court actions and centralized collection unit actions taken under or in connection with Iowa Code chapter 272D and shall provide the fire marshal with copies, within 7 days of filing or issuance, of all applications filed with the district court pursuant to Iowa Code section 272D.9, all court orders entered in such actions, and withdrawals of certificates of noncompliance by the centralized collection unit.

d. All applicable fees for an application or reinstatement must be paid by the licensee before a license will be issued, renewed, or reinstated after the fire marshal has denied the issuance or renewal of a license or has suspended or revoked a license pursuant to Iowa Code chapter 272D.

e. In the event the licensee files a timely district court action following service of a notice pursuant to Iowa Code section 272D.8, the fire marshal shall continue with the intended action described in the notice upon the receipt of a court order lifting the stay, dismissing the action, or otherwise directing the fire marshal to proceed. For the purpose of determining the effective date of revocation or suspension of the license, the fire marshal shall count the number of days before the action was filed and the number of days after the action was disposed of by the court.

f. Suspensions or revocations imposed pursuant to this subrule may not be appealed administratively to the fire marshal or within the department of public safety.

NOTE: The procedures established in subrule 276.6(6) implement the requirements of Iowa Code chapter 272D. The provisions of Iowa Code chapter 272D establish mandatory requirements for an agency which administers a licensing program, such as the one established in this chapter, and provide that actions brought under these provisions are not subject to contested case procedures established in Iowa Code chapter 17A but must be appealed directly to district court.

276.6(7) *Appeals.* Any denial, suspension, or revocation of a license, or any civil penalty imposed upon a licensee or other person under this rule, other than one imposed pursuant to subrule 276.6(5) or 276.6(6), may be appealed by the licensee or other person within 14 days of receipt of the notice. Appeals of actions taken by the fire marshal under this rule shall be to the commissioner of public safety and shall be treated as contested cases following the procedures established in rules 661—10.301(17A) through 661—10.332(17A).

[**ARC 9032B**, IAB 8/25/10, effective 10/1/10]

These rules are intended to implement 2009 Iowa Code Supplement chapter 100D as amended by 2010 Iowa Acts, Senate File 2355.

[Filed ARC 9032B (Notice ARC 8855B, IAB 6/16/10), IAB 8/25/10, effective 10/1/10][1]

[Editorial change: IAC Supplement 10/6/10]

[1] October 1, 2010, effective date of 276.3(1) delayed 70 days by the Administrative Rules Review Committee at its meeting held September 14, 2010.

CHAPTER 21
ELECTION FORMS AND INSTRUCTIONS
[Prior to 7/13/88, see Secretary of State(750), Ch 11]

DIVISION I
GENERAL ADMINISTRATIVE PROCEDURES

721—21.1(47) Emergency election procedures. The state commissioner of elections may exercise emergency powers over any election being held in a district in which either a natural or other disaster or extremely inclement weather has occurred. The state commissioner may also exercise emergency powers during an armed conflict involving United States armed forces, or mobilization of those forces, or if an election contest court finds that there were errors in the conduct of an election making it impossible to determine the result.

21.1(1) *Definitions.*

"Commissioner" means the county commissioner of elections.

"Election contest court" means any of the courts specified in Iowa Code sections 57.1, 58.4, 61.1, 62.1 and 376.10.

"Extremely inclement weather" means a natural occurrence, such as a rainstorm, windstorm, ice storm, blizzard, tornado or other weather conditions, which makes travel extremely dangerous or which threatens the public peace, health and safety of the people or which damages and destroys public and private property.

"Natural disaster" means a natural occurrence, such as a fire, flood, blizzard, earthquake, tornado, windstorm, ice storm, or other events, which threatens the public peace, health and safety of the people or which damages and destroys public and private property.

"Other disaster" means an occurrence caused by machines or people, such as fire, hazardous substance or nuclear power plant accident or incident, which threatens the public peace, health and safety of the people or which damages and destroys public and private property.

"State commissioner" means the state commissioner of elections.

21.1(2) *Notice of natural or other disaster or extremely inclement weather.* The county commissioner of elections, or the commissioner's designee, may notify the state commissioner of elections that due to a natural or other disaster or extremely inclement weather an election cannot safely be conducted in the time or place for which the election is scheduled to be held. If the commissioner or the commissioner's designee is unable to transmit notice of the hazardous conditions, the notice may be given by any elected county official. Verification of the commissioner's agreement with the severity of the conditions and the danger to the election process shall be transmitted to the state commissioner as soon as possible. Notice may be given by telephone or by facsimile machine, but a signed notice shall also be delivered to the state commissioner.

21.1(3) *Declaration of emergency due to natural or other disaster or extremely inclement weather.* After receiving notice of hazardous conditions, the state commissioner of elections, or the state commissioner's designee, may declare that an emergency exists in the affected precinct or precincts. A copy of the declaration of the emergency shall be provided to the commissioner.

21.1(4) *Emergency modifications to conduct of elections.* When the state commissioner of elections has declared that an emergency exists due to a natural or other disaster or to extremely inclement weather, the county commissioner of elections, or the commissioner's designee, shall consult with the state commissioner to develop a plan to conduct the election under the emergency conditions. All modifications to the usual method for conducting elections shall be approved in advance by the state commissioner unless prior approval is impossible to obtain.

Modifications may be made to the method for conducting the election including relocation of the polling place, postponement of the hour of opening the polls, postponement of the date of the election if no candidates for federal offices are on the ballot, reduction in the number of precinct election officials in nonpartisan elections, or other reasonable and prudent modifications that will permit the election to be conducted.

21.1(5) *Relocation of polling place.* The substitute polling place shall be as close as possible to the usual polling place and shall be within the same precinct if possible. Preference shall be given to buildings which are accessible to the elderly and disabled. Buildings supported by taxation shall be made available without charge by the authorities responsible for their administration. If it is necessary, more than one precinct may be located in the same room.

A notice of the location of the substitute polling place shall be posted on the door of the former polling place not later than one hour before the scheduled time for opening the polls or as soon as possible. If it is unsafe or impossible to post the sign on the door of the former polling place, the notice shall be posted in some other visible place at or near the site of the former polling place. If time permits, notice of the relocation of the polling place shall be published in the same newspaper in which notice of election was published, otherwise notice of relocation may be published in any newspaper of general circulation in the political subdivision which will appear on or before election day. The commissioner shall inform all broadcast media and print news organizations serving the jurisdiction of the modifications.

21.1(6) *Postponement of election.* An election, other than an election at which a federal office appears on the ballot, may be postponed until the following Tuesday. If the election involves more than one precinct, the postponement must include all precincts within the political subdivision. If the election is postponed, ballots shall not be reprinted to reflect the modification in the election date. The date of the close of voter preregistration by mail for the election shall not be extended. Precinct election registers prepared for the original election date may be used or reprinted at the commissioner's discretion.

On the day that the postponed election is actually held, all election day procedures must be repeated.

21.1(7) *Absentee voting in postponed elections.* Absentee ballots shall be delivered to voters pursuant to Iowa Code section 53.22 until the date the election is actually held. Absentee ballots shall be accepted at the commissioner's office until the hour the polls close on the date the election is held. Absentee ballots which are postmarked no later than the day before the election is actually held shall be accepted if received no later than the time prescribed by the Iowa Code for the usual conduct of the election. The time shall be calculated from the date on which the election is held, not the date for which the election was originally scheduled. However, if absentee ballots have been tabulated before the election is postponed, the absentee ballots shall be sealed in an envelope by the absentee and special voters precinct board and stored securely until the date the election is actually held. The sealed envelopes shall be opened by the absentee and special voters precinct board on the date the election is actually held, counters on the tabulating equipment (if any) shall be reset to zero, and all absentee ballots tabulated on the original election date shall be retabulated.

21.1(8) *Absentee and special voters precinct board in postponed elections.* The absentee and special voters precinct board shall meet to consider provisional ballots at the times specified in Iowa Code sections 50.22 and 52.23, calculated from the date the election is held. No absentee ballots shall be counted until the date the election is held.

21.1(9) *Canvass of votes in postponed elections.* The canvass of votes shall also be rescheduled for one week after the originally scheduled canvass date.

21.1(10) *Postponements made on election day.* If the emergency is declared while the polls are open and the decision is made to postpone the election, each precinct polling place in the political subdivision shall be notified to close its doors and to halt all voting immediately. People present in the polling place who are waiting to vote shall not be given ballots. People who have received and marked their ballots shall deposit them in the ballot box; unmarked ballots may be returned to the precinct election officials.

The precinct election officials shall seal all ballots which were cast before the declaration of the emergency in secure containers. The containers shall be clearly marked as ballots from the postponed election. If it is safe to do so, the ballot containers, election register, and other election supplies shall be transported to the commissioner's office. The ballots shall be stored in a secure place. If it is unsafe to travel to the commissioner's office, the chairperson of the precinct election board shall see that the ballots and the election register are securely stored until it is safe to return them to the commissioner. If no contest is pending six months after the canvass for the election is completed, the unopened, sealed ballot containers shall be destroyed.

If automatic tabulating equipment is used, the automatic tabulating equipment shall be closed and sealed without printing the results. Before the date the election is held, the automatic tabulating equipment shall be reset to zero. Documents showing the progress of the count, if any, shall be sealed in an envelope and stored. No one shall reveal the progress of the count. After six months, the sealed envelope containing the vote totals shall be destroyed if no contest is pending.

21.1(11) *Records kept.* The state commissioner of elections shall maintain records of each emergency declaration. The records of emergency declarations for federal elections shall be kept for 22 months, and records for all other elections shall be kept for six months following the election. The records shall include the following information:

a. The county in which the emergency occurred.

b. The date and time the emergency declaration was requested.

c. The name and title of the person making the request.

d. Name and date of the election affected.

e. The jurisdiction for which the election is to be conducted (school, city, county, or other).

f. The number of precincts in the jurisdiction.

g. The number of precincts affected by the emergency.

h. The nature of the emergency, i.e., natural or other disaster, or extremely inclement weather.

i. The date or dates of the occurrence of the natural or other disaster or extremely inclement weather.

j. Conditions affecting the conduct of the election.

k. Whether the polling places may safely be opened on time.

l. Action taken: such as moving the polling place, change voting system, postpone election until the following Tuesday.

m. Method to be used to inform the public of changes made in the election procedure.

n. The signature of the state commissioner or the state commissioner's designee who was responsible for declaring the emergency.

21.1(12) *Federal elections.*

a. If an emergency occurs that will adversely affect the conduct of an election at which candidates for federal office will appear on the ballot, the election shall not be postponed or delayed. Emergency measures shall be limited to relocation of polling places, modification of the method of voting, reduction of the number of precinct election officials at a precinct and other modifications of prescribed election procedures which will enable the election to be conducted on the date and during the hours required by law.

The primary election held in June of even-numbered years and the general election held in November of even-numbered years shall not be postponed. Special elections called by the governor pursuant to Iowa Code section 69.14 shall not be postponed unless no federal office appears on the ballot.

b. If a federal or state court order extends the time established for closing the polls pursuant to Iowa Code section 49.73, any person who votes after the statutory hour for closing the polls shall vote only by casting a provisional ballot pursuant to Iowa Code section 49.81. Provisional ballots cast after the statutory hour for closing the polls shall be sealed in a separate envelope from provisional ballots cast during the statutory polling hours. The absentee and special voters precinct board shall tabulate and report the results of the two sets of provisional ballots separately.

21.1(13) *Military emergencies.* A voter who is entitled to vote by absentee ballot under the federal Uniformed and Overseas Citizens Absentee Voting Act (UOCAVA) and Iowa Code chapter 53, division II, "Absent Voting by Armed Forces," may return an absentee ballot via electronic transmission only if the voter is located in an area designated by the U.S. Department of Defense to be an imminent danger pay area. Procedures for the return of absentee ballots by electronic transmission are described in subrule 21.320(4).

21.1(14) *Election contest emergency.* If an election contest court finds that there were errors in the conduct of an election which make it impossible to determine the result of the election, the contest court shall notify the state commissioner of elections of its finding. The state commissioner shall order a repeat

election to be held. The repeat election date shall be set by the state commissioner. The repeat election shall be conducted under the state commissioner's supervision.

The repeat election shall be held at the earliest possible time, but it shall not be held earlier than 14 days after the date the election was set aside. Voter registration, publication, equipment testing and other applicable deadlines shall be calculated from the date of the repeat election.

The repeat election shall be conducted under the same procedures required for the election that was set aside, except that all known errors in preparation and procedure shall be corrected. The nominations from the initial election shall be used in the repeat election unless the contest court specifically rejects the initial nomination process in its findings. Precinct election officials for the repeat election may be replaced at the discretion of the auditor.

The following materials prepared for the original election shall be used or reconstructed for the repeat election:

Ballots (showing the date of repeat election). This may be stamped on ballots printed for the original election.

Notice of election (showing the date of repeat election).

This rule is intended to implement Iowa Code section 47.1.

[**ARC 8045B**, IAB 8/26/09, effective 7/27/09]

721—21.2(47) Electronic submission of absentee ballot applications and affidavits of candidacy. Absentee ballot applications and affidavits of candidacy may be submitted electronically using either fax or E-mail.

21.2(1) *Electronic copies of absentee ballot applications and affidavits of candidacy accepted for filing.* Assuming that all other legal requirements are met, absentee ballot applications and affidavits of candidacy required by Iowa Code chapters 43, 44, 45, 161A, 260C, 277, 376 and 420 may be submitted electronically by either fax or E-mail if presented to the appropriate filing officer as an exact copy of the original and if the submission is in compliance with subrule 21.2(2).

21.2(2) *Original absentee ballot applications.* The original absentee ballot application submitted electronically shall also be mailed to the commissioner. The envelope bearing the original absentee ballot application shall be postmarked not later than the Friday before the election. This subrule shall not apply to documents submitted electronically by UOCAVA voters pursuant to rule 721—21.320(53).

a. The voter's absentee ballot shall be rejected by the absentee and special voters precinct board if the original absentee ballot application filed electronically is not received in the mail by the time the polls close on election day.

b. The voter's absentee ballot shall be rejected by the absentee and special voters precinct board if the postmark on the envelope containing the original absentee ballot application is later than the Friday before the election.

21.2(3) *Original affidavits of candidacy.* The original copy of an affidavit of candidacy submitted electronically shall also be filed with the appropriate commissioner. The envelope bearing the original affidavit (if any) shall be postmarked not later than the last day to file the document.

a. The filing shall be void if the original affidavit of candidacy filed electronically is not received within seven days after the filing deadline for the original affidavit of candidacy.

b. The filing shall be void if the postmark on the envelope containing the original affidavit of candidacy is later than the filing deadline.

c. If an affidavit of candidacy filing is voided because the original affidavit of candidacy submitted by facsimile machine was postmarked too late or arrives too late, the person who filed the document shall be notified immediately in writing.

This rule is intended to implement Iowa Code sections 43.11, 43.19, 43.54, 43.67, 43.78, 44.3, 45.3, 45.4, 46.20, 47.1, and 47.2; sections 53.2, 53.8, 53.17, 53.22, 53.25, and 53.40 as amended by 2009 Iowa Acts, House File 475; sections 53.45, 61.3, 161A.5, and 277.4; sections 260C.15 and 376.4 as amended by 2009 Iowa Acts, House File 475; and sections 376.11 and 420.130.

[**ARC 8045B**, IAB 8/26/09, effective 7/27/09]

721—21.3(49,48A) Voter identification documents.

21.3(1) *Identification documents for persons other than election day registrants.* Unless the person is registering to vote at the polls on election day, precinct election officials shall accept the identification documents listed in Iowa Code section 48A.8 from any person who is asked or required to present identification pursuant to Iowa Code section 49.77 as amended by 2009 Iowa Acts, House File 475.

21.3(2) *Identification for election day registrants.*

a. A person who applies to register to vote on election day shall provide proof of identity and residence pursuant to Iowa Code section 48A.7A in the precinct where the person is applying to register and vote.

b. Any registered voter who attests for another person registering to vote at the polls on election day shall be a registered voter of the same precinct. The registered voter may be a precinct election official or a pollwatcher, but may not attest for more than one person applying to register at the same election.

21.3(3) *Current and valid identification.*

a. "Current and valid" or "identification," for the purposes of this rule, means identification that meets the following criteria:

(1) The expiration date on the identification has not passed. An identification is still valid on the expiration date. An Iowa nonoperator's identification that shows "none" as the expiration date shall be considered current and valid.

(2) The identification has not been revoked or suspended.

b. A current and valid identification may include a former address.

21.3(4) *Identification not provided.* A person who has been requested to provide identification and does not provide it shall vote only by provisional ballot pursuant to Iowa Code section 49.81. However, a person who is registering to vote on election day pursuant to Iowa Code section 48A.7A may establish identity and residency in the precinct by written oath of a person who is registered to vote in the precinct.

This rule is intended to implement Iowa Code section 48A.7A and section 49.77 as amended by 2009 Iowa Acts, House File 475, and P.L. 107-252, Section 303.

[**ARC 8045B**, IAB 8/26/09, effective 7/27/09]

721—21.4(49) Changes of address at the polls. An Iowa voter who has moved from one precinct to another in the county where the person is registered to vote may report a change of address at the polls on election day.

21.4(1) To qualify to vote in the election being held that day, the voter shall:

a. Go to the polling place for the precinct where the voter lives on election day.

b. Complete a registration form showing the person's current address in the precinct.

c. Present proof of identity as required by subrule 21.3(1).

21.4(2) The officials shall require a person who is reporting a change of address at the polls to cast a provisional ballot if the person's registration in the county cannot be confirmed. Registration may be confirmed by:

a. Telephoning the office of the county commissioner of elections, or

b. Reviewing a printed list of all registered voters who are qualified to vote in the county for the election being held that day, or

c. Researching the county's voter registration records using a computer.

21.4(3) In precincts where the voter's declaration of eligibility is included in the election register pursuant to rule 721—21.5(49) and Iowa Code section 49.77, the commissioner shall provide to each precinct one of the two following methods for recording changes of address:

a. The voter shall be given both an eligibility declaration and a voter registration form. The eligibility declaration may be printed on the same piece of paper as the voter registration form.

b. The commissioner shall provide blank lines on the election register for the precinct election officials to record the voter's name, address, and, if provided, telephone number, and, in primary

elections, political party affiliation. The voter shall sign the election register next to the printed information. The voter shall also complete a voter registration form showing the voter's current address.

This rule is intended to implement Iowa Code section 49.77 as amended by 2009 Iowa Acts, House File 475.

[**ARC 8045B**, IAB 8/26/09, effective 7/27/09]

721—21.5(49) Eligibility declarations in the election register. To compensate for the absence of a separate declaration of eligibility form, the commissioner shall provide to each precinct a voter roster with space for each person who appears at the precinct to vote to print the following information: first and last name, address, and, at the voter's option, telephone number, and, in primary elections, political party affiliation.

The roster forms shall include the name and date of the election and the name of the precinct, and may be provided on paper that makes carbonless copies. If a multicopy form is used, the commissioner shall retain the original copy of the voter roster with other records of the election.

This rule is intended to implement Iowa Code section 49.77.

[**ARC 8045B**, IAB 8/26/09, effective 7/27/09]

721—21.6(43,50) Turnout reports. Rescinded IAB 6/2/10, effective 7/1/10.

721—21.7(48A) Election day registration. In addition to complying with the identification provisions in rule 721—21.3(49,48A), precinct election officials shall comply with the following requirements:

21.7(1) Precinct election officials shall inspect the identification documents presented by election day registrants to verify the following:

a. The photograph shows the person who is registering to vote.

b. The name on the identification document is the same as the name of the applicant.

c. The address on the identification document is in the precinct where the person is registering to vote.

21.7(2) Precinct election officials shall verify that each person who attempts to attest to the identity and residence of a person who is registering to vote on election day is a registered voter in the precinct and has not attested for any other voter in the election. The officials shall note in the election register that the person has attested for an election day registrant.

21.7(3) Precinct election officials shall permit any person who is in line to vote at the time the polls close to register and vote on election day if the person otherwise meets all of the election day registration requirements.

21.7(4) In precincts where an electronic program is not used to check the name of an election day registrant against the statewide list of felons who have had their right to vote revoked, precinct election officials shall provide each election day registrant with a "Notice to Election Day Registrants" prepared by the state commissioner before allowing the voter to register and vote on election day. The "Notice to Election Day Registrants" prepared by the state commissioner will be posted on the state commissioner's Web site.

This rule is intended to implement 2007 Iowa Acts, House File 653.

[**ARC 8045B**, IAB 8/26/09, effective 7/27/09; **ARC 8777B**, IAB 6/2/10, effective 5/7/10]

721—21.8(48A) Notice to election day registrant. The commissioner shall send to each person who registers to vote on election day, pursuant to Iowa Code section 48A.7A, an acknowledgment of the registration by nonforwardable mail. If the postal service returns the acknowledgment as undeliverable, the commissioner shall send a notice to the voter by forwardable mail. The notice shall be substantially in the form titled "Notice to Election Day Registrant" posted on the state commissioner's Web site.

This rule is intended to implement Iowa Code sections 48A.7A and 48A.26A.

[**ARC 8045B**, IAB 8/26/09, effective 7/27/09]

721—21.9(49) "Vote here" signs.

1. Size. The signs shall be no smaller than 16 inches by 24 inches.

2. Exceptions. If a driveway leads away from the entrance to the voting area, or if the driveway is located in such a way that posting a "vote here" sign at the driveway entrance would not help potential voters find the voting area, no "vote here" sign shall be posted at the entrance to that driveway.

This rule is intended to implement Iowa Code section 49.21.

721—21.10(43) Application for status as a political party. A political organization which is not currently qualified as a political party may file an application for determination of political party status with the state commissioner of elections. The application may be filed after the completion of the executive council's canvass of votes for the general election, but not later than one year after the date of the election at which the organization's candidate for President of the United States or governor received at least 2 percent of the vote.

21.10(1) *Application form.* The application shall be substantially in the form titled "Application for Political Party Status" posted on the state commissioner's Web site.

21.10(2) *Response.* If the political organization meets the requirements established in Iowa Code section 43.2, the commissioner shall declare that the organization has qualified as a political party, effective 21 days after the application is approved. If the organization does not meet the requirements, the state commissioner shall immediately notify the applicant in writing of the reason for the rejection of the application.

21.10(3) *Disqualification of political party.* If at the close of nominations for the general election a political party has not nominated a candidate for the office of President of the United States, or for governor, as the case may be, the political party shall be disqualified immediately.

If the candidate of a political party for President of the United States or for governor, as the case may be, does not receive 2 percent of the votes cast for that office at a general election, the political party shall be disqualified. The effective date of the disqualification shall be the date of the completion of the state canvass of votes.

When a political party is disqualified, the state commissioner shall immediately notify the chairperson or central committee of the disqualified political party.

21.10(4) *Notice of qualification and disqualification of political parties.* The state commissioner of elections shall immediately notify the state registrar of voters, the voter registration commission, and the county commissioners of elections when a political party is qualified or disqualified. The notice shall include the name of the political party and the date upon which change in political party status becomes effective.

The state commissioner of elections shall also publish notice of the qualification or disqualification of a political party in a newspaper of general circulation in each congressional district. The publication shall be made within 30 days of the approval of an application for qualification or within 30 days of the effective date of a disqualification.

This rule is intended to implement Iowa Code sections 43.2 and 47.1.

[**ARC 8045B**, IAB 8/26/09, effective 7/27/09]

721—21.11(44) Nonparty political organizations—nominations by petition. Rescinded IAB 9/10/97, effective 10/15/97.

721—21.12 to **21.19** Reserved.

721—21.20(62) Election contest costs. In determining the amount of the bond for election contests, the commissioner shall consider the following aspects of the cost of the election contest proceedings:

1. Fees as provided in Iowa Code section 62.22.
2. Fees for judges as provided in Iowa Code section 62.23.
3. The cost of making an official record of the proceedings.

721—21.21(62) Limitations. The amount of the bond shall not include costs not directly related to the contest court proceedings. Specifically, the amount of the bond shall not be intended to replace any

potential lost income to the county caused by the delay in implementing the decision of the voters at the election being contested.

Rules 721—21.20(62) and 721—21.21(62) are intended to implement Iowa Code sections 62.6, 62.22, 62.23, and 62.24.

721—21.22 to **21.24** Reserved.

721—21.25(50) Administrative recounts. When the commissioner suspects that voting equipment used in the election malfunctioned or that programming errors may have affected the outcome of the election, the commissioner may request an administrative recount after the day of the election but not later than three days after the canvass of votes. The request shall be made in writing to the board of supervisors explaining the nature of the problem and listing the precincts to be recounted and which offices and questions shall be included in the administrative recount. The board of supervisors shall respond as soon as possible after receipt of the commissioner's request.

The recount shall be conducted by members of the absentee and special voters precinct board following the provisions of Iowa Code section 50.48 as amended by 2009 Iowa Acts, House File 475, Iowa Code section 50.49 and 721—Chapter 26. The commissioner may use different memory cards for the recount and shall retain the information on the memory cards used in the election pursuant to 721—subrule 22.51(13). The commissioner may also use different election definition files if the commissioner believes the original election definition files were flawed. If the commissioner uses different election definition files for the recount, the commissioner shall also retain the election definition files for the election as required by 721—subrule 22.51(14).

This rule is intended to implement Iowa Code section 50.48 as amended by 2009 Iowa Acts, House File 475, and Iowa Code section 50.49.
[**ARC 8045B**, IAB 8/26/09, effective 7/27/09]

721—21.26 to **21.29** Reserved.

721—21.30(49) Inclusion of annexed territory in city reprecincting and redistricting plans. If a city has annexed territory after January 1 of a year ending in zero and before the completion of the redrawing of precinct and ward boundaries during a year ending in one, the city shall include the annexed land in precincts drawn pursuant to Iowa Code sections 49.3 and 49.5.

21.30(1) When the city council draws precinct and ward boundaries, if any, the city shall use the population of the annexed territory as certified by the city to the state treasurer pursuant to Iowa Code section 312.3(4).

21.30(2) When the board of supervisors, or the temporary county redistricting commission, draws precinct and county supervisor district boundaries, if any, it shall subtract from the population of the adjacent unincorporated area the population of the annexed territory as certified by the city to the state treasurer pursuant to Iowa Code section 312.3(4).

21.30(3) The use of population figures for reprecincting or redistricting shall not affect the official population of the city or the county. Only the U.S. Bureau of the Census may adjust the official population figures, by corrections or by conducting special censuses. See Iowa Code section 9F.6.

This rule is intended to implement Iowa Code sections 49.3 and 49.5.

721—21.31 to **21.49** Reserved.

721—21.50(49) Polling place accessibility standards.

21.50(1) *Inspection required.* Before any building may be designated for use as a polling place, the county commissioner of elections or the commissioner's designee shall inspect the building to determine whether it is accessible to persons with disabilities.

21.50(2) *Frequency of inspection.* Polling places that have been inspected using the Polling Place Accessibility Survey Form prescribed in subrule 21.50(4) shall be reinspected if structural changes are made to the building or if the location of the polling place inside the building is changed.

21.50(3) *Review of accessibility.* Not less than 90 days before each primary election, the commissioner shall determine whether each polling place needs to be reinspected.

21.50(4) *Standards for determining polling place accessibility.* The survey form available on the state commissioner's Web site titled "Polling Place Accessibility Survey" shall be used to evaluate polling places for accessibility to persons with disabilities.

The term "off-street parking" used in the polling place accessibility survey means parking places in lots separated from the street and includes angle parking along the street if the accessible route from the parking place to the polling place is entirely out of the path of traffic. Parking arrangements that require either the driver or passengers of the vehicle to go into the traveled part of the street are not accessible.

An access aisle at street level that is at least 60 inches wide and the same length as each accessible parking space shall be provided. An accessible public sidewalk curb ramp shall connect the access aisle to the continuous passage to the polling place. At least one parking place shall be van-accessible with a 96-inch access aisle connected to the continuous passage to the polling place by an accessible public sidewalk curb ramp. Two accessible parking spaces may share a common access aisle.

21.50(5) *Temporary waiver of accessibility requirements.* Notwithstanding the waiver provisions of 721—Chapter 10, if the county commissioner is unable to provide an accessible polling place for any precinct, the commissioner shall apply for a temporary waiver of accessibility requirements pursuant to this subrule. Applications shall be filed with the secretary of state not later than 60 days before the date of any scheduled election. If a waiver is granted, it shall be valid for two years from the date of approval by the secretary of state.

a. Each application shall include the following documents:

(1) Application for Temporary Waiver of Accessibility Requirements.

(2) A copy of the Polling Place Accessibility Survey Form for the polling place to be used.

(3) A copy of the Polling Place Accessibility Survey Form for any other buildings that were surveyed and rejected as possible polling place sites for the precinct.

b. If an accessible place becomes available at least 30 days before an election, the commissioner shall change polling places and shall notify the secretary of state. The notice shall include a copy of the Polling Place Accessibility Survey Form for the new polling place.

21.50(6) *Emergency waivers.* During the 60 days preceding an election, if a polling place becomes unavailable for use due to fire, flood, or changes made to the building, or for other reasons, the commissioner must apply for an emergency waiver of accessibility requirements in order to move the polling place to an inaccessible building. Emergency waiver applications must be filed with the secretary of state as soon as possible before election day. To apply for an emergency waiver, the commissioner shall send the following documents:

a. Application for Temporary Waiver of Accessibility Requirements.

b. A copy of the Polling Place Accessibility Survey Form for the polling place selected.

c. A copy of the Polling Place Accessibility Survey Form for any other buildings that were surveyed and rejected as possible polling place sites for this precinct (if any).

21.50(7) *Application form.* The form posted on the state commissioner's Web site titled "Temporary Waiver of Accessibility Requirements" shall be used to apply for a temporary waiver of accessibility requirements.

21.50(8) *Evaluation of waivers.* When the secretary of state receives waiver applications, the applications shall be reviewed carefully. A response shall be sent to the commissioner within one week by E-mail or by fax to notify the commissioner when the waiver request was received and whether additional information is needed.

21.50(9) *Granting waivers.* If the secretary of state determines from the documents filed with the waiver request that conditions justify the use of a polling place that does not meet accessibility standards, the secretary of state shall grant the waiver of accessibility requirements. If the secretary of state determines from the documents filed with the waiver request that all potential polling places have been surveyed and no accessible place is available, and the available building cannot be made temporarily accessible, the waiver shall be granted.

21.50(10) *Notice required.* Each notice of election published pursuant to Iowa Code section 49.53 shall clearly describe which polling places are inaccessible. The notice shall include a description of the services available to persons with disabilities who live in precincts with inaccessible polling places. The notice shall be in substantially the following form:

Any voter who is physically unable to enter a polling place has the right to vote in the voter's vehicle. For further information, please contact the county auditor's office at the telephone or TTY number or E-mail address listed below:

Telephone: _____ TTY: _____ E-mail address: _____

21.50(11) *Denial of waiver requests.* The secretary of state shall review each waiver request. The secretary of state shall consider the totality of the circumstances as shown by the information on the waiver request, information contained in previous applications for waivers for the same precinct and for other precincts in the county, and other relevant available information. The waiver request may be denied if it appears that the commissioner has not made a good-faith effort to find an accessible polling place. If the waiver request is denied, the secretary of state shall notify the commissioner in writing of the reason for denying the request.

This rule is intended to implement Iowa Code section 49.21.

[**ARC 8045B**, IAB 8/26/09, effective 7/27/09]

721—21.51 to **21.74** Reserved.

721—21.75(49) Voting centers for certain elections. The commissioner may establish voting centers for the regular city election, city primary election, city runoff election, regular school election, and special elections.

21.75(1) *Definition.*

"Voting center" means a location established by the commissioner for the purpose of providing ballots to all registered voters who are qualified to vote in a particular jurisdiction for a regular city election, city primary election, city runoff election, regular school election, or special election.

21.75(2) *Minimum requirements.*

a. Establishment. One or more voting centers may be established in lieu of precinct polling places for the elections at which the use of voting centers is permitted. Regular polling place sites that are accessible to people with disabilities may be used as voting centers for any election at which the use of voting centers is permitted. Other suitable locations may also be used.

b. Location of voting centers. If voting centers are established for an election, at least one voting center must be located within the boundaries of the political subdivision for which the election is being conducted. At the commissioner's discretion, additional vote centers may be established as long as the voting center is located within the boundaries of the political subdivision for which the election is being conducted.

c. Accessibility. A voting center is subject to the requirements of Iowa Code section 49.21 relating to accessibility to persons who are elderly and persons with disabilities and relating to the posting of signs.

21.75(3) *Hours.* Voting center hours shall be the same as permitted for an election pursuant to Iowa Code section 49.73.

21.75(4) *Publications.* The location of each voting center shall be published in the notice of election by the commissioner in the same manner as the location of polling places is required to be published. The notice of election shall also include a description of the voting center in substantially the following form:

For the _____ election to be held on [date], voting centers will be available. Any registered voter of [jurisdiction name] may vote at any of the following places in this election:

[List addresses of voting centers.]

21.75(5) *Posting notices at regular polling places on election day.* If voting centers are established in lieu of regular polling places for an election, the commissioner shall post a notice of voting center

locations, not later than the hour at which the polls open on the day of the election, on each door to the usual polling place in the precinct. The notice shall remain posted until the polls have closed.

21.75(6) *I-Voters use prohibited.* The commissioner shall not provide direct access from voting centers to the I-Voters system on election day.

21.75(7) *Determining ballot rotations.* For the purposes of determining ballot rotations pursuant to Iowa Code section 49.31 in an election for which the commissioner has established voting centers, the commissioner may use either precincts established pursuant to Iowa Code sections 49.3 to 49.5 or consolidated precincts established pursuant to Iowa Code section 49.11, subsection 3, paragraph *"a."* If the commissioner uses consolidated precincts established pursuant to Iowa Code section 49.11, subsection 3, paragraph *"a,"* the commissioner shall use the same consolidated precincts used in the last regularly scheduled election conducted for the political subdivision in which voting centers were not used.

21.75(8) *Operation of voting centers.*

a. Election registers and voter lists. Each voting center shall have an election register containing the names, addresses and voter statuses of all registered voters who are eligible to vote in that election. The election register may be a paper list or may be available on computers in an electronic format, rather than as an interactive connection to I-Voters.

b. Election day registration at voting centers. A person who needs to register to vote may register and vote at a voting center provided that the person has appropriate identification and is a resident of the jurisdiction served by the voting center.

c. Voters reporting address changes at voting centers. Any person who is already registered in the county and updates the person's voter registration address at a voting center shall show identification listed in Iowa Code section 48A.8. Persons unable to provide requested identification shall be offered a provisional ballot pursuant to Iowa Code section 49.81.

d. Ballots. Each voting center shall have all ballot styles necessary to provide a ballot to any voter who is eligible to vote in the election for the jurisdiction served by the voting center.

e. Precinct election officials. Voting centers shall be administered by a minimum of three precinct election officials selected pursuant to Iowa Code sections 49.12 to 49.16. These officials shall be trained before each election and shall have specific instructions regarding the differences between voting centers and polling places.

f. Ballot boxes used with optical scan voting equipment at voting centers. The commissioner may instruct two precinct election officials not of the same political party to open the ballot box periodically throughout election day to ensure the ballots are stacking evenly in the ballot box to prevent a voting equipment malfunction. The precinct election officials charged with inspecting the ballot box shall ensure the ballot box is locked and secured at all times. As an alternative to this procedure, the commissioner may supply any voting center with additional ballot boxes and the precinct election officials may move the optical scan voting equipment to a new ballot box if necessary. All ballot boxes containing voted ballots shall be locked and secured by the precinct election officials at all times.

21.75(9) *Postelection review of voter participation.*

a. Within 45 days after the election, the commissioner shall review the signed declarations of eligibility or the signed election registers from each voting center, and if any person is found to have voted in more than one voting center in the election, the commissioner shall immediately notify the county attorney.

b. The notice to the county attorney shall include a copy of the person's voter registration record and copies of the declarations of eligibility signed by the voter. The notice shall also include a reference to Iowa Code sections 39A.2(2) and 49.11(3)*"b."*

This rule is intended to implement Iowa Code sections 49.9 and 49.11.

[**ARC 8045B**, IAB 8/26/09, effective 7/27/09]

721—21.76 to **21.199** Reserved.

DIVISION II
BALLOT PREPARATION

721—21.200(49) Constitutional amendments and public measures.

21.200(1) The order of placement on the ballot for constitutional amendments and statewide public measures to be voted upon at a single election shall be determined by the state commissioner, and a number shall be assigned to each constitutional amendment or statewide public measure by the state commissioner.

a. The number assigned by the state commissioner to each constitutional amendment or statewide public measure to appear on the ballot for a single election shall be printed on the ballot immediately preceding and above the words "Shall the following amendment to the Constitution (or public measure) be adopted?" or the words "Shall there be a Convention to revise the Constitution, and propose amendment or amendments to same?"

b. The number assigned by the state commissioner shall be printed on the ballot at least 1/8 of an inch high in the designated place.

c. Even if only one constitutional amendment or statewide public measure is to appear on a ballot to be voted upon at a single election, an identifying number shall be assigned by the state commissioner and shall be printed on the ballot in the prescribed manner.

21.200(2) The order of placement on the ballot for each local public measure to be voted upon at a single election shall be determined by the commissioner, and a letter shall be assigned to each local public measure by the commissioner.

a. The letter assigned by the commissioner shall be printed on the ballot at least ⅛ of an inch high in the designated place.

b. Even if only one public measure is to appear on a ballot to be voted upon at a single election, an identifying letter shall be assigned by the commissioner and shall be printed on the ballot in the prescribed manner.

21.200(3) The words describing proposed constitutional amendments and statewide public measures when they appear on the ballot shall be determined by the state commissioner. The state commissioner shall select the words describing the proposed constitutional amendments and statewide public measures in the following manner:

a. Not less than 150 days prior to the election at which a proposed constitutional amendment or statewide public measure is to be voted on by the voters, the state commissioner shall prepare a proposed description to be used on the ballots in administrative rule form and shall file the proposed rules with the administrative rules coordinator for publication in the Iowa Administrative Bulletin.

b. The rules shall provide that written comments regarding the proposed description will be accepted by the state commissioner for a period of time not less than 20 days after the date of publication in the Iowa Administrative Bulletin.

c. The state commissioner shall review any written comments which have been timely received and make any changes deemed to be warranted in the description to be printed on the ballots.

This rule is intended to implement Iowa Code sections 47.1 and 49.44.

[**ARC 8045B**, IAB 8/26/09, effective 7/27/09]

721—21.201(44) Competing nominations by nonparty political organizations.

21.201(1) *Nominations by convention and by petitions.* If one or more nomination petitions are received from nonparty political organization candidates for an office for which the same organization has also nominated one candidate by convention, the candidate nominated by convention shall be considered the nominee of the organization. The names of the other candidates shall appear on the ballot as candidates "nominated by petition," and those candidates shall be notified in writing not later than seven days after the close of the filing period.

21.201(2) *Multiple nomination petitions.* If nomination petitions are received from more than one candidate from the same nonparty political organization for the same office and the organization has not nominated a candidate for the office by convention, the name of each of these candidates shall be written on a separate piece of paper, all of which shall be as nearly uniform in size and material as possible and

placed in a receptacle so that the names cannot be seen. On the next working day following the close of the nomination period, all affected candidates shall be notified of the time and place of the drawing. The candidates shall be invited to attend or to send a representative. In the presence of witnesses, the state commissioner of elections or the county commissioner, as appropriate, or a designee of the state or county commissioner, shall publicly draw one of the names; and that person shall be declared to be the nominee of the nonparty political organization. The names of the other candidates shall appear on the ballot as candidates "nominated by petition." A copy of the written record of the result of the drawing shall be kept with the nomination petition of each affected candidate, and each candidate shall be sent a copy for the candidate's records not later than seven days after the close of the filing period.

21.201(3) *Multiple nomination certificates.* If more than one nomination certificate is received for the same office from groups with the same nonparty political organization name, the name of each of these candidates shall be written on a separate piece of paper, all of which shall be as nearly uniform in size and material as possible and placed in a receptacle so that the names cannot be seen. On the next working day following the close of the nomination period, all affected candidates shall be notified of the time and place of the drawing. The candidates shall be invited to attend or to send a representative. In the presence of witnesses, the state commissioner of elections or the county commissioner, as appropriate, or a designee of the state or county commissioner, shall publicly draw one of the names; and that person shall be declared to be the nominee of the nonparty political organization. The names of the other candidates, including any candidate who filed nomination petitions, shall appear on the ballot as candidates "nominated by petition." A copy of the written record of the result of the drawing shall be kept with the nomination certificate of each affected candidate, and each candidate shall be sent a copy for the candidate's records not later than seven days after the close of the filing period.

This rule is intended to implement Iowa Code section 44.17.

721—21.202(43,52) Form of primary election ballot. All primary election ballots shall meet the following formatting requirements:

21.202(1) *Required information.* In addition to other requirements listed in the Iowa Code, primary election ballots shall also include the following information:

a. The name of the election.

b. The name of the party, which shall be printed at the top of the ballot in at least 24-point type.

c. The name of the county.

d. Instructions for how to mark the ballot.

21.202(2) *Headings and lines.* Rescinded IAB 9/8/10, effective 8/16/10.

21.202(3) *Office titles and order of offices.* Each office printed on the ballot shall be preceded by an office title. The order of offices on the primary election ballot shall be as follows:

a. In gubernatorial election years, the order of office titles on the primary election ballot shall be listed as follows:

(1) U.S. Senator (if any).
(2) U.S. Representative, District ___.
(3) Governor.
(4) Secretary of State.
(5) Auditor of State.
(6) Treasurer of State.
(7) Secretary of Agriculture.
(8) Attorney General.
(9) State Senator, district ___ (if any).
(10) State Representative, District ___.
(11) Board of Supervisors (if plan II or plan III, then Board of Supervisors, District ___).
(12) Treasurer.
(13) Recorder.
(14) County Attorney.

b. In presidential election years, the order of office titles on the primary election ballot shall be listed as follows:

(1) U.S. Senator (if any).
(2) U.S. Representative, District ___.
(3) State Senator, District ___ (if any).
(4) State Representative, District ___.
(5) Board of Supervisors (if plan II or plan III, then Board of Supervisors, District ___).
(6) Auditor.
(7) Sheriff.

c. If an office is printed on the primary election ballot followed by the words "To Fill Vacancy," that office shall be listed after the other offices under the appropriate heading. If the office followed by the words "To Fill Vacancy" is the board of supervisors, that office shall appear after the other board of supervisors office(s).

21.202(4) *Vote for number.* Under each office title, the number of choices a voter may make in the race shall be printed in the following form: "Vote for no more than ___." The number of choices the voter may make for each race is the number of individuals to be elected to the office at the general election.

21.202(5) *Write-in vote targets.* After the candidates' names for each office (if any), a target shall be placed next to a line for voters to write in a nominee for the office. The number of write-in targets and lines printed under each office shall match the vote for number referenced in subrule 21.202(4). Under each write-in line, the following words shall be printed: "Write-in vote, if any."

21.202(6) *Font size.* Candidates' names shall be printed in upper and lower case letters, and the font size shall be no less than 10-point type.

21.202(7) *Two-sided ballots.* If a primary election ballot must be printed on two sides, the words "Turn the ballot over" shall be printed on both sides of the ballot, at the bottom.

This rule is intended to implement 2009 Iowa Code Supplement section 43.31 [2009 Iowa Acts, House File 475, section 6].

[**ARC 8698B**, IAB 4/21/10, effective 6/15/10; **ARC 9049B**, IAB 9/8/10, effective 8/16/10]

721—21.203(49,52) Form of general election ballot. All general election ballots shall meet the following formatting requirements:

21.203(1) *Required information.* In addition to other requirements listed in the Iowa Code, general election ballots shall also include the following information:

a. The name of the election.
b. The name of the county.
c. Instructions for how to mark the ballot, including instructions for voting on judicial retentions and constitutional amendments or public measures and instructions for straight-party voting.
d. Ballot location of the judges' names and any constitutional amendment(s).

21.203(2) *Headings and lines.* Rescinded IAB 9/8/10, effective 8/16/10.

21.203(3) *Office titles, order of offices and public measures.* Each office printed on the ballot shall be preceded by an office title. The order of offices and public measures listed on the general election ballot shall be as follows:

a. In gubernatorial election years, the order of office titles and public measures on the general election ballot shall be listed as follows:

(1) U.S. Senator (if any).
(2) U.S. Representative, District ___.
(3) Governor and Lt. Governor.
(4) Secretary of State.
(5) Auditor of State.
(6) Treasurer of State.
(7) Secretary of Agriculture.
(8) Attorney General.
(9) State Senator, District ___ (if any).

(10) State Representative, District ___.
(11) Board of Supervisors (if plan II or plan III, then Board of Supervisors, District ___).
(12) Treasurer.
(13) Recorder.
(14) County Attorney.
(15) Township Trustee (if any).
(16) Township Clerk (if any).
(17) County Public Hospital Trustee (if any).
(18) Soil and Water Conservation District Commissioner.
(19) County Agricultural Extension Council Member.
(20) Other nonpartisan offices (if any).
(21) Supreme Court Justice (if any).
(22) Court of Appeals Judge (if any).
(23) District Court Judge (if any).
(24) District Court Associate Judge (if any).
(25) Associate Juvenile Judge (if any).
(26) Associate Probate Judge (if any).
(27) Public Measures (if any). Under the public measures heading, measures shall be listed in the following order:
1. Constitutional Amendment (if any).
2. State Public Measure (if any).
3. County Public Measure (if any).
4. City Public Measure (if any).

b. In presidential election years, the order of office titles on the general election ballot shall be listed as follows:
(1) President and Vice President.
(2) U.S. Senator (if any).
(3) U.S. Representative, District ___.
(4) State Senator, District ___ (if any).
(5) State Representative, District ___.
(6) Board of Supervisors (if plan II or plan III, then Board of Supervisors, district ___).
(7) Auditor.
(8) Sheriff.
(9) Township Trustee (if any).
(10) Township Clerk (if any).
(11) County Public Hospital Trustee (if any).
(12) Soil and Water Conservation District Commissioner.
(13) County Agricultural Extension Council Member.
(14) Other nonpartisan offices (if any).
(15) Supreme Court Justice (if any).
(16) Court of Appeals Judge (if any).
(17) District Court Judge (if any).
(18) District Court Associate Judge (if any).
(19) Associate Juvenile Judge (if any).
(20) Associate Probate Judge (if any).
(21) Public Measures (if any). Under the public measures heading, measures shall be listed in the following order:
1. Constitutional Amendment (if any).
2. State Public Measure (if any).
3. County Public Measure (if any).
4. City Public Measure (if any).

c. If an office is printed on the general election ballot followed by the words "To Fill Vacancy," that office shall be listed after the other offices under the appropriate heading. If the office followed by the words "To Fill Vacancy" is the board of supervisors, that office shall appear after the other board of supervisors office(s).

21.203(4) *Vote for number.* Under each office title, the number of choices a voter may make in the race shall be printed in the following form: "Vote for no more than ___". The number of choices the voter may make for each race is the number of individuals to be elected to the office at the general election. Under the "President and Vice President" office title, "Vote for no more than one team" shall be printed on the ballot. Under the "Governor and Lt. Governor" office title, "Vote for no more than one team" shall be printed on the ballot.

21.203(5) *Write-in vote targets.* After the candidates' names for each office (if any), a target shall be placed next to a line for voters to write in a nominee for the office. The number of write-in targets and lines printed under each office shall match the vote for number referenced in subrule 21.203(4). Under each write-in line, the following words shall be printed: "Write-in vote, if any". For the offices of President and Vice President, there shall be one write-in target printed to the left of two write-in lines. Under the write-in lines, the commissioner shall print the following: "Write-in vote for President, if any" and "Write-in vote for Vice President, if any". For the offices of governor and lieutenant governor, there shall be one write-in target printed to the left of two write-in lines. Under the write-in lines, the commissioner shall print the following: "Write-in vote for Governor, if any" and "Write-in vote for Lt. Governor, if any".

21.203(6) *Font size.* Candidates' names shall be printed in upper and lower case letters, and the font size shall be no less than 10-point type.

21.203(7) *Two-sided ballots.* If a general election ballot must be printed on two sides, the words "Turn the ballot over" shall be printed on both sides of the ballot, at the bottom.

This rule is intended to implement 2009 Iowa Code Supplement section 49.57A [2009 Iowa Acts, House File 475, section 32].

[**ARC 8698B**, IAB 4/21/10, effective 6/15/10; **ARC 9049B**, IAB 9/8/10, effective 8/16/10]

721—21.204 to **21.299** Reserved.

DIVISION III
ABSENTEE VOTING

721—21.300(53) Satellite absentee voting stations.

21.300(1) *Establishment of stations.* Satellite absentee voting stations may be established by the county commissioner of elections or by a petition of eligible electors of the jurisdiction conducting the election.

a. Satellite absentee voting stations established by the county commissioner. The county commissioner of elections may designate locations in the county for satellite absentee voting stations. Satellite absentee voting stations established by the commissioner shall be accessible to elderly and disabled voters. Satellite absentee voting stations must also be established so as to provide for voting in secret and ballot security.

b. Satellite absentee voting stations established after receipt of a valid petition. A petition requesting a satellite absentee voting station shall be substantially in the form titled "Petition Requesting Satellite Absentee Voting Station" available on the state commissioner's Web site. If the commissioner receives a petition requesting a satellite absentee voting station on or before the petition deadline set forth in Iowa Code section 53.11, the commissioner shall determine the validity of the petition within 24 hours. A petition requesting a satellite absentee voting station is valid if it contains signatures of not less than 100 eligible electors of the jurisdiction conducting the election. Electors signing the petition must include their signature, house number, street, and date the petition was signed. Signatures on lines not containing all of the required information shall not be counted. The heading on each page of the petition shall include the satellite location requested and the election name or date for which the location is requested. Signatures on petition pages without the required heading shall not be counted.

c. Mandatory rejection of certain satellite absentee voting stations. Otherwise valid petitions for satellite absentee voting stations shall be rejected within four days of the commissioner's receipt of the petition if:

(1) The site requested is not accessible to elderly and disabled voters,

(2) The site requested has other physical limitations that make it impossible to meet the requirements for ballot security and secret voting, or

(3) The owner of the site refuses permission to locate the satellite absentee voting station at the site requested on the petition.

d. Discretionary rejection of certain satellite absentee voting stations. Otherwise valid petitions for satellite absentee voting stations may be rejected within four days of the commissioner's receipt of the petition if:

(1) A petition is received requesting satellite voting for a city runoff election and a special election is scheduled to be held between the regular city election and a city runoff election.

(2) The owner of the site demands payment for its use.

e. Provision of ballots. Only ballots from the county in which the site is located may be provided at the satellite absentee voting station. Ballots must be provided for the precinct in which the satellite absentee voting station is located; however, it is not necessary to provide ballots from all of the precincts in the political subdivision for which the election is being conducted.

21.300(2) *Notice provided.* Notice shall be published at least seven days before the opening of any satellite absentee voting station. If more than one satellite absentee voting station will be provided, a single publication may be used to notify the public of their availability. If it is not possible to publish the notice at least seven days before the station opens due to the receipt of a petition, the notice shall be published as soon as possible.

A notice shall also be posted at each satellite absentee voting station at least seven days before the opening of the satellite absentee voting station. The notice shall remain posted as long as the satellite absentee voting station is scheduled for service. If it is not possible to post the notice at least seven days before the station opens due to the receipt of a petition, the notice shall be posted as soon as possible.

Both the published and posted notices shall include the following information:

a. The name and date of the election for which ballots will be available.

b. The location(s) of the satellite absentee voting station(s).

c. The dates and times that the station(s) will be open.

d. The precincts for which ballots will be available.

e. An announcement that voter registration forms will be available for new registrations in the county and that changes in the registration records of people who are currently registered within the county may be made at any time.

If the satellite absentee voting station is located in a building with more than one public entrance, brief notices of the location of the satellite absentee voting station shall be posted on building directories, bulletin boards, or doors. These notices shall be posted no later than the time the station opens and shall be removed immediately after the satellite absentee voting station has ceased operation for an election.

21.300(3) *Staff.* Satellite absentee voting station workers may be selected from among the staff members of the commissioner's office, from the election board panel drawn up pursuant to Iowa Code sections 49.15 and 49.16, or a combination of these two sources. Compensation of workers selected from the election board panel shall be at the rate provided in Iowa Code section 49.20.

At least three people shall be assigned to work at each satellite absentee voting station; more workers may be added at the commissioner's discretion. All workers must be registered voters of the county, and for primary and general elections the workers must be registered with a political party; however, workers not affiliated with any party may be assigned to work at a satellite absentee voting station as long as not more than one-third of the workers assigned to a particular satellite absentee voting station are not affiliated with a political party. For all elections, no more than a simple majority of the workers shall be members of the same political party.

People who are prohibited from working at the polls pursuant to Iowa Code section 49.16 may not work at satellite absentee voting stations.

21.300(4) *Oath required.* Before the first day of service at a satellite absentee voting station, each worker shall take an oath substantially in the form titled "Election Official/Clerk Oath" available on the state commissioner's Web site. The oath must be taken before each election.

21.300(5) *Suggested supplies for each satellite absentee voting station.* A list of supplies suggested for each satellite absentee voting station is available on the state commissioner's Web site.

21.300(6) *Ballot transport and storage.* At the commissioner's discretion the ballots may be transported between the commissioner's office and the satellite absentee voting station by the workers who will be on duty that day, or by two people of different political parties who have been designated as couriers by the commissioner. It is not necessary for the same people to transport the ballots in both directions.

If the ballots are transported by the satellite absentee voting station workers, two workers who are members of different political parties and the ballots must travel together in the same vehicle.

Ballots may be stored at the satellite absentee voting station during hours when the station is closed only if they are kept in a locked cabinet or container. The cabinet must be located in a room which is kept locked when not in use. Voted absentee ballots must be delivered to the commissioner's office at least once each week.

21.300(7) *Ballot receipts.* Satellite absentee voting station workers shall sign receipts for the ballots taken to the satellite absentee voting site. The receipt shall be substantially in the form titled "Satellite Absentee Voting Station Ballot Record and Receipt" available on the state commissioner's Web site. A copy of the ballot record and receipt shall be retained in the commissioner's office. The original shall be sent with the ballots to the satellite absentee voting station.

21.300(8) *Arrangement of the satellite absentee voting station.* Protection of the security of the ballots (both voted and unvoted) and the secrecy of each person's vote shall be considered in the arranging of the satellite absentee voting station.

a. Security. The satellite absentee voting station shall be arranged so that ballots are protected against removal from the station by unauthorized persons.

b. Voting area. Voting booths without curtains shall be placed so that passersby and other voters may not walk directly behind a person using the booth. At least one voting booth must be accessible to the disabled. The booth must be designed to accommodate a person seated in a chair or wheelchair. A chair must be provided for voters who wish to sit down while voting or waiting in line.

c. Campaign signs and electioneering. No signs supporting or opposing any candidate or question on the ballot shall be posted on the premises of or within 300 feet of any outside door of any building affording access to a satellite absentee voting station during the hours when absentee ballots are available at the satellite absentee voting station. No electioneering shall be allowed within the sight or hearing of voters while they are at the satellite absentee voting station.

21.300(9) *Operation of the satellite absentee voting station.* At all times the satellite absentee voting station shall have at least two workers present to preserve the security of the ballots, both voted and unvoted.

21.300(10) *Voter registration at the satellite absentee voting station.* Each satellite absentee voting station shall provide forms necessary to register voters, including the oaths necessary to process voters registering pursuant to Iowa Code section 48A.7A, and to record changes in voter registration records. Workers shall also be provided with a method of verifying whether people applying for absentee ballots are registered voters.

The commissioner may provide a list of registered voters in the precincts served by the station. The list may be on paper or contained in a computerized data file. As an alternative, the commissioner may provide a computer connection with the commissioner's office.

21.300(11) *Procedure for issuing absentee ballot.* The instructions for absentee voting are available on the state commissioner's Web site and shall be provided to satellite absentee voting station workers unless the commissioner prepares instructions containing substantially the same information as the instructions available on the state commissioner's Web site.

21.300(12) *Closing a station.* The instructions for closing a satellite absentee voting station are available on the state commissioner's Web site and shall be provided to satellite absentee voting station

workers unless the commissioner prepares instructions containing substantially the same information as the instructions available on the state commissioner's Web site.

21.300(13) *Use of I-Voters at satellite absentee voting stations.* Any county commissioner who wants to use the I-Voters statewide voter registration database at a satellite absentee voting station shall:

a. Complete an application to use I-Voters at a satellite absentee voting station. A separate application shall be completed for each satellite absentee voting station. The application is available on the state commissioner's Web site. The application shall be submitted at least seven days before the opening of the satellite absentee voting station. If it is not possible to submit an application at least seven days before the station opens due to the receipt of a petition, the application shall be submitted as soon as possible. The application will be considered by the state commissioner as soon as practicable after it is received. The state commissioner reserves the right to reject an application for any reason or to limit the number of users at any satellite absentee voting station.

b. Use a cellular telephone service or a wired Internet connection to connect to the Internet from the satellite absentee voting station. If the county uses a wired Internet connection, the commissioner shall use either a regular or a wireless router between the wired Internet connection and the county's computers. Connection to a facility's wireless network is not permitted.

c. Configure any wireless routers to be used between the facility's wired Internet connection and the county's laptop computers as follows:

(1) A minimum 10-character password must be assigned to the router administration screens.

(2) WPA (AES) security for wireless connections with a minimum 10-character password must be used.

(3) Remote management of the router must be prohibited.

(4) Universal Plug & Play must be turned off.

(5) Port forwarding on the router must not be disabled.

(6) Unauthorized connections shall be prohibited, including smartphones, personal digital assistants (PDAs) and laptops.

d. Configure any wired routers to be used between the facility's wired Internet connection and the county's laptop computers as follows:

(1) Remote management of the router must be prohibited.

(2) Universal Plug & Play must be turned off.

(3) Port forwarding on the router must not be disabled.

(4) Unauthorized connections shall be prohibited, including smartphones, PDAs and laptops.

(5) Administrator passwords for the routers must be changed from the default passwords, and standard county password policies shall be followed.

e. Laptops used at a satellite absentee voting station shall be configured as follows:

(1) The hard drives must be encrypted.

(2) The operating system must be fully supported by the operating system vendor.

(3) The operating system must be fully patched.

(4) Antivirus software and anti-spyware must be installed and up to date.

(5) A full antivirus and anti-spyware scan must be done during the week before a laptop is used at a satellite absentee voting station and at least once a week thereafter while the laptop is being used at satellite absentee voting stations.

(6) The administrator password must be changed from the default password.

(7) Guest user accounts must be disabled or renamed.

(8) File/print sharing must be turned off, and remote access must be disabled.

(9) Bluetooth must be turned off.

(10) The Windows firewall must be turned on.

f. Laptops connected to I-Voters at a satellite absentee voting station shall never be left unattended.

g. Laptops connected to I-Voters at a satellite absentee voting station shall not have any USB memory sticks or CDs/DVDs inserted in the computer after the virus scan is conducted pursuant to subrule 21.300(13), paragraph *"e."*

h. Laptops connected to I-Voters at a satellite absentee voting station shall not be used to visit any other Web sites.

i. No software applications, other than I-Voters, shall be used while the I-Voters application is in use at a satellite absentee voting station.

This rule is intended to implement Iowa Code section 53.11.
[**ARC 8045B**, IAB 8/26/09, effective 7/27/09; **ARC 9139B**, IAB 10/6/10, effective 9/16/10]

721—21.301(53) Absentee ballot requests from voters whose registration records are "inactive."

21.301(1) *In person.* Absentee voters whose registration records are "inactive" and who appear in person to vote, either at the office of the commissioner or at a satellite absentee voting station, shall be assigned a status of "active" after requesting an absentee ballot.

21.301(2) *By mail.* When a request for an absentee ballot is received by mail from a voter whose registration record has been made "inactive" pursuant to Iowa Code section 48A.29, the commissioner shall update the voter's residential address to the address listed on the absentee ballot request if requested by the voter and assign the voter a status of "active."

21.301(3) *Absentee ballots received from a voter subsequently assigned "inactive" status.* The commissioner shall set aside the absentee ballot of a voter whose status is changed to "inactive" pursuant to Iowa Code section 48A.26, subsection 6, after the voter has submitted the voter's ballot. The commissioner shall notify the voter, pursuant to Iowa Code section 53.31, informing the voter that the absentee ballot may be counted if the voter personally delivers or mails a copy of the voter's identification as set forth in Iowa Code section 48A.8 to the commissioner's office before the absentee and special voters precinct board convenes to count absentee ballots, or reconvenes to consider challenged absentee ballots pursuant to Iowa Code section 50.22. If the commissioner does not receive a copy of the voter's identification before the absentee and special voters precinct board reconvenes to consider challenged absentee ballots pursuant to Iowa Code section 50.22, the absentee and special voters precinct board shall reject the absentee ballot.

This rule is intended to implement Iowa Code section 48A.29 and sections 48A.26, 48A.37 and 53.25 as amended by 2009 Iowa Acts, House File 475.
[**ARC 8045B**, IAB 8/26/09, effective 7/27/09]

721—21.302(48A) In-person absentee registration. After the close of voter registration for an election, a person who appears in person to apply for and vote an absentee ballot may register to vote if the person provides proof of identity and residence in the precinct in which the voter intends to vote using identification that meets the requirements set forth in Iowa Code section 48A.7A. The voter must also complete an oath of person registering on election day. If the voter does not have appropriate identification, the voter may establish identity and residence using the attestation procedure in Iowa Code section 48A.7A, subsection 1, paragraph *"c."* Otherwise, the person may cast only a provisional ballot pursuant to Iowa Code section 49.81. Provisional ballot envelopes shall be used.

This rule is intended to implement Iowa Code section 48A.7A.
[**ARC 8045B**, IAB 8/26/09, effective 7/27/09]

721—21.303(53) Mailing absentee ballots. The commissioner shall mail the following materials to each person who has requested an absentee ballot:

1. Ballot. The ballot that corresponds to the voter's residence, as indicated by the address on the absentee ballot application.
2. Public measure text. The full text of any public measures that are summarized on the ballot, but not printed in full.
3. Secrecy envelope. Secrecy envelope, if the ballot cannot be folded to cover all of the voting ovals, as required by Iowa Code section 53.8(1).
4. Affidavit envelope. The affidavit envelope, which shall be marked with the I-Voters-assigned sequence number used to identify the absentee request in the commissioner's records.
5. Return carrier envelope. The return carrier envelope, which shall be addressed to the commissioner's office and bear appropriate return postage or a postal permit guaranteeing that the

commissioner will pay the return postage and which shall be marked with the I-Voters-assigned sequence number used to identify the absentee request in the commissioner's records.

6. Delivery envelope. The delivery envelope, which shall be addressed to the voter and bear the I-Voters-assigned sequence number used to identify the absentee request in the commissioner's records. All other materials shall be enclosed in the delivery envelope.

7. Instructions. Absentee voting instructions, which shall be in substantially the form prescribed by the state commissioner of elections.

8. Receipt. The receipt form required by 2007 Iowa Acts, Senate File 601, section 227, which may be printed on the instructions required by numbered paragraph "7" above.

This rule is intended to implement Iowa Code sections 53.8 and 53.17 as amended by 2009 Iowa Acts, House File 475.

[**ARC 8045B**, IAB 8/26/09, effective 7/27/09]

721—21.304(53) Absentee ballot requests from voters whose registration records are "pending." A voter who requests an absentee ballot and is assigned a status of "pending" must provide identification pursuant to Iowa Code section 48A.8 as amended by 2009 Iowa Acts, House File 475.

21.304(1) *In-person applicants.* In-person applicants for absentee ballots assigned a status of "pending" must show identification pursuant to Iowa Code section 48A.8 as amended by 2009 Iowa Acts, House File 475, before casting a ballot. If an in-person applicant provides identification as required by Iowa Code section 48A.8 when casting an absentee ballot in person, the commissioner shall assign the voter's registration record a status of "active" and provide the voter with an absentee ballot. Voters who are unable to provide identification as required by Iowa Code section 48A.8 shall be offered a provisional ballot pursuant to Iowa Code section 49.81.

21.304(2) *By-mail applicants.* By-mail applicants for absentee ballots assigned a status of "pending" must either come to the commissioner's office and show identification pursuant to Iowa Code section 48A.8 as amended by 2009 Iowa Acts, House File 475, or mail a photocopy of identification pursuant to Iowa Code section 48A.8 before the voter's absentee ballot can be counted by the absentee and special voters precinct board. The commissioner shall mail the voter a notice informing the voter of the requirement to provide one of the identification documents listed in Iowa Code section 48A.8 before the voter's absentee ballot can be considered for counting by the absentee and special voters precinct board. If a by-mail applicant provides identification as required by Iowa Code section 48A.8, the commissioner shall assign the voter's registration record a status of "active."

21.304(3) *By-mail absentee voters assigned a status of "pending" who do not provide identification prior to election day.* The ballot of a by-mail absentee voter assigned a status of "pending" who has not shown identification in person at the commissioner's office or provided a photocopy of identification by mail pursuant to Iowa Code section 48A.8 as amended by 2009 Iowa Acts, House File 475, shall be challenged by a member of the absentee and special voters precinct board on election day pursuant to Iowa Code section 53.31. The absentee and special voters precinct board shall immediately mail notice of the challenge to the voter. The notice shall include the deadline for the voter to provide identification pursuant to Iowa Code section 48A.8. If the voter provides identification pursuant to Iowa Code section 48A.8 prior to the time the absentee and special voters precinct board reconvenes to consider challenged absentee ballots pursuant to Iowa Code section 50.22, the voter's ballot shall be considered for counting by the absentee and special voters precinct board. If the voter does not provide identification pursuant to Iowa Code section 48A.8 prior to the time the absentee and special voters precinct board reconvenes to consider challenged absentee ballots pursuant to Iowa Code section 50.22, the voter's absentee ballot shall be rejected by the absentee and special voters precinct board. The voter shall be notified of the reason for rejection pursuant to Iowa Code section 53.25 as amended by 2009 Iowa Acts, House File 475.

This rule is intended to implement Iowa Code section 53.31 and sections 48A.8 and 53.25 as amended by 2009 Iowa Acts, House File 475.

[**ARC 8045B**, IAB 8/26/09, effective 7/27/09]

721—21.305(53) Confirming commissioner's receipt of an absentee ballot on election day. If a voter's name is on the absentee list prepared pursuant to Iowa Code sections 49.72 and 53.19 as amended by 2010 Iowa Acts, Senate File 2196, and the voter appears at the polling place to vote on election day, the precinct election officials may contact the commissioner's office to confirm whether the commissioner has received the voter's absentee ballot. If the precinct election officials are able to confirm either that the commissioner has not received the voter's absentee ballot or that the voter's absentee ballot has been received but cannot be counted due to a defective or incomplete affidavit, the precinct election officials shall permit the voter to cast a regular ballot at the polling place.

After confirming that a voter's absentee ballot has not been received or that a voter's absentee ballot has been received but cannot be counted due to a defective or incomplete affidavit, the commissioner shall mark the voter's absentee ballot as "Void" in the statewide voter registration system. The commissioner shall enter "Voted at polls" in the comment box that appears when the ballot is marked as "Void."

If a voter's absentee ballot is returned to the commissioner's office after being marked as "Void" pursuant to this rule, the absentee ballot shall be rejected by the absentee and special voters precinct board pursuant to Iowa Code section 53.25 because the voter cast a ballot in person at the polling place.

This rule is intended to implement Iowa Code sections 49.72, 49.81 and 53.19 as amended by 2010 Iowa Acts, Senate File 2196.
[**ARC 8779B**, IAB 6/2/10, effective 7/1/10]

721—21.306 to **21.319** Reserved.

721—21.320(53) Absentee voting by UOCAVA voters. This rule applies only to absentee voting by persons who are entitled to vote by absentee ballot under the federal Uniformed and Overseas Citizens Absentee Voting Act (UOCAVA) and Iowa Code chapter 53, division II, "Absent Voting by Armed Forces."

21.320(1) *Definitions.* The following definitions apply to this rule:

"Armed forces," as used in this rule, is defined in Iowa Code section 53.37(3).

"FPCA" means the federal postcard absentee ballot application and voter registration form authorized for use in Iowa by Iowa Code section 53.38.

"UOCAVA voter" means any person who is entitled to vote by absentee ballot under the Uniformed and Overseas Citizens Absentee Voting Act (UOCAVA) and Iowa Code chapter 53, division II, "Absent Voting by Armed Forces."

21.320(2) *Requests for absentee ballots.* All requests for absentee ballots shall be made in writing. Additional requirements for requesting absentee ballots and for processing the requests are set forth below.

a. Forms. UOCAVA voters may use the following official forms to request absentee ballots:

(1) A federal postcard absentee ballot application and voter registration form (FPCA).

(2) A state of Iowa official absentee ballot request form.

(3) For general elections only, a proxy absentee ballot application prescribed by the state commissioner of elections and submitted pursuant to Iowa Code Supplement section 53.40(1)*"b."*

b. Form not required. UOCAVA voters may request absentee ballots in writing without using an official form. The written request shall be honored if it includes all of the following information about the voter:

(1) Name.

(2) Age or date of birth.

(3) Iowa residence, including street address (if any) and city.

(4) Address to which the ballot shall be sent.

(5) Township of residence, if applicable.

(6) County of residence.

(7) Party affiliation, if the request is for a ballot for a primary election.

(8) Signature of voter.

(9) Statement explaining why the voter is eligible to receive ballots under the provisions of Iowa Code chapter 53, division II. For example, "I am a U.S. citizen living in France."

c. Methods for transmitting absentee ballot requests. UOCAVA voters may transmit absentee ballot requests by any of the following methods:

(1) Mail.

(2) Personal delivery by the voter or a person designated by the voter.

(3) Facsimile machine.

(4) Scanned application form or letter transmitted by E-mail. Requests by E-mail that do not include either an image of the physical signature or a digital signature shall not be accepted.

d. Original request not needed. If the request is sent by E-mail or by fax, it is not necessary for the UOCAVA voter to send to the commissioner the original copy of the FPCA or other official form or written request for an absentee ballot.

e. Multiple requests from the same person. Before the ballot is ready to mail, if the commissioner receives more than one request for an absentee ballot for a particular election (or series of elections) by or on behalf of a UOCAVA voter, the last request received shall be the one honored. However, if one of the requests is for a general election ballot and is made using the proxy absentee ballot application process permitted by Iowa Code Supplement section 53.40(1)*"b,"* the request received from the voter shall be the one honored, not the proxy request.

f. Subsequent request after ballot has been sent. Not more than one ballot shall be transmitted by the commissioner to any UOCAVA voter for a particular election unless, after the ballot has been mailed or transmitted electronically pursuant to rule 721—21.320(53), the voter reports a change in the address, E-mail address or fax number to which the ballot should be sent. The commissioner shall void the original absentee ballot request and include a comment in the voter's registration record, noting the I-Voters-sequence number of the original ballot and noting that a replacement ballot was sent to an updated address. If the original ballot is returned voted, it shall be counted only if the replacement ballot does not arrive before the deadline for receiving absentee ballots set forth in Iowa Code section 53.17.

g. Requests for absentee ballots through the end of the calendar year. 2009 Iowa Code Supplement section 53.40 as amended by 2010 Iowa Acts, Senate File 2194, permits UOCAVA voters to request the commissioner to send absentee ballots for all elections as permitted by state law. In response to an absentee ballot request in which the UOCAVA voter requests ballots for all elections, the commissioner shall send the applicant a ballot for each election held after the request is received through the end of the calendar year in which the request is received. If the applicant does not request ballots for all elections or does not specify which elections the request is for, the commissioner shall send the applicant a ballot only for federal elections through the end of the calendar year in which the request is received.

(1) When an absentee ballot for a UOCAVA voter is returned as undeliverable by the United States Postal Service or an E-mail server or a fax cannot be transmitted to the number provided by the voter, the commissioner shall do the following:

1. Verify that the commissioner's office sent the absentee ballot to the address, E-mail address or fax number requested by the UOCAVA voter. If the absentee ballot was sent incorrectly, the commissioner shall correct the error and immediately transmit a new absentee ballot.

2. If the absentee ballot was sent to the correct mailing address, E-mail address or fax number, the commissioner shall E-mail the voter if the commissioner has an E-mail address on file to inform the voter that the voter's ballot was returned undeliverable, and the commissioner must be provided with a new FPCA containing a new mailing address if the voter wishes to continue to receive absentee ballots.

3. If the absentee ballot was sent to the correct mailing address, E-mail address or fax number, the commissioner shall also attempt to contact the voter by sending a forwardable notice to both the voter's residential address and the voter's absentee mailing address informing the voter that the voter's ballot was returned undeliverable, and the commissioner must be provided with a new FPCA containing a new mailing address, E-mail address or fax number if the voter wishes to continue to receive absentee ballots.

4. If the absentee ballot was mailed, E-mailed or sent to the correct address or fax number, the commissioner shall terminate the voter's current FPCA request and shall not send the voter any further ballots unless a new absentee ballot request is received from the voter.

(2) If the voter provides a new FPCA with a new mailing address, E-mail address or fax number before election day, the commissioner shall enter a new absentee request on the voter's registration record and transmit the ballot via the method requested by the voter. The voter may request that the commissioner transmit the ballot electronically pursuant to subrule 21.320(3).

21.320(3) *Electronic transmission of absentee ballots to UOCAVA voters.*

a. Electronic transmission of absentee ballots by facsimile machine or by E-mail is limited to UOCAVA voters who specifically ask for this service. A UOCAVA voter who asks for electronic transmission of an absentee ballot may request this service for all elections for which the person is qualified to vote or for specific elections either individually or for a specific period of time. The commissioner may employ FVAP's secure transmission program to facilitate electronic transmission of absentee ballots to UOCAVA voters.

b. Forms. The state commissioner shall provide the following forms and instructions for the electronic transmission of absentee ballots to UOCAVA voters:

(1) Instructions to the county commissioners of elections for providing this service.

(2) Instructions to the voter for marking and returning the ballot.

(3) The affidavit envelope form, which can be printed by the voter on an envelope and used for the voter's declaration of eligibility and voter registration application, if necessary.

(4) The return envelope form, which can be printed by the voter on an envelope and used to return the ballot, postage paid through the FPO/APO postal service.

21.320(4) *Ballot return by electronic transmission.*

a. Electronic transmission of a voted absentee ballot from the voter to the commissioner is permitted only for UOCAVA voters who are in an area designated as an imminent danger pay area, as provided in subrule 21.1(13). In addition, the absentee ballot may be returned via electronic transmission only if the voter waives the right to a secret ballot. In addition to signing the affidavit required by Iowa Code section 53.13, the voter shall sign a statement in substantially the following form: "I understand that by returning this ballot by electronic transmission my voted ballot will not be secret. I hereby waive my right to a secret ballot."

b. When an absentee ballot is received via electronic transmission, the person receiving the transmission shall examine it to determine that all pages have been received and are legible. The person receiving an electronic transmission shall not reveal how the voter voted.

c. The absentee ballot shall be sealed in an envelope marked with the voter's name. The affidavit of the voter and the application for the ballot shall be attached to the envelope. These materials shall be stored with other returned absentee ballots.

This rule is intended to implement Iowa Code sections 53.40 and 53.46.

[**ARC 8045B**, IAB 8/26/09, effective 7/27/09; **ARC 8777B**, IAB 6/2/10, effective 5/7/10]

721—21.321 to **21.349** Reserved.

721—21.350(53) Absentee ballot processing for elections held following July 1, 2007. Rescinded IAB 9/26/07, effective 9/7/07.

721—21.351(53) Receiving absentee ballots. The commissioner shall carefully account for and protect all absentee ballots returned to the office.

21.351(1) *Note receipt.* The commissioner shall write or file-stamp on the return carrier envelope the date that the ballot arrived in the commissioner's office. The commissioner shall also record receipt of the ballot in I-Voters.

21.351(2) *Temporary storage.* If necessary, the commissioner shall immediately put the ballot into a secure container, such as a locked ballot box, until the ballots can be moved to the secure storage area.

21.351(3) *Secure area.* The commissioner shall deliver the ballots to a secure area where returned absentee ballots will be reviewed for completeness and defects.

[**ARC 8779B**, IAB 6/2/10, effective 7/1/10]

721—21.352(53) Review of returned affidavit envelopes.

21.352(1) *Personnel.* The commissioner may assign staff members to complete the review of returned affidavit envelopes. Only persons who have been trained for this responsibility shall be authorized to review affidavit envelopes.

21.352(2) *Affidavit envelopes reviewed.* The affidavit envelopes of all absentee ballots returned to the commissioner's office shall be reviewed, including those of ballots returned by the bipartisan team delivering absentee ballots to health care facilities, such as hospitals and nursing homes. If a reviewer finds that any absentee affidavits returned from any health care facility are incomplete or defective, the commissioner shall send the bipartisan delivery team back to assist voters as needed with completing affidavits or to deliver any replacement ballots.

21.352(3) *Instructions.* Each reviewer shall receive instructions in substantially the form prepared by the state commissioner of elections. The instructions shall provide basic security and procedural guidance and include a method for accounting for all returned absentee ballots. The prohibitions shall include:

a. Leaving unsecured ballots unattended.

b. Altering any information on any affidavit.

c. Adding any information to any affidavit, except as specifically required to comply with the requirements of the law.

d. Sealing any affidavit envelope found open.

e. Discarding any return carrier envelopes, ballots, or affidavit envelopes returned by voters.

[**ARC 8045B**, IAB 8/26/09, effective 7/27/09; **ARC 8779B**, IAB 6/2/10, effective 7/1/10]

721—21.353(53) Opening the return carrier envelopes. The commissioner may direct a staff member to open the return carrier envelopes either manually or with an automatic letter opener, if one is available. Only a trained reviewer may remove the contents of the envelope.

721—21.354(53) Review process. A reviewer shall remove the contents from only one return carrier envelope at a time.

21.354(1) *Return carrier envelopes preserved.* The return carrier envelopes shall be stored in a manner that will facilitate their retrieval, if necessary. They shall be stored for 22 months for federal elections and 6 months for local elections.

21.354(2) *Examination of affidavit envelope.* The reviewer shall make sure that:

a. The affidavit envelope is sealed, apparently with the ballot inside.

b. The affidavit envelope has not been opened and resealed.

c. The affidavit includes all of the following:

(1) A signature.

(2) For primary elections only, political party affiliation.

21.354(3) *No defects or incomplete information.* If the reviewer finds that the required information on the affidavit is complete and that there are no defects that would cause the absentee and special voters precinct board to reject the ballot, the reviewer shall put the affidavit envelope into a group of envelopes to be retained in the secure storage area with others that require no further attention until they are delivered to the absentee and special voters precinct board.

21.354(4) *Defective and incomplete affidavits.* The commissioner shall contact the voter if the reviewer finds any of the following flaws in the affidavit or affidavit envelope:

a. The commissioner shall contact the voter immediately if the affidavit envelope is defective. An affidavit envelope is defective if:

(1) The absentee ballot is not enclosed in the affidavit envelope.

(2) The affidavit envelope is not sealed.

(3) The affidavit envelope has been opened and resealed.

(4) The voter submits a change of address in a new precinct after returning a voted absentee ballot.

b. The commissioner shall contact the voter within 24 hours if the affidavit is incomplete. An incomplete affidavit lacks:

(1) The signature of the voter.

(2) For primary elections only, political party affiliation.

c. If an affidavit envelope has flaws that are included in both paragraphs *"a"* and *"b,"* the commissioner shall follow the process in paragraph *"a."*

21.354(5) *Defective and incomplete affidavits stored separately.* The commissioner shall store the defective and incomplete affidavit envelopes separately from other returned absentee ballot affidavit envelopes.

a. Incomplete affidavit envelopes requiring voter correction must be available for retrieval when the voter comes to make corrections.

b. Defective affidavit envelopes must be attached to the replacement ballot (if any) for review by the absentee and special voters precinct board.

[**ARC 8045B**, IAB 8/26/09, effective 7/27/09; **ARC 8779B**, IAB 6/2/10, effective 7/1/10]

721—21.355(53) Notice to voter. When the commissioner finds an incomplete absentee ballot affidavit or finds a defective affidavit envelope, the commissioner shall notify the voter in writing and, if possible, by telephone and by E-mail. The commissioner shall keep a separate checklist for each voter showing the reasons for which the voter was contacted and the methods used to contact the voter.

21.355(1) *Notice to voter—incomplete ballot affidavit.* Within 24 hours after receipt of an absentee ballot with an incomplete affidavit, the commissioner shall send a notice to the voter at the address where the voter is registered to vote, as well as to the address where the ballot was sent, if it is a different address. The notice shall include:

a. Explanation of missing required information (lack of signature or, for primary elections only, political party affiliation).

b. The voter's options for correcting the affidavit as follows:

(1) Completing the affidavit at the commissioner's office by 5 p.m. the day before the election;

(2) Requesting a replacement ballot pursuant to Iowa Code section 53.18; or

(3) Voting at the polls on election day.

c. Address of commissioner's office, business hours and contact information.

21.355(2) *Notice to voter—defective ballot affidavit.* Immediately after determining that an absentee ballot affidavit envelope is defective, the commissioner shall send a notice to the voter at the address where the voter is registered to vote, as well as to the address where the ballot was sent, if it is a different address. The notice shall include the following information:

a. Reason for defect.

b. The voter's options for correcting the defect as follows:

(1) Requesting a replacement ballot; or

(2) Voting at the polls on election day.

c. Process for requesting a replacement ballot.

d. Address of commissioner's office, business hours and contact information.

21.355(3) *Telephone contact.* If the voter has provided a telephone number, either on the absentee ballot application or on the voter's registration record, the commissioner shall also attempt to contact the voter by telephone. The commissioner shall keep a written record of the telephone conversation. The written record shall include the following information:

a. Name of the person making the call.

b. Date and time of the call.

c. Whether the person making the call spoke to the voter.

21.355(4) *E-mail contact.* If the voter has provided an E-mail address, either on the absentee ballot application or on the voter's registration record, the commissioner shall also attempt to contact the voter by E-mail. The E-mail message shall be the same message that was mailed to the voter. A copy of the E-mail message shall be attached to the checklist.

[**ARC 8045B**, IAB 8/26/09, effective 7/27/09; **ARC 8779B**, IAB 6/2/10, effective 7/1/10]

Rules 721—21.351(53) through 721—21.355(53) are intended to implement 2009 Iowa Code Supplement section 53.18 as amended by 2010 Iowa Acts, Senate file 2196, and section 53.25.

721—21.356 to **21.358** Reserved.

721—21.359(53) Processing absentee ballots before election day. The commissioner may only direct the absentee and special voters precinct board to open affidavit envelopes on the Monday before election day under the following circumstances:

For any election, only if the commissioner has provided secrecy envelopes (or folders) pursuant to subrule 21.359(1) and the commissioner determines removing secrecy envelopes from affidavit envelopes is necessary due to the quantity of voted absentee ballots received as set forth in Iowa Code section 53.23, subsection 3, paragraph *"a."*

For general elections, if the commissioner convenes the absentee and special voters precinct board pursuant to Iowa Code section 53.23, subsection 3, paragraph *"c,"* to begin tabulation of absentee ballots.

21.359(1) The secrecy envelope shall completely cover the ballot. The envelope shall have the following message printed on it using at least 24-point type:

Secrecy Envelope

After you vote, put your ballot in here.

21.359(2) When the absentee and special voters precinct board convenes to begin processing absentee ballots, the board shall first review voters' affidavits to determine which ballots will be accepted for counting and prepare the notices to those voters whose ballots have been rejected for the reasons set forth in 2009 Iowa Code Supplement section 53.25. Affidavit envelopes containing ballots that are rejected shall be stored in the manner prescribed by Iowa Code section 53.26. The applications submitted for rejected ballots shall be stored in a secure location for the time period required by Iowa Code section 50.19.

21.359(3) The affidavit envelopes containing ballots that have been accepted for counting by the absentee and special voters precinct board shall be stacked with the affidavits facing down. The envelopes shall be opened and the secrecy envelope containing the ballot shall be removed.

21.359(4) If a voter has not enclosed the ballot in a secrecy envelope and the ballot has not been folded in a manner that conceals all votes marked on the ballot, the officials shall put the ballot in a secrecy envelope without examining the ballot.

21.359(5) The following security procedures shall be followed:

a. The process shall be witnessed by observers appointed by the county chairperson of each of the political parties referred to in Iowa Code section 49.13, subsection 2. If, after receiving notice from the commissioner pursuant to Iowa Code section 53.23, subsection 3, paragraph *"a,"* either or both political parties fail to appoint an observer, the commissioner may continue with the proceedings.

b. No ballots shall be counted or examined before election day except as provided in Iowa Code section 53.23, subsection 3, paragraph *"c,"* as amended by 2009 Iowa Acts, House File 670, section 1.

c. When secrecy envelopes are removed from affidavit envelopes on the day before an election and not tabulated as permitted by Iowa Code section 53.23, subsection 3, paragraph *"c,"* as amended by 2009 Iowa Acts, House File 670, section 1, the number of secrecy envelopes shall be recorded before the ballots are stored and the number shall be verified before any ballots are removed from the secrecy envelopes on election day. The ballots may be bundled and sealed in groups of a specified number to make counting easier.

This rule is intended to implement Iowa Code section 53.23 as amended by 2009 Iowa Acts, House File 670.

[**ARC 8045B**, IAB 8/26/09, effective 7/27/09; **ARC 8779B**, IAB 6/2/10, effective 7/1/10]

721—21.360(53) Failure to affix postmark date. For any absentee ballot referred to in Iowa Code section 53.17, if the officially authorized postal service fails to affix a postmark date on the return carrier envelope, or the postmark date is illegible, but the date written on the voter's affidavit envelope is a date no later than the day prior to the election, the ballot shall be counted as provided in Iowa Code section

53.17. If no date can be read on either the return carrier envelope or the affidavit envelope, the affidavit envelope shall not be opened, and the ballot shall be rejected as provided in Iowa Code section 53.25 as amended by 2009 Iowa Acts, House File 475.

This rule is intended to implement Iowa Code section 53.17 and section 53.25 as amended by 2009 Iowa Acts, House File 475.

[**ARC 8045B**, IAB 8/26/09, effective 7/27/09]

721—21.361(53) Rejection of absentee ballot. The absentee and special voters precinct board shall reject absentee ballots without opening the affidavit envelope if any of the conditions cited in Iowa Code section 53.25 as amended by 2009 Iowa Acts, House File 475, exist.

21.361(1) An absentee ballot shall be rejected if the affidavit lacks the voter's signature.

21.361(2) An absentee ballot shall be rejected if the applicant is not a duly registered voter in the precinct in which the ballot is cast. "Precinct" means a precinct established pursuant to Iowa Code sections 49.3 through 49.5 or a consolidated precinct established by the commissioner pursuant to Iowa Code section 49.11, subsection 3, paragraph *"a."*

21.361(3) An absentee ballot shall be rejected if the affidavit envelope is open.

21.361(4) An absentee ballot shall be rejected if the affidavit envelope has been opened and resealed.

21.361(5) An absentee ballot shall be rejected if the affidavit envelope contains more than one ballot of any kind.

21.361(6) An absentee ballot shall be rejected if the voter has voted in person at the polls.

21.361(7) An absentee ballot shall be rejected if in primary elections the voter does not declare a party affiliation on the voter's affidavit.

This rule is intended to implement Iowa Code sections 49.9 and 53.14 and section 53.25 as amended by 2009 Iowa Acts, House File 475.

[**ARC 8045B**, IAB 8/26/09, effective 7/27/09]

721—21.362 to **21.369** Reserved.

721—21.370(53) Training for absentee ballot couriers. Rescinded IAB 8/1/07, effective 7/1/07.

721—21.371(53) Certificate. Rescinded IAB 8/1/07, effective 7/1/07.

721—21.372(53) Frequency of training. Rescinded IAB 8/1/07, effective 7/1/07.

721—21.373(53) Registration of absentee ballot couriers. Rescinded IAB 8/1/07, effective 7/1/07.

721—21.374(53) County commissioner's duties. Rescinded IAB 8/1/07, effective 7/1/07.

721—21.375(53) Absentee ballot courier training. Rescinded IAB 8/1/07, effective 7/1/07.

721—21.376(53) Receiving absentee ballots. Rescinded IAB 8/1/07, effective 7/1/07.

721—21.377 to **21.399** Reserved.

DIVISION IV
INSTRUCTIONS FOR SPECIFIC ELECTIONS

721—21.400(376) Signature requirements for certain cities. This rule applies to cities which have all of the following characteristics:

1. Nomination procedures under Iowa Code section 376.3 are used. (This includes cities with primary or runoff election provisions. It does not include cities with nominations under Iowa Code chapter 44 or 45.)
2. Some or all council members are voted upon by the electors of wards, rather than by the electors of the entire city.

3. Ward boundaries have been changed since the last regular city election at which the ward seat was on the ballot.

4. The number of wards has not changed.

Calculation of the number of signatures for ward seats shall use the vote totals from the wards as the wards were configured at the time of the last regular city election at which the ward seat was on the ballot.

This rule is intended to implement Iowa Code section 376.4.

721—21.401(376) Signature requirements in cities with primary or runoff election provisions. In cities using the provisions of Iowa Code section 376.4 for nomination of candidates and in which more than one council member was elected at-large at the last preceding regular city election, the number of signatures shall be calculated by the following formula:

V = the total number of votes cast for all candidates for council member at-large at the last regular city election;

E = the number of people to be elected at the last regular city election;

$$\frac{V}{E} \times .02 = \text{the number of signatures needed by each candidate in the next regular city election.}$$

This rule is intended to implement Iowa Code section 376.4.

721—21.402(372) Filing deadline for charter commission appointment petition. If a special election has been called by a city to present to the voters the question of adopting a different form of city government, receipt by the city council of a petition requesting appointment of a charter commission shall stay the special election if the petition is received no later than 5 p.m. on the Friday preceding the date of the special election.

This rule is intended to implement Iowa Code section 372.3.

721—21.403(81GA,HF2282) Special elections to fill vacancies in elective city offices for cities that may be required to conduct primary elections.

21.403(1) *Notice to the commissioner.* At least 60 days before the proposed date of the special election, the city council shall give written notice to the commissioner who will be responsible for conducting the special election.

a. If the commissioner finds no conflict with other previously scheduled elections, or with other limitations on the dates of special elections, the commissioner shall immediately notify the council that the date has been approved.

b. No special city elections to fill vacancies for cities that may be required to conduct primary elections shall be held with the general election, with the primary election, or with the annual school election. To do so would be contrary to the provisions of Iowa Code section 39.2.

21.403(2) *Election calendar.* The election calendar shall be adjusted as follows:

a. The deadline for candidates to file nomination papers with the city clerk shall be not later than 12 noon on the fifty-third day before the election.

b. The city clerk shall deliver all nomination papers accepted by the clerk to the county commissioner of elections not later than 5 p.m. on the fifty-third day before the election.

c. A candidate who has filed nomination papers for the special election may withdraw not later than 5 p.m. on the fiftieth day before the election.

d. A person who would have the right to vote for the office in question may file a written objection to the legal sufficiency of a candidate's nomination papers or to the qualifications of the candidate for this special election not later than 12 noon on the fiftieth day before the election.

e. The hearing on the objection must be held within 24 hours of receipt of the objection.

This rule is intended to implement Iowa Code section 372.13(2) as amended by 2006 Iowa Acts, House File 2282, section 2.

721—21.404(81GA,HF2282) Special elections to fill vacancies in elective city offices for cities without primary election requirements. This rule applies to cities that have adopted by ordinance one of the following options: nominations under Iowa Code chapter 44 or chapter 45, or a runoff election requirement if no candidate in the special election receives a majority of the votes cast.

21.404(1) *Notice to the commissioner.* At least 32 days before the proposed date of the special election, the city council shall give written notice to the commissioner who will be responsible for conducting the special election. If the commissioner finds no conflict with other previously scheduled elections, or with other limitations on the dates of special elections, the commissioner shall immediately notify the council that the date has been approved.

21.404(2) *Special elections to fill vacancies held in conjunction with the general election.* If the proposed date of the special election coincides with the date of the general election, the council shall give notice of the proposed date of the special city election not later than 76 days before the date of the general election. Candidates shall file nomination papers with the city clerk not later than 5 p.m. on the seventieth day before the general election. The city clerk shall deliver the nomination papers accepted by the clerk not later than 5 p.m. on the sixty-ninth day before the general election. Objection and withdrawal deadlines shall be 64 days before the general election, the same as the deadlines for candidates who file their nomination papers with the commissioner. Hearings on objections shall be held as soon as possible in order to facilitate printing of the general election ballot.

21.404(3) *Election calendar.* If the special election date is not the same as the date of the general election, the election calendar shall be adjusted as follows:

a. The deadline for candidates to file nomination papers with the city clerk shall be not later than 12 noon on the twenty-fifth day before the election.

b. The city clerk shall deliver all nomination papers accepted by the clerk to the county commissioner of elections not later than 5 p.m. on the twenty-fifth day before the election.

c. A candidate who has filed nomination papers for the special election may withdraw not later than 5 p.m. on the twenty-second day before the election.

d. A person who would have the right to vote for the office in question may file a written objection to the legal sufficiency of a candidate's nomination papers or to the qualifications of the candidate for this special election not later than 12 noon on the twenty-second day before the election.

e. The hearing on the objection must be held within 24 hours of receipt of the objection.

This rule is intended to implement Iowa Code section 372.13(2) as amended by 2006 Iowa Acts, House File 2282, section 2.

721—21.405 to **21.499** Reserved.

721—21.500(277) Signature requirements for school director candidates. The number of signatures required to be filed by candidates for the office of director in the regular school election shall be calculated from the number of registered voters in the district on May 1 of the year in which the election will be held. Candidates who are seeking election in districts with election plans as specified in Iowa Code section 275.12(2)*"b"* and *"c,"* where the candidate must reside in a specific director district, but is voted upon by all of the electors of the school district, shall be required to file a number of signatures calculated from the number of registered voters in the whole school district. Candidates who will be voted upon only by the electors of a director district shall be required to file a number of signatures calculated from the number of registered voters in the director district in which the candidate resides and seeks to represent.

If a special election is to be held to fill a vacancy on the school board, the number of registered voters on the first day of the month preceding the date the commissioner receives notice of the special election shall be used to calculate the number of signatures required for the special election.

This rule is intended to implement Iowa Code sections 277.4 and 279.7.

721—21.501 to **21.599** Reserved.

721—21.600(43) Primary election signatures—plan three supervisor candidates. The minimum number of signatures needed by candidates for the office of county supervisor elected under plan three, where candidates are voted upon only by the voters of the supervisor district, shall be determined by one of the two following methods.

21.600(1) If there were 5,000 or more votes cast in the supervisor district for a political party's candidate for governor or for president of the United States, the minimum number of signatures needed is 100.

21.600(2) If there were less than 5,000 votes cast in the supervisor district for a political party's candidate for governor or for president of the United States, the minimum number of signatures is determined by using one of the following formulas:

Democratic candidate's signature requirement: ([AD ÷ S] + VD) × .02

Republican candidate's signature requirement: ([AR ÷ S] + VR) × .02

AD = the number of absentee votes received in the entire county by the Democratic party's candidate for governor or for president of the United States in the previous general election.

AR = the number of absentee votes received in the entire county by the Republican party's candidate for governor or for president of the United States in the previous general election.

S = the number of supervisor districts in the county (3 or 5).

VD = the number of votes cast in the supervisor district for the Democratic party's candidate for governor or for president of the United States in the previous general election. (If this number is 5,000 or more, the minimum number of signatures needed is 100.)

VR = the number of votes cast in the supervisor district for the Republican party's candidate for governor or for president of the United States in the previous general election. (If this number is 5,000 or more, the minimum number of signatures needed is 100.)

This rule is intended to implement Iowa Code section 43.20(1)*"d."*

721—21.601(43) Plan III supervisor district candidate signatures after a change in the number of supervisors. After the number of supervisors has been increased or decreased pursuant to Iowa Code section 331.203 or 331.204, the signatures for candidates at the next primary and general elections shall be calculated as follows:

21.601(1) *Primary election.* Divide the total number of votes cast in the county at the previous general election for the office of president or for governor, as applicable, by the number of supervisor districts and multiply the quotient by .02. If the result of the calculation is less than 100, the result shall be the minimum number of signatures required. If the result of the calculation is greater than or equal to 100, the minimum requirement shall be 100 signatures.

21.601(2) *Nominations by petition.* If the effective date of the change in the number of districts was later than the date specified in Iowa Code section 45.1(6), divide the total number of registered voters in the county on the date specified in Iowa Code section 45.1(6) by the number of supervisor districts and multiply the quotient by .01. If the result of the calculation is less than 150, the result shall be the minimum number of signatures required. If the result of the calculation is greater than or equal to 150, the minimum requirement shall be 150 signatures.

721—21.602(43) Primary election—nominations by write-in votes for certain offices.

21.602(1) The process described in subrule 21.602(2) shall be used to determine whether the primary election is conclusive and a candidate was nominated for partisan offices that are:

a. Not mentioned in Iowa Code section 43.53 (township offices) or 43.66 (state representative and state senator), and

b. For which no candidate's name was printed on the primary election ballot, and

c. For which no candidate's name was printed on the primary election ballot in any previous primary election.

21.602(2) To be nominated by write-in votes, the person must receive at least 35 percent of the number of votes cast in the previous general election for that party's candidate for president of the United States or for governor, as the case may be, as follows:

a. Statewide office: 35 percent of votes cast statewide.

b. Congressional district: 35 percent of votes cast within the current boundaries of the Congressional district.

c. County office, including plan II supervisors: 35 percent of the votes cast within the county.

d. Plan III county supervisor: 35 percent of the votes cast within the supervisor district. If the boundaries of the supervisor district have changed since the previous general election, the number of votes cast within the county for the party candidate for president or for governor, as the case may be, shall be divided by the number of supervisor districts in the county; then the quotient shall be multiplied by 0.35.

21.602(3) If a write-in candidate is declared nominated at the canvass of votes, Iowa Code section 43.67, which requires the appropriate election commissioner to notify the candidate, shall apply.

This rule is intended to implement Iowa Code section 43.66.

721—21.603 to **21.799** Reserved.

721—21.800(423B) Local sales and services tax elections.

21.800(1) Petitions requesting imposition, rate change, use change, or repeal of local sales and services taxes shall be filed with the county board of supervisors.

a. Each person signing the petition shall include the person's address (including street number, if any) and the date that the person signed the petition.

b. Within 30 days after receipt of the petition, the supervisors shall provide written notice to the county commissioner of elections directing that an election be held to present to the voters of the entire county the question of imposition, rate change, use change, or repeal of a local sales and services tax. In the notice the supervisors shall include the date of the election.

c. The election shall be held on the first possible special election date for counties set forth in Iowa Code section 39.2, subsection 4, paragraph *"c,"* but no sooner than 84 days after the date upon which notice is given to the commissioner.

21.800(2) As an alternative to the method of initiating a local option tax election described in subrule 21.800(1), governing bodies of cities and the county may initiate a local option tax election by filing motions with the county auditor pursuant to Iowa Code section 423B.1, subsection 4, paragraph *"b,"* requesting submission of a local option tax imposition, rate change, use change, or repeal to the qualified electors. Within 30 days of receiving a sufficient number of motions, the county commissioner shall notify affected jurisdictions of the local option tax election date. The election shall be held on the first possible special election date for counties set forth in Iowa Code section 39.2, subsection 4, paragraph *"c,"* but no sooner than 84 days after the date upon which the commissioner received the motion triggering the election.

21.800(3) Notice of local sales and services tax election.

a. Not less than 60 days before the date that a local sales and services tax election will be held, the county commissioner of elections shall publish notice of the ballot proposition. The notice does not need to include sample ballots, but shall include all of the information that will appear on the ballot for each city and for the voters in the unincorporated areas of the county.

b. The city councils and the supervisors shall provide to the county commissioner the following information to be included in the notice and on the ballots for imposition elections:

(1) The rate of the tax.

(2) The date the tax will be imposed (which shall be the next implementation date provided in Iowa Code section 423B.6 following the date of the election and at least 90 days after the date of the election, except that an election to impose a local option tax on a date immediately following the scheduled repeal date of an existing similar tax may be held at any time that otherwise complies with the requirements of

Iowa Code chapter 423B). The imposition date shall be uniform in all areas of the county voting on the tax at the same election.

(3) The approximate amount of local option tax revenues that will be used for property tax relief in the jurisdiction.

(4) A statement of the specific purposes other than property tax relief for which revenues will be expended in the jurisdiction.

c. The information to be included in the notice shall be provided to the commissioner by the city councils of each city in the county not later than 67 days before the date of the election. If a jurisdiction fails to provide the information in subparagraphs 21.800(3)*"b"*(1), 21.800(3)*"b"*(3), and 21.800(3)*"b"*(4) above, the following information shall be substituted in the notice and on the ballot:

(1) One percent (1%) for the rate of the tax.

(2) Zero percent (0%) for property tax relief.

(3) The specific purpose for which the revenues will otherwise be expended is: Any lawful purpose of the city (or county).

d. The notice of election provided for in Iowa Code section 49.53 as amended by 2009 Iowa Acts, House File 475, shall also be published at the time and in the manner specified in that section.

This rule is intended to implement Iowa Code section 423B.1.

[**ARC 8045B**, IAB 8/26/09, effective 7/27/09]

721—21.801(423B) Form of ballot for local option tax elections. If questions pertaining to more than one of the authorized local option taxes are submitted at a single election, all of the public measures shall be printed on the same ballot. The form of ballots to be used throughout the state of Iowa for the purpose of submitting questions pertaining to local option taxes shall be as follows:

21.801(1) *Local sales and services tax propositions.* Sales and services tax propositions shall be submitted to the voters of an entire county. If the election is being held for the voters to decide whether to impose the tax in a county where a local option sales and services tax has previously been approved for part of the county, the question of imposition shall be voted upon in all parts of the county where the tax has not been approved. If the election is being held for the voters to decide whether to repeal the tax in a county where a local option sales and services tax has previously been approved for part of the county, the question of repeal shall be voted upon in all parts of the county where the tax was previously imposed. If the election is being held for the voters to decide whether to change the rate or use of the tax in a county where a local option sales and services tax has previously been approved for part of the county, the question of rate or use change shall be voted upon in all parts of the county where the tax was previously imposed.

The ballot submitted to the voters of each incorporated area and the unincorporated area of the county shall show the intended uses for that jurisdiction. The ballot submitted to the voters in contiguous cities within a county shall show the intended uses and repeal dates, if not uniform, for each of the contiguous cities. The ballots shall be in substantially the following form:

a. Imposition question for voters in a single city or the unincorporated area of the county:

(Insert letter to be assigned by the commissioner)

SHALL THE FOLLOWING PUBLIC MEASURE BE ADOPTED? YES □
NO □

Summary: To authorize imposition of a local sales and services tax in the [city of _____] [unincorporated area of the county of _____], at the rate of _____ percent (_____ %) to be effective on _____ (month and day), _____ (year).

(Insert in substantially the following form the entire text of the proposed public measure immediately below the summary on all paper ballots as provided in Iowa Code section 49.45. Counties using special

paper ballots which are read by computerized tabulating equipment may summarize the question on the ballot and post the complete text as provided in Iowa Code section 52.25 as amended by 2009 Iowa Acts, House File 475.)

A local sales and services tax shall be imposed in the [city of _____] [unincorporated area of the county of _____] at the rate of _____ percent (_____ %) to be effective on _____ (month and day), _____ (year).

Revenues from the sales and services tax shall be allocated as follows:

(Choose one or more of the following:)

[_____ for property tax relief (insert percentage or dollar amount)]

[_____ for property tax relief (insert percentage or dollar amount) in the unincorporated area of the county of _____]

[_____ for property tax relief (insert percentage or dollar amount) in the county of _____]

The specific purpose (or purposes) for which the revenues shall otherwise be expended is (are):

(List specific purpose or purposes)

b. Imposition question for voters in contiguous cities:

(Insert letter to be assigned by the commissioner)

SHALL THE FOLLOWING PUBLIC MEASURE BE ADOPTED? YES □
NO □

Summary: To authorize imposition of a local sales and services tax in the cities of _____, _____, _____, (list additional cities, if applicable) at the rate of _____ percent (_____%) to be effective on _____ (month and day), _____ (year).

(Insert in substantially the following form the entire text of the proposed public measure immediately below the summary on all paper ballots as provided in Iowa Code section 49.45. Counties using special paper ballots which are read by computerized tabulating equipment may summarize the question on the ballot and post the complete text as provided in Iowa Code section 52.25 as amended by 2009 Iowa Acts, House File 475.)

A local sales and services tax shall be imposed in the cities of _____, _____, _____, (list additional cities, if applicable) at the rate of _____ percent (_____%) to be effective on _____ (month and day), _____ (year).

Revenues from the sales and services tax are to be allocated as follows:

FOR THE CITY OF _____:

_____ for property tax relief (insert percentage or dollar amount)

The specific purpose (or purposes) for which the revenues shall otherwise be expended is (are):

(List specific purpose or purposes)

FOR THE CITY OF _____:

_____ for property tax relief (insert percentage or dollar amount)

The specific purpose (or purposes) for which the revenues shall otherwise be expended is (are):

(List specific purpose or purposes)

FOR THE CITY OF _____:

_____ for property tax relief (insert percentage or dollar amount)

The specific purpose (or purposes) for which the revenues shall otherwise be expended is (are):

(List specific purpose or purposes)

c. Imposition question with an automatic repeal date for voters in a single city or the unincorporated area of the county:

(Insert letter to be assigned by the commissioner)

SHALL THE FOLLOWING PUBLIC MEASURE BE ADOPTED? YES □
NO □

Summary: To authorize imposition of a local sales and services tax in the [city of _____] [unincorporated area of the county of _____], at the rate of _____ percent (_____%) to be effective from _____ (month and day), _____ (year), until _____ (month and day), _____ (year).

(Insert in substantially the following form the entire text of the proposed public measure immediately below the summary on all paper ballots as provided in Iowa Code section 49.45. Counties using special paper ballots which are read by computerized tabulating equipment may summarize the question on the ballot and post the complete text as provided in Iowa Code section 52.25 as amended by 2009 Iowa Acts, House File 475.)

A local sales and services tax shall be imposed in the [city of _____] [unincorporated area of the county of _____] at the rate of _____ percent (_____%) to be effective from _____ (month and day), _____ (year), until _____ (month and day), _____ (year).

Revenues from the sales and services tax shall be allocated as follows:

(Choose one or more of the following:)

[_____ for property tax relief (insert percentage or dollar amount)]

[_____ for property tax relief (insert percentage or dollar amount) in the unincorporated area of the county of _____]

[_____ for property tax relief (insert percentage or dollar amount) in the county of _____]

The specific purpose (or purposes) for which the revenues shall otherwise be expended is (are):

(List specific purpose or purposes)

d. Imposition question with an automatic repeal date for voters in contiguous cities:

(Insert letter to be assigned by the commissioner)

SHALL THE FOLLOWING PUBLIC MEASURE BE ADOPTED? YES □
NO □

Summary: To authorize imposition of a local sales and services tax in the cities of _____, _____, _____, (list additional cities, if applicable) at the rate of ____ percent (____%) to be effective from _____ (month and day), _____ (year), until _____ (month and day), _____ (year).

(Insert in substantially the following form the entire text of the proposed public measure immediately below the summary on all paper ballots as provided in Iowa Code section 49.45. Counties using special paper ballots which are read by computerized tabulating equipment may summarize the question on the ballot and post the complete text as provided in Iowa Code section 52.25 as amended by 2009 Iowa Acts, House File 475.)

A local sales and services tax shall be imposed in the cities of _____, _____, _____, (list additional cities, if applicable) at the rate of _____ percent (_____%) to be effective from _____ (month and day), _____ (year), until _____ (month and day), _____ (year).

Revenues from the sales and services tax are to be allocated as follows:

FOR THE CITY OF _____:
_____ for property tax relief (insert percentage or dollar amount)
The specific purpose (or purposes) for which the revenues shall otherwise be expended is (are):
(List specific purpose or purposes)

FOR THE CITY OF _____:
_____ for property tax relief (insert percentage or dollar amount)
The specific purpose (or purposes) for which the revenues shall otherwise be expended is (are):
(List specific purpose or purposes)

FOR THE CITY OF _____:
_____ for property tax relief (insert percentage or dollar amount)
The specific purpose (or purposes) for which the revenues shall otherwise be expended is (are):
(List specific purpose or purposes)

e. Repeal question for voters in a single city or the unincorporated area of the county:

(Insert letter to be assigned by the commissioner)

SHALL THE FOLLOWING PUBLIC MEASURE BE ADOPTED? YES □
NO □

Summary: To authorize repeal of the ____ percent (_____%) local sales and services tax in the [city of _____] [unincorporated area of the county of _____] effective _____ (month and day), _____ (year).

(Insert in substantially the following form the entire text of the proposed public measure immediately below the summary on all paper ballots as provided in Iowa Code section 49.45. Counties using special paper ballots which are read by computerized tabulating equipment may summarize the question on the ballot and post the complete text as provided in Iowa Code section 52.25 as amended by 2009 Iowa Acts, House File 475.)

The _____ percent (_____%) local sales and services tax shall be repealed in the [city of _____] [unincorporated area of the county of _____] effective _____ (month and day), _____ (year).

Revenues from the sales and services tax have been allocated as follows:

(Choose one or more of the following:)

[_____ for property tax relief (insert percentage or dollar amount)]

[_____ for property tax relief (insert percentage or dollar amount) in the unincorporated area of the county of _____]

[_____ for property tax relief (insert percentage or dollar amount) in the county of _____]

The specific purpose (or purposes) for which the revenues were otherwise expended was (were):

(List specific purpose or purposes)

f. Repeal question for voters in contiguous cities:

(Insert letter to be assigned by the commissioner)

SHALL THE FOLLOWING PUBLIC MEASURE BE ADOPTED? YES □
NO □

Summary: To authorize repeal of the ____ percent (_____%) local sales and services tax in the cities of _____, _____, _____, (list additional cities, if applicable) effective _____ (month and day), _____ (year).

(Insert in substantially the following form the entire text of the proposed public measure immediately below the summary on all paper ballots as provided in Iowa Code section 49.45. Counties using special paper ballots which are read by computerized tabulating equipment may summarize the question on the ballot and post the complete text as provided in Iowa Code section 52.25 as amended by 2009 Iowa Acts, House File 475.)

The _____ percent (_____%) local sales and services tax shall be repealed in the cities of _____, _____, _____, (list additional cities, if applicable) effective _____ (month and day), _____ (year).

Revenues from the sales and services tax have been allocated as follows:

FOR THE CITY OF _____:

_____ for property tax relief (insert percentage or dollar amount)

The specific purpose (or purposes) for which the revenues were otherwise expended was (were):

(List specific purpose or purposes)

FOR THE CITY OF _____:

_____ for property tax relief (insert percentage or dollar amount)

The specific purpose (or purposes) for which the revenues were otherwise expended was (were):

(List specific purpose or purposes)

FOR THE CITY OF _____:

_____ for property tax relief (insert percentage or dollar amount)

The specific purpose (or purposes) for which the revenues were otherwise expended was (were):

(List specific purpose or purposes)

g. Rate change question for voters in a single city or the unincorporated area of the county:

(Insert letter to be assigned by the commissioner)

SHALL THE FOLLOWING PUBLIC MEASURE BE ADOPTED? YES □
NO □

Summary: To authorize an increase (or decrease) in the rate of the local sales and services tax to _____ percent (_____%) in the [city of _____] [unincorporated area of the county of _____] effective _____ (month and day), _____ (year).

(Insert in substantially the following form the entire text of the proposed public measure immediately below the summary on all paper ballots as provided in Iowa Code section 49.45. Counties using special paper ballots which are read by computerized tabulating equipment may summarize the question on the ballot and post the complete text as provided in Iowa Code section 52.25 as amended by 2009 Iowa Acts, House File 475.)

The rate of the local sales and services tax shall be increased (or decreased) to ____ percent (_____%) in the [city of _____] [unincorporated area of the county of _____] effective _____ (month and day), _____ (year). The current rate is ____ percent (_____%).

Revenues from the sales and services tax are allocated as follows:

(Choose one or more of the following:)

[_____ for property tax relief (insert percentage or dollar amount)]

[_____ for property tax relief (insert percentage or dollar amount) in the unincorporated area of the county of _____]

[_____ for property tax relief (insert percentage or dollar amount) in the county of _____]

The specific purpose (or purposes) for which the revenues are otherwise expended is (are):

(List specific purpose or purposes)

h. Rate change question for voters in contiguous cities:

(Insert letter to be assigned by the commissioner)

SHALL THE FOLLOWING PUBLIC MEASURE BE ADOPTED? YES □
NO □

Summary: To authorize an increase (or decrease) in the rate of the local sales and services tax to _____ percent (_____%) in the cities of _____, _____, _____, (list additional cities, if applicable) effective _____ (month and day), _____ (year).

(Insert in substantially the following form the entire text of the proposed public measure immediately below the summary on all paper ballots as provided in Iowa Code section 49.45. Counties using special paper ballots which are read by computerized tabulating equipment may summarize the question on the ballot and post the complete text as provided in Iowa Code section 52.25 as amended by 2009 Iowa Acts, House File 475.)

The rate of the local sales and services tax shall be increased (or decreased) to _____ percent (_____%) in the cities of _____, _____, _____, (list additional cities, if applicable) effective _____ (month and day), _____ (year).

Revenues from the sales and services tax are allocated as follows:

FOR THE CITY OF _____:

_____ for property tax relief (insert percentage or dollar amount)

The specific purpose (or purposes) for which the revenues are otherwise expended is (are):

(List specific purpose or purposes)

FOR THE CITY OF _____:

_____ for property tax relief (insert percentage or dollar amount)

The specific purpose (or purposes) for which the revenues are otherwise expended is (are):

(List specific purpose or purposes)

FOR THE CITY OF _____:

_____ for property tax relief (insert percentage or dollar amount)

The specific purpose (or purposes) for which the revenues are otherwise expended is (are):

(List specific purpose or purposes)

i. Use change question for voters in a single city or the unincorporated area of the county:

(Insert letter to be assigned by the commissioner)

SHALL THE FOLLOWING PUBLIC MEASURE BE ADOPTED? YES □
NO □

Summary: To authorize a change in the use of the _____ percent (_____%) local sales and services tax in the [city of _____] [unincorporated area of the county of _____] effective _____ (month and day), _____ (year).

(Insert in substantially the following form the entire text of the proposed public measure immediately below the summary on all paper ballots as provided in Iowa Code section 49.45. Counties using special paper ballots which are read by computerized tabulating equipment may summarize the question on the ballot and post the complete text as provided in Iowa Code section 52.25 as amended by 2009 Iowa Acts, House File 475.)

The use of the _____ percent (_____%) local sales and services tax shall be changed in the [city of _____] [unincorporated area of the county of _____] effective _____ (month and day), _____ (year).

PROPOSED USES OF THE TAX:

If the change is approved, revenues from the sales and services tax shall be allocated as follows:

(Choose one or more of the following:)

[_____ for property tax relief (insert percentage or dollar amount)]

[_____ for property tax relief (insert percentage or dollar amount) in the unincorporated area of the county of _____]

[_____ for property tax relief (insert percentage or dollar amount) in the county of _____]

The specific purpose (or purposes) for which the revenues shall otherwise be expended is (are):

(List specific purpose or purposes)

CURRENT USES OF THE TAX:

Revenues from the sales and services tax are currently allocated as follows:

(Choose one or more of the following:)

[_____ for property tax relief (insert percentage or dollar amount)]

[_____ for property tax relief (insert percentage or dollar amount) in the unincorporated area of the county of _____]

[_____ for property tax relief (insert percentage or dollar amount) in the county of _____]

The specific purpose (or purposes) for which the revenues are otherwise expended is (are):

(List specific purpose or purposes)

j. Use change question for voters in contiguous cities:

(Insert letter to be assigned by the commissioner)

SHALL THE FOLLOWING PUBLIC MEASURE BE ADOPTED? YES □
NO □

Summary: To authorize a change in the use of the _____ percent (_____%) local sales and services tax in the cities of _____, _____, _____, (list additional cities, if applicable) effective _____ (month and day), _____ (year).

(Insert in substantially the following form the entire text of the proposed public measure immediately below the summary on all paper ballots as provided in Iowa Code section 49.45. Counties using special paper ballots which are read by computerized tabulating equipment may summarize the question on the ballot and post the complete text as provided in Iowa Code section 52.25 as amended by 2009 Iowa Acts, House File 475.)

The use of the _____ percent (_____%) local sales and services tax shall be changed in the cities of _____, _____, _____, (list additional cities, if applicable) effective _____ (month and day), _____ (year).

PROPOSED USES OF THE TAX:

If the change is approved, revenues from the sales and services tax are to be allocated as follows:

FOR THE CITY OF _____:

_____ for property tax relief (insert percentage or dollar amount)

The specific purpose (or purposes) for which the revenues shall otherwise be expended is (are):

(List specific purpose or purposes)

FOR THE CITY OF _____:
_____ for property tax relief (insert percentage or dollar amount)
The specific purpose (or purposes) for which the revenues shall otherwise be expended is (are):
(List specific purpose or purposes)

FOR THE CITY OF _____:
_____ for property tax relief (insert percentage or dollar amount)
The specific purpose (or purposes) for which the revenues shall otherwise be expended is (are):
(List specific purpose or purposes)

CURRENT USES OF THE TAX:

FOR THE CITY OF _____:
_____ for property tax relief (insert percentage or dollar amount)
The specific purpose (or purposes) for which the revenues are otherwise expended is (are):
(List specific purpose or purposes)
FOR THE CITY OF _____:
_____ for property tax relief (insert percentage or dollar amount)
The specific purpose (or purposes) for which the revenues are otherwise expended is (are):
(List specific purpose or purposes)
FOR THE CITY OF _____:
_____ for property tax relief (insert percentage or dollar amount)
The specific purpose (or purposes) for which the revenues are otherwise expended is (are):
(List specific purpose or purposes)

k. Imposition question with differing automatic repeal dates for voters in contiguous cities:

(Insert letter to be assigned by the commissioner)

SHALL THE FOLLOWING PUBLIC MEASURE BE ADOPTED? YES □
NO □

Summary: To authorize imposition of a local sales and services tax in the cities of _____, _____, _____, (list additional cities, if applicable) at the rate of _____ percent (_____%) to be effective from _____ (month/day/year) until automatic repeal date specified.

A local sales and services tax shall be imposed in the following cities at the rate of _____ percent (_____%) to be effective from _____ (month/day/year) until the date specified below and the revenues from the sales and services tax are to be allocated as follows:

FOR THE CITY OF _____:
The tax shall be repealed on _____ (month/day/year).
_____ for property tax relief (insert percentage or dollar amount)

The specific purpose (or purposes) for which the revenues shall otherwise be expended is (are):

FOR THE CITY OF _____:
The tax shall be repealed on _____ (month/day/year).
_____ for property tax relief (insert percentage or dollar amount)
The specific purpose (or purposes) for which the revenues shall otherwise be expended is (are):

FOR THE CITY OF _____:
The tax shall be repealed on _____ (month/day/year).
_____ for property tax relief (insert percentage or dollar amount)
The specific purpose (or purposes) for which the revenues shall otherwise be expended is (are):

21.801(2) *For a local vehicle tax:*

(Insert letter to be assigned by the commissioner)

SHALL THE FOLLOWING PUBLIC MEASURE BE ADOPTED? YES □
NO □

Summary: To authorize the county of (insert name of county) to impose a local vehicle tax at the rate of _____ dollars ($_____) per vehicle and to exempt the following classes from the tax:

_____.

The revenues are to be expended as set forth in the text of the public measure.

(Insert in substantially the following form the entire text of the proposed public measure immediately below the summary on all paper ballots as provided in Iowa Code section 49.45. Counties using optical scan ballots which are read by automatic tabulating equipment may summarize the question on the ballot and post the complete text as provided in Iowa Code section 52.25 as amended by 2009 Iowa Acts, House File 475.)

The county of _____, Iowa shall be authorized to impose a local vehicle tax at the rate of _____ dollars ($_____) per vehicle and to exempt the following classes of vehicles from the tax:

_____

_____ (insert percentage or dollar amount) of the revenues is/are to be used for property tax relief.
The balance of the revenues is to be expended for:
(List purposes for which remaining revenues will be used)

[**ARC 8045B**, IAB 8/26/09, effective 7/27/09]

721—21.802(423B) Local vehicle tax elections.

21.802(1) Petitions requesting imposition of local vehicle taxes shall be filed with the county board of supervisors.

a. Each person signing the petition shall add the person's address (including street number, if any) and the date that the person signed the petition.

b. Within 30 days after receipt of the petition, the supervisors shall provide written notice to the county commissioner of elections directing that an election be held to present to the voters of the entire county the question of imposition of a local vehicle tax. In the notice the supervisors shall include the date of the election.

c. The election shall be held on the first possible special election date for counties set forth in Iowa Code section 39.2, subsection 4, paragraph *"c,"* but no sooner than 84 days after the date upon which notice is given to the commissioner.

21.802(2) Notice of local vehicle tax election. Not less than 60 days before the date that a local vehicle tax election will be held, the county commissioner of elections shall publish notice of the ballot proposition. The notice does not need to include a sample ballot, but shall include all of the information that will appear on the ballot. The notice of election provided for in Iowa Code section 49.53 as amended by 2009 Iowa Acts, House File 475, shall also be published at the time and in the manner specified in that section.

[**ARC 8045B**, IAB 8/26/09, effective 7/27/09]

721—21.803(82GA,HF2663) Revenue purpose statement ballots. When a school district wishes to adopt, amend or extend the revenue purpose statement specifying the uses of the funds received from the secure an advanced vision for education fund, which is also referred to as the "penny sales and services tax for schools," the following ballot formats shall be used.

21.803(1) *Ballot to propose a revenue purpose statement.* The ballot for an election to propose a revenue purpose statement specifying the use of funds received from the secure an advanced vision for education fund shall be in substantially the following form:

(Insert letter to be assigned by the commissioner.)

Shall the following public measure be adopted?

⬭ YES

⬭ NO

Summary: To adopt a revenue purpose statement specifying the use of money from the penny sales and services tax for schools received by _____ School District.

In the _____ School District, the following revenue purpose statement, which specifies the use of the penny sales and services tax for schools (sales and services tax funds from the secure an advanced vision for education fund for school infrastructure) shall be adopted:

(Insert here the revenue purpose statement that was adopted by the school board and that states the intended uses of the funds by the school district. The use or uses must be among the approved uses of the tax that are authorized by 2008 Iowa Acts, House File 2663, section 29.)

21.803(2) *Ballot to amend a revenue purpose statement.* The ballot for an election to decide a change in the revenue purpose statement specifying the use of funds received from the secure an advanced vision for education fund shall be in substantially the following form:

(Insert letter to be assigned by the commissioner.)

Shall the following public measure be adopted?

⬭ YES

⬭ NO

Summary: To authorize a change in the use of money from the penny sales and services tax for schools received by _____ School District.

In the _____ School District, the revenue purpose statement, which specifies the use of the penny sales and services tax for schools (sales and services tax funds from the secure an advanced vision for education fund for school infrastructure) shall be changed.

Proposed uses. If the change is approved, the revenue purpose statement shall read as follows:

(Insert here the revenue purpose statement that was adopted by the school board and that states the intended uses of the funds by the school district. The use or uses must be among the approved uses of the tax that are authorized by 2008 Iowa Acts, House File 2663, section 29.)

Current uses. If the change is not approved, the funds shall continue to be used as follows:

(Insert here the current revenue purpose statement or list the current voter-approved uses of the funds by the school district, if the school infrastructure local option tax was adopted before the revenue purpose statement was required.)

21.803(3) *Ballot to extend a revenue purpose statement.* The ballot for an election to extend a revenue purpose statement specifying the use of funds received from the secure an advanced vision for education fund shall be in substantially the following form:

(Insert letter to be assigned by the commissioner.)

Shall the following public measure be adopted?

⬭ YES

⬭ NO

Summary: To authorize _____ School District to continue to spend money from the penny sales and services tax for schools for the previously approved uses until (specify date or insert amended date).

_____ School District is authorized to extend the current revenue purpose statement which specifies use of the penny sales and services tax for schools (sales and services tax funds from the secure an advanced vision for education fund for school infrastructure) received from (date) until (specify date or insert amended date). If an extension is not approved, the current revenue purpose statement will expire on (date). If an extension is approved, the revenue purpose statement will read as follows:

(Insert here the revenue purpose statement, including the new expiration date. If there is not a predicted expiration date, the ballot language must state that the revenue purpose statement will remain in effect until it is changed.)

This rule is intended to implement 2008 Iowa Acts, House File 2663, section 29.

721—21.804 to **21.809** Reserved.

721—21.810(34A) Referendum on enhanced 911 emergency telephone communication system funding.

21.810(1) *Form of ballot.* The ballot for the E911 referendum shall be in substantially the following form:

(Insert letter to be assigned by the commissioner)

SHALL THE FOLLOWING PUBLIC MEASURE BE ADOPTED? YES □
NO □

Enhanced 911 emergency telephone service shall be funded, in whole or in part, by a monthly surcharge of (an amount to be determined by the local joint E911 service board of up to one dollar) on each telephone access line collected as part of each telephone subscriber's monthly phone bill if provided within (description of the proposed service area).

A map may be used to show the proposed E911 service area. If a map is used the public measure shall read as follows:

"Enhanced 911 emergency telephone service shall be funded, in whole or in part, by a monthly surcharge of (an amount to be determined by the local joint E911 service board of up to one dollar) on each telephone access line collected as part of each telephone subscriber's monthly phone bill if provided within the proposed E911 service area shown on the map below."

21.810(2) *Cost of election.* The E911 service board shall pay the costs of the referendum election.

21.810(3) *Enhanced 911 emergency service funding referendum held in conjunction with a scheduled election.*

a. Notice to commissioner. The joint E911 service board shall notify the commissioner in writing, no later than the last day upon which nomination papers may be filed, of their intention to conduct the referendum with the scheduled election. The notice shall contain the complete text of the referendum question including the description of the proposed E911 service area. If a map is to be used on the ballot to describe the proposed E911 service area, the map shall be included. If the E911 service area includes more than one county, the service board shall notify the commissioner of each of the counties.

b. Conduct of election. All qualified electors in a precinct which is to be served, in whole or in part, by the proposed E911 service area, shall be permitted to vote on the question. The results of the referendum shall be canvassed by the board of supervisors at the time of the canvass of the scheduled election. The commissioner shall immediately certify the results to the joint E911 board.

c. Service board duties. If subscribers from more than one county are included within the proposed service area, the E911 service board shall meet as a board of canvassers to compile the results from the counties. The canvass shall be held on the tenth day following the election at a time established by the E911 service board. The service board shall prepare an abstract showing in words and numbers the number of votes cast for and against the question and, if a simple majority of those voting on the question has voted in the affirmative, the board shall declare that the surcharge has been adopted. Votes cast and not counted as a vote for or against the question shall not be used in computing the total vote cast for and against the question.

21.810(4) *Form of ballot for alternative surcharge.* The ballot for elections conducted pursuant to Iowa Code section 34A.6A shall be in the following form:

(Insert letter to be assigned by the commissioner)

SHALL THE FOLLOWING PUBLIC MEASURE BE ADOPTED? YES □
NO □

Enhanced 911 emergency telephone service shall be funded, in whole or in part, by a temporary monthly surcharge increase to (an amount between one dollar and two dollars and fifty cents to be determined by the local joint E911 service board) on each telephone access line collected as part of each telephone subscriber's monthly phone bill if provided within (description of the proposed service area). The surcharge shall be collected for not more than 24 months, after which the surcharge shall revert to one dollar per month for each line.

A map may be used to show the proposed E911 service area. If a map is used the public measure shall read as follows:

"Enhanced 911 emergency telephone service shall be funded, in whole or in part, by a temporary monthly surcharge increase to (an amount between one dollar and two dollars and fifty cents to be determined by the local joint E911 service board) on each telephone access line collected as part of each telephone subscriber's monthly phone bill if provided within the proposed E911 service area shown on the map below. The surcharge shall be collected for not more than 24 months, after which the surcharge shall revert to one dollar per month for each line."

This rule is intended to implement Iowa Code sections 34A.6 and 34A.6A.

721—21.811 to **21.819** Reserved.

721—21.820(99F) Gambling elections.

21.820(1) Petitions requesting elections to approve or disapprove the conduct of gambling games on an excursion gambling boat or at a gambling structure shall be filed with the county board of supervisors and shall be substantially in the form posted on the state commissioner's Web site titled "Petition Requesting Special Election."

a. Within 10 days after receipt of a valid petition, the supervisors shall provide written notice to the county commissioner of elections directing the commissioner to submit to the qualified electors of the county a proposition to approve or disapprove the conduct of gambling games on an excursion gambling boat or at a gambling structure in the county. The election shall be held on the next possible special election date pursuant to Iowa Code section 39.2, subsection 4, paragraph *"a,"* but no fewer than 46 days from the date notice is given to the county commissioner.

b. If a regularly scheduled or special election is to be held in the county on the date selected by the supervisors, notice shall be given to the commissioner no later than the last day upon which nomination papers may be filed for that election. If the excursion gambling boat or the gambling structure election is to be held with a local option tax election, the supervisors shall provide the commissioner at least 60 days' written notice. Otherwise, the supervisors shall give at least 46 days' written notice.

21.820(2) Form of ballot for election called by petition. Ballots shall be in substantially the following form:

(Insert letter to be assigned by the commissioner)

Shall the following public measure be adopted?

⬭ YES

⬭ NO

Gambling games on an excursion gambling boat or at a gambling structure in _____ County are approved.

21.820(3) Form of ballot for elections to continue gambling games on an excursion gambling boat or at a gambling structure:

(Insert letter to be assigned by the commissioner)

Shall the following public measure be adopted?

⬭ YES

⬭ NO

Summary: Gambling games on an excursion gambling boat or at a gambling structure in _____ County are approved.

Gambling games, with no wager or loss limits, on an excursion gambling boat or at a gambling structure in _____ County are approved. If approved by a majority of the voters, operation of gambling games with no wager or loss limits may continue until the question is voted upon again at the general election held in 2010. If disapproved by a majority of the voters, the operation of gambling games on an excursion gambling boat or at a gambling structure will end within 60 days of this election. (Iowa Code section 99F.7(10)*"c"*)

21.820(4) Ballot form to permit gambling games at existing pari-mutuel racetracks:

(Insert letter to be assigned by the commissioner)

Shall the following public measure be adopted?

⬭ YES

⬭ NO

The operation of gambling games at (name of pari-mutuel racetrack) in _____ County is approved.

21.820(5) Abstract of votes. A copy of the abstract of votes of the election shall be sent to the state racing and gaming commission.

21.820(6) Ballot form for general election for continuing operation of gambling games at pari-mutuel racetracks:

(Insert letter to be assigned by the commissioner)

Shall the following public measure be adopted?

⬭ YES

⬭ NO

Summary: The continued operation of gambling games at (name of pari-mutuel racetrack) in _____ County is approved.

The continued operation of gambling games at (name of pari-mutuel racetrack) in _____ County is approved. If approved by a majority of the voters, operation of gambling games may continue at (name of pari-mutuel racetrack) in _____ County until the question is voted on again at the general election in eight years. If disapproved by a majority of the voters, gambling games at (name of pari-mutuel racetrack) in _____ County will end.

21.820(7) Ballot form for general election for continuing gambling games on an excursion gambling boat or at a gambling structure:

(Insert letter to be assigned by the commissioner)

Shall the following public measure be adopted?

⬭ YES

⬭ NO

Summary: The continued operation of gambling games on an excursion gambling boat or at a gambling structure in _____ County is approved.

The continued operation of gambling games on an excursion gambling boat or at a gambling structure in _____ County is approved. If approved by a majority of the voters, operation of gambling games may continue on an excursion gambling boat or at a gambling structure in _____ County until the question is voted on again at the general election in eight years. If disapproved by a majority of voters, gambling games on an excursion gambling boat or at a gambling structure in _____ County will end nine years from the date of the original issue of the license to the current licensee.

This rule is intended to implement Iowa Code section 99F.7 and Iowa Code Supplement section 99F.4D.

[**ARC 8045B**, IAB 8/26/09, effective 7/27/09; **ARC 8779B**, IAB 6/2/10, effective 7/1/10]

721—21.821 to **21.829** Reserved.

721—21.830(357E) Benefited recreational lake district elections. Elections for benefited recreational lake districts shall be conducted according to the following procedures.

21.830(1) *Conduct of election.* It is not mandatory for the county commissioner of elections to conduct elections for a benefited recreational lake district. However, if both a public measure and a

candidate election will be held on the same day in a benefited recreational lake district, the same person shall be responsible for conducting both elections. All elections must be held on a Tuesday.

21.830(2) *Ballots.* Ballots for benefited recreational lake district trustee elections shall be printed on opaque white paper, 8 by 11 inches in size. The ballots for the initial election for the office of trustee shall be in substantially the following form:

OFFICIAL BALLOT
BENEFITED RECREATIONAL LAKE DISTRICT
Election date
(facsimile signature of person responsible for printing ballots)

FOR TRUSTEE:
To vote: Neatly print the names of at least three people you would like to see elected to the office of Trustee of the Benefited Recreational Lake District. You may vote for as many people as you wish, but you must vote for at least three.
(At the bottom of the ballot a space shall be included for the endorsement of the precinct election official, like this:)

Precinct official's endorsement: _____

21.830(3) *Canvass of votes.* On the Monday following the election, the board of supervisors shall canvass the votes cast at the election. At the initial election the supervisors shall choose three trustees from among the five persons who received the most votes. The results of benefited recreational lake district elections shall be certified to the district board of trustees.

This rule is intended to implement Iowa Code section 357E.8.

[Filed emergency 4/22/76—published 5/17/76, effective 4/22/76]
[Filed emergency 6/2/76—published 6/28/76, effective 8/2/76]
[Filed 10/7/81, Notice 9/2/81—published 10/28/81, effective 12/2/81]
[Filed emergency 11/15/84—published 12/5/84, effective 11/15/84]
[Filed 1/22/85, Notice 12/5/84—published 2/13/85, effective 3/20/85]
[Filed 5/17/85, Notice 4/10/85—published 6/5/85, effective 7/10/85]
[Filed emergency 7/2/85—published 7/31/85, effective 7/2/85]
[Filed emergency 7/26/85—published 8/14/85, effective 7/26/85]
[Filed emergency 8/14/85—published 9/11/85, effective 8/14/85]
[Filed 9/6/85, Notice 7/31/85—published 9/25/85, effective 10/30/85]
[Filed 10/30/85, Notice 9/25/85—published 11/20/85, effective 12/25/85]
[Filed emergency 12/18/86—published 1/14/87, effective 12/18/86]
[Filed emergency 4/20/87—published 5/20/87, effective 4/20/87]◊
[Filed 6/23/88, Notice 5/18/88—published 7/13/88, effective 8/17/88]
[Filed 9/2/88, Notice 7/27/88—published 9/21/88, effective 10/26/88]
[Filed 3/1/89, Notice 1/25/89—published 3/22/89, effective 4/26/89]
[Filed emergency 5/10/89—published 5/31/89, effective 5/10/89]
[Filed emergency 6/9/89—published 6/28/89, effective 7/1/89]
[Filed emergency 6/22/89, after Notice of 5/31/89—published 7/12/89, effective 7/1/89]
[Filed 8/16/89, Notice 6/28/89—published 9/6/89, effective 10/11/89]
[Filed 11/9/89, Notice 10/4/89—published 11/29/89, effective 1/3/90]
[Filed 12/7/89, Notice 11/1/89—published 12/27/89, effective 1/31/90]
[Filed 3/26/92, Notice 2/5/92—published 4/15/92, effective 5/20/92]
[Filed 11/19/92, Notice 9/30/92—published 12/9/92, effective 1/13/93]◊
[Filed 1/14/93, Notice 12/9/92—published 2/3/93, effective 3/10/93]
[Filed 6/4/93, Notice 4/28/93—published 6/23/93, effective 7/28/93]
[Filed emergency 6/28/93—published 7/21/93, effective 7/1/93]

[Filed 9/8/93, Notice 7/21/93—published 9/29/93, effective 11/3/93]
[Filed 11/5/93, Notice 9/29/93—published 11/24/93, effective 12/29/93]
[Filed emergency 4/4/94—published 4/27/94, effective 4/4/94]
[Filed 7/1/94, Notice 5/25/94—published 7/20/94, effective 8/24/94]
[Filed 6/30/95, Notice 5/24/95—published 7/19/95, effective 8/23/95]
[Filed 2/8/96, Notice 1/3/96—published 2/28/96, effective 4/3/96]
[Filed 5/31/96, Notice 4/10/96—published 6/19/96, effective 7/24/96]
[Filed 6/13/96, Notice 5/8/96—published 7/3/96, effective 8/7/96]
[Filed emergency 7/25/96 after Notice 6/19/96—published 8/14/96, effective 7/25/96]
[Filed emergency 5/21/97—published 6/18/97, effective 5/21/97]
[Filed emergency 7/30/97—published 8/27/97, effective 7/30/97]
[Filed 8/22/97, Notice 7/16/97—published 9/10/97, effective 10/15/97]
[Filed 12/12/97, Notice 11/5/97—published 12/31/97, effective 2/4/98]
Filed emergency 5/1/98—published 5/20/98, effective 5/1/98]◊
[Filed emergency 8/7/98—published 8/26/98, effective 8/7/98]
[Filed emergency 8/11/99—published 9/8/99, effective 8/11/99]
[Filed 10/29/99, Notice 9/22/99—published 11/17/99, effective 12/22/99]
[Filed emergency 12/22/99—published 1/12/00, effective 12/22/99]
[Filed 2/3/00, Notice 12/29/99—published 2/23/00, effective 4/1/00]
[Filed 5/26/00, Notice 4/19/00—published 6/14/00, effective 7/19/00]
[Filed 9/14/00, Notice 8/9/00—published 10/4/00, effective 11/8/00]
[Filed emergency 10/10/00 after Notice 8/9/00—published 11/1/00, effective 11/7/00]
[Filed emergency 7/20/01 after Notice 6/13/01—published 8/8/01, effective 7/20/01]
[Filed 2/1/02, Notice 8/8/01—published 2/20/02, effective 3/27/02]
[Filed emergency 3/15/02—published 4/3/02, effective 3/15/02]
[Filed emergency 7/19/02—published 8/7/02, effective 7/19/02]
[Filed 2/13/03, Notice 12/25/02—published 3/5/03, effective 4/9/03]
[Filed emergency 3/28/03—published 4/16/03, effective 3/28/03]
[Filed 2/26/04, Notice 1/7/04—published 3/17/04, effective 4/21/04]◊
[Filed 2/26/04, Notice 1/21/04—published 3/17/04, effective 4/21/04]
[Filed emergency 8/27/04 after Notice 7/21/04—published 9/15/04, effective 8/27/04]
[Filed emergency 10/12/04—published 11/10/04, effective 10/12/04]
[Filed 1/25/06, Notice 12/21/05—published 2/15/06, effective 3/22/06]
[Filed emergency 3/10/06—published 3/29/06, effective 3/10/06]
[Filed emergency 5/5/06 after Notice 3/29/06—published 5/24/06, effective 5/5/06]
[Filed emergency 8/25/06—published 9/27/06, effective 8/25/06]
[Filed emergency 10/4/06 after Notice 8/30/06—published 10/25/06, effective 10/4/06]
[Filed emergency 5/14/07—published 6/6/07, effective 5/14/07]
[Filed emergency 6/27/07—published 8/1/07, effective 7/1/07]
[Filed emergency 7/13/07—published 8/1/07, effective 7/13/07]
[Filed emergency 9/7/07 after Notice 8/1/07—published 9/26/07, effective 9/7/07]
[Filed emergency 12/18/07 after Notice 11/7/07—published 1/16/08, effective 1/1/08]
[Filed emergency 1/9/08 after Notice 11/21/07—published 1/30/08, effective 1/9/08]◊
[Filed emergency 7/1/08—published 7/30/08, effective 7/1/08]
[Filed emergency 7/11/08—published 7/30/08, effective 7/11/08]
[Filed 7/17/08, Notice 6/4/08—published 8/13/08, effective 9/17/08]
[Filed 12/5/08, Notice 7/30/08—published 12/31/08, effective 2/4/09]
[Filed Emergency ARC 8045B, IAB 8/26/09, effective 7/27/09]
[Filed ARC 8698B (Notice ARC 8541B, IAB 2/24/10), IAB 4/21/10, effective 6/15/10]
[Filed Emergency ARC 8779B, IAB 6/2/10, effective 7/1/10]
[Filed Emergency ARC 8777B, IAB 6/2/10, effective 5/7/10]
[Filed Emergency ARC 9049B, IAB 9/8/10, effective 8/16/10]

[Filed Emergency ARC 9139B, IAB 10/6/10, effective 9/16/10]

◊ Two or more ARCs

CHAPTER 1
DESCRIPTION OF ORGANIZATION

751—1.1(17A,8D) Purpose. The Iowa telecommunications and technology commission and the Iowa communications network were established by Iowa Code chapter 8D to coordinate communications of state government, effect maximum practical consolidation and joint use of communications services and manage, develop, operate and ensure compatibility of the fiberoptic network.

751—1.2(17A,8D) Organization. The commission's structure consists of five commissioners and the state auditor as an ex officio member of the commission. The commission has the sole authority to manage, develop, operate and ensure compatibility of the state communications network. The network is supervised by the commission and operated by the executive director of the network or the commission's designee. The commission has rule-making authority.

751—1.3(17A,8D) Advisory committees.

1. The telemedicine advisory committee performs advisory functions related to the delivery of telemedicine applications.
2. The telecommunications advisory committee provides technical expertise to the network.
3. The commission may establish or dissolve other committees and advisory groups from time to time as necessary.

751—1.4(17A,8D) Education telecommunications council. The education telecommunications council establishes scheduling and site usage policies for educational users of the network, coordinates the activities of the regional telecommunications councils and develops proposed rules and changes to rules for recommendations to the commission. The council also may recommend long-range plans for enhancements needed for educational applications.

The regional telecommunications councils advise the education telecommunications council on the assessment of local educational needs and the coordination of program activities including scheduling.

751—1.5(17A,8D) Administrative elements of the commission.

1.5(1) *Executive director.* The executive director or the commission's designee administers the programs and services of the commission in compliance with the Iowa Code and the rules adopted by the commission.

1.5(2) *Administrative elements.* In order to carry out the functions of the commission, the following divisions and offices have been established:

a. The office of the deputy director is responsible for agency information systems functions, legislative liaison, public information, maintenance of a circuit database, and administrative support to the commission. The office also provides information and education to the public about the commission and the fiberoptic network and maintains the commission's Web site.

b. The office of the chief financial officer is responsible for final review of the financial books and records prepared by the finance division prior to providing them to the commission, asset inventory and management, personnel transactions, and purchasing and contracting activities, as well as coordination with the attorney general's office for legal counsel.

c. The finance division is responsible for maintaining the financial books and records of the commission, accounting, billing, asset inventory and management, personnel transactions, travel vouchers, claims for payments of goods and services, processing cash receipts, purchasing and contracting activities, and facilities.

d. The network operations and engineering division is responsible for provisioning of video services, data/Internet services, and voice services for authorized users. The division is responsible for all operational aspects of the fiberoptic network. The division is also responsible for the technical operation of the fiberoptic network, including research and development, and network systems.

e. The service delivery division coordinates the activities between the engineers, individual sites, and authorized users. The division is responsible for providing cost estimates for services; tracking

service requests; executing installation services; assisting authorized users in finding the best structure to meet the users' needs; developing new products and services; maintaining price tables; and providing customer service and assistance.
[**ARC 9148B**, IAB 10/6/10, effective 11/10/10]

751—1.6(17A,8D) Location of offices.

1.6(1) *Main office.* The main office is located in the Grimes State Office Building, 400 E. 14th Street, Des Moines, Iowa 50319. The telephone number is (515)725-4692. The toll-free number is 1-877-426-4692. The fax number is (515)725-4727. The E-mail address is ICN.info@iowa.gov. The home page address on the World Wide Web is http://www.icn.state.ia.us.

1.6(2) *Network.* The hub for the network is located in the Joint Forces Headquarters (JFHQ) Armory, 6100 N.W. 78th Avenue, Johnston, Iowa 50131.

751—1.7(8D) Business hours.

1.7(1) *Normal business hours.* The normal business hours of the main office are 8 a.m. to 4:30 p.m., Monday through Friday, except holidays. The Network Operations Center (NOC) operates on a 24-hour, seven-day-a-week basis at the network hub in the JFHQ Armory in Johnston, Iowa.

1.7(2) *Emergency incident reports.* The 24-hour emergency telephone number for reporting cable cuts, system failures or other incidents is 1-800-572-3940, or (515)323-4400.

These rules are intended to implement Iowa Code sections 17A.3(1)*"a,"* 8D.1, 8D.3(3)*"b,"* 8D.5 and 8D.6.

[Filed 9/17/96, Notice 7/31/96—published 10/9/96, effective 11/13/96]
[Filed 12/1/04, Notice 10/13/04—published 12/22/04, effective 1/26/05]
[Filed 1/26/06, Notice 12/21/05—published 2/15/06, effective 3/22/06]
[Filed 9/21/07, Notice 6/20/07—published 10/10/07, effective 11/14/07]
[Filed 6/19/08, Notice 2/27/08—published 7/16/08, effective 8/20/08]
[Filed ARC 9148B (Notice ARC 8895B, IAB 6/30/10), IAB 10/6/10, effective 11/10/10]