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

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

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

INSTRUCTIONS

FOR UPDATING THE

IOWA ADMINISTRATIVE CODE

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

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

Human Services Department[441]

Replace Analysis
Replace Chapter 7
Replace Chapters 78 and 79
Replace Chapter 118
Replace Chapter 176

Inspections and Appeals Department[481]

Replace Analysis
Replace Chapter 51

Environmental Protection Commission[567]

Replace Chapter 23

Homeland Security and Emergency Management Division[605]

Replace Chapter 9

Public Health Department[641]

Replace Analysis
Replace Chapter 1
Replace Chapter 9
Replace Chapter 90
Remove Reserved Chapter 111 and insert Chapter 111
Replace Reserved Chapters 179 to 190 with Reserved Chapters 179 to 185
Insert Chapter 186 and Reserved Chapters 187 to 190

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.

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[Ch 7, July 1973 IDR Supplement, renumbered as Ch 81]
[Prior to 7/1/83, Social Services[770] Ch 7]
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PREAMBLE

This chapter applies to contested case proceedings conducted by or on behalf of the department.

441—7.1(17A) Definitions.

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

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

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

"Aggrieved person" means a person against whom the department has taken an adverse action. This includes a person who meets any of the following conditions:

1. For financial assistance (including the family investment program, refugee cash assistance, child care assistance, emergency or disaster assistance, family or community self-sufficiency grants, family investment program hardship exemptions, and state supplementary assistance dependent person, in-home health related care, and residential care facility benefits), a person:

- Whose request to be given an application was denied.
- Whose application for assistance has been denied or has not been acted on in a timely manner.
- Who contests the effective date of assistance.
- Who contests the amount of benefits granted.
- Who has been notified that there will be a reduction or cancellation of assistance.
- Who has been notified that an overpayment of benefits has been established and repayment is requested.

2. For food assistance, a person:

- Whose request to be given an application was denied.
- Whose application has been denied or has not been acted on in a timely manner.
- Who contests the effective date of assistance.
- Who contests the amount of benefits granted.
- Who has been notified that there will be a reduction or cancellation of benefits.
- Whose request to receive a credit for benefits from an electronic benefit transfer (EBT) account has been denied.
- Who has been notified that an overpayment of benefits has been established and repayment is requested.

3. For medical assistance, healthy and well kids in Iowa, IowaCare, family planning services, and waiver services, a person (see numbered paragraph "7" for providers):

- Whose request to be given an application was denied.
- Whose application has been denied or has not been acted on in a timely manner.
- Who has been notified that level of care requirements have not been met.
- Who has been aggrieved by a failure to take into account the appellant's choice in assignment to a coverage group.
- Who contests the effective date of assistance, services, or premium payments.

- Who contests the amount of health insurance premium payments, healthy and well kids in Iowa premium payments, Medicaid for employed people with disabilities premium payments, IowaCare premium payments, or the spenddown amount under the medically needy program.
- Who contests the amount of client participation.
- Whose claim for payment or prior authorization has been denied.
- Who has been notified that the reconsideration process has been exhausted and who remains dissatisfied with the outcome.
- Who has received notice from the medical assistance hotline that services not received or services for which an individual is being billed are not payable by medical assistance.
- Who has been notified that there will be a reduction or cancellation of assistance or waiver services.
- Who has been notified that an overpayment of benefits has been established and repayment is requested.
- Who has been denied requested nonemergency medical transportation services by the broker designated by the department pursuant to rule 441—78.13(249A) and has exhausted the grievance procedures established by the broker pursuant to 441—subrule 78.13(7).

4. For social services, including, but not limited to, adoption, foster care, and family-centered services, a person (see numbered paragraph "7" for providers):

- Whose request to be given an application was denied.
- Whose application for services or payment for adoption subsidy or foster care has been denied or has not been acted on in a timely manner.
- For whom it is determined that the person must participate in a service program.
- Whose claim for payment of services has been denied.
- Who has been notified that a protective or vendor payment will be established.
- Who has been notified that there will be a reduction or cancellation of services.
- Who has been notified that an overpayment of services has been established and repayment is requested.
- Who applies for an adoption subsidy after the adoption has been finalized.
- Who alleges that the adoptive placement of a child has been denied or delayed when an adoptive family is available outside the jurisdiction with responsibility for handling the child's case.
- Who has not been referred to community care as provided in rule 441—186.2(234).
- Who has been referred to community care as provided in rule 441—186.2(234) and has exhausted the community care provider's dispute resolution process.
- Who has been referred to aftercare services under 441—Chapter 187 and has exhausted the aftercare provider's dispute resolution process.

5. For child support recovery, a person:

- Who is not entitled to a support payment in full or in part because of the date of collection, as provided under rule 441—95.13(17A), or whose dispute based on the date of collection has not been acted on in a timely manner.
- Who is contesting a claim or offset as provided in 441—subrule 95.6(3), 95.7(8), or 98.81(3) by alleging a mistake of fact. "Mistake of fact" means a mistake in the identity of the obligor or whether the delinquency meets the criteria for referral or submission. The issue on appeal shall be limited to a mistake of fact. Any other issue may be determined only by a court of competent jurisdiction.
- Whose name has been certified for passport sanction as provided in Iowa Code section 252B.5.
- Who has been notified that there will be a termination in services as provided in rule 441—95.14(252B).

6. For PROMISE JOBS, a person:

- Whose claim for participation allowances has been denied, reduced, or canceled.
- Who claims that the contents of the family investment agreement are not sufficient or necessary for the family to reach self-sufficiency.
- Who is dissatisfied with the results of informal grievance resolution procedures, or who fails or refuses to receive informal grievance resolution procedures.

- Who has been notified that PROMISE JOBS services will be canceled due to imposition of a limited benefit plan.
- Who has been notified that an overpayment of benefits has been established and repayment is requested.
- Who alleges acts of discrimination on the basis of race, creed, color, sex, age, physical or mental disability, religion, national origin, or political belief.
- Who claims displacement by a PROMISE JOBS participant.

7. For providers, a person or entity:

- Whose license, certification, registration, approval, or accreditation has been denied or revoked or has not been acted on in a timely manner.
- Whose claim for payment or request for prior authorization of payment has been denied in whole or in part and who states that the denial was not made according to department policy. Providers of Medicaid services must accept reimbursement based on the department's methodology.
- Whose contract as a Medicaid patient manager has been terminated.
- Who has been subject to the withholding of a payment to recover a prior overpayment or who has received an order to repay an overpayment pursuant to 441—subrule 79.4(7).
- Who has been notified that the managed care reconsideration process has been exhausted and who remains dissatisfied with the outcome.
- Whose application for child care quality rating has not been acted upon in a timely fashion, who disagrees with the department's quality rating decision, or whose certificate of quality rating has been revoked.
- Who has been subject to an adverse action related to the Iowa electronic health record incentive program pursuant to rule 441—79.16(249A).

8. For the child or dependent adult abuse registry, juvenile sex offender registry or criminal record check evaluation, a person:

- Who has requested correction of child abuse or dependent adult abuse information.
- Who has been restricted from or denied employment in a health care facility, state institution, or other facility based on a record check. "Employment" includes, but is not limited to, service as an employee, a volunteer, a provider, or a contractor. "Facilities" include, but are not limited to, county or multicounty juvenile detention homes and juvenile shelter care homes, child-placing agencies, substance abuse treatment programs, group living foster care facilities, child development homes, child care centers, state resource centers, mental health institutes, and state training schools.
- Who is contesting a risk assessment decision as provided in rule 441—103.34(692A) by alleging that the risk assessment factors have not been properly applied, the information relied upon to support the assessment findings is inaccurate, or the procedures were not correctly followed.

9. For mental health and developmental disabilities, a person:

- Whose application for state community mental health or mental retardation service funds has been denied or has not been acted upon in a timely manner.
- Who has been notified that there will be a reduction or cancellation of state community mental health or mental retardation service funds.

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

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

11. For drug manufacturers, a manufacturer that has received a notice of decision regarding disputed drug rebates pursuant to the dispute resolution procedures of a national drug rebate agreement or an Iowa Medicaid supplemental drug rebate agreement.

12. Individuals and providers that are not listed in paragraphs "1" to "11" may meet the definition of an aggrieved person if the department has taken an adverse action against that individual or provider.

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

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

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

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

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

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

"Department" means the Iowa department of human services.

"Department of inspections and appeals" means the state agency which contracts with the department to conduct appeal hearings.

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

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

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

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

"Intentional program violation" means deliberately making a false or misleading statement; or misrepresenting, concealing, or withholding facts; or committing any act that is a violation of the Food and Nutrition Act of 2008, food assistance program regulations, or any state law relating to the use, presentation, transfer, acquisition, receipt, possession, or trafficking of an electronic benefit transfer (EBT) card. An intentional program violation is determined through a food assistance administrative disqualification hearing. The hearing may result in a period of ineligibility for the program, a claim for overpayment of benefits, or both.

"Issues of fact or judgment" denotes disputed issues of facts or of the application of state or federal law or policy to the facts of the individual's personal situation.

"Issues of policy" denotes issues of the legality, fairness, equity, or constitutionality of state or federal law or agency policy where the facts and applicability of the law or policy are undisputed.

"Joint or group hearings" denotes an opportunity for several persons to present their case jointly when all have the same complaint against agency policy.

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

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

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

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

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

"Reconsideration" means a review process that must be exhausted before an appeal hearing is granted. Such review processes include, but are not limited to, a reconsideration request through the Iowa Medicaid enterprise or its subcontractors, Magellan Behavioral Health Care, a health maintenance organization, a prepaid health plan, medical assistance patient management services, the managed health care review committee, a division or bureau within the department, the mental health, mental retardation, developmental disabilities, and brain injury commission, or a licensed health care professional as specified in 441—paragraph 9.9(1)*"i."* Once the reconsideration process is complete, a notice of decision will be issued with appeal rights.

"Teleconference hearing" means an appeal hearing conducted by an administrative law judge over the telephone.

"Timely notice period" is the time from the date a notice is mailed to the effective date of action. That period of time shall be at least ten calendar days, except in the case of probable fraud of the appellant. When probable fraud of the appellant exists, "timely notice period" shall be at least five calendar days from the date a notice is sent by certified mail.

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

[**ARC 8003B**, IAB 7/29/09, effective 9/2/09; **ARC 8994B**, IAB 8/11/10, effective 10/1/10; **ARC 9254B**, IAB 12/1/10, effective 1/1/11]

441—7.2(17A) Application of rules. Rescinded IAB 7/29/09, effective 9/2/09.

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

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

441—7.5(17A) The right to appeal. Any person or group of persons may file an appeal with the department concerning any issue. The department shall determine whether a hearing shall be granted.

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

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

a. One of the following issues is appealed:

(1) The service is no longer available through the department.

(2) Repayment of food assistance benefits as a result of trafficking has been requested on Form 470-4179, Notice of Food Assistance Trafficking Debt.

(3) Payment for a medical claim has been made in accordance with the Medicaid payment schedule for the service billed.

(4) Children have been removed from or placed in a specific foster care setting.

(5) Children have not been placed with or have been removed from a preadoptive family.

(6) A qualified provider or qualified entity has denied a person presumptive eligibility for Medicaid under 441—subrule 75.1(30), 75.1(40), or 75.1(44).

(7) A qualified provider or qualified entity has determined a person to be presumptively eligible for Medicaid under 441—subrule 75.1(30), 75.1(40), or 75.1(44), but presumptive eligibility ends due to the person's failure to file an application.

(8) Notice has been issued from the treasury offset program for a food assistance overpayment.

(9) A rate determination has been reviewed under rule 441—152.3(234).

(10) The maximum provider rate ceiling has been contested for child care assistance under 441—subrule 170.4(7).

(11) The risk pool board has accepted or rejected an application for assistance from the risk pool fund or the tobacco settlement fund risk pool fund in whole or in part under rules 441—25.66(426B) and 441—25.77(78GA,ch1221).

(12) The appellant has a complaint about child support recovery matters other than those described in numbered paragraph "5" of the definition of an aggrieved person in rule 441—7.1(17A). This includes collection of an annual fee for child support services as specified in Iowa Code chapter 252B.

(13) The appellant has a complaint about a local office employee (when this is the only issue of the appeal).

(14) A request for an exception to policy under 441—subrule 1.8(1) has been denied.

(15) A final decision from a previous hearing with a presiding officer has been implemented.

(16) The issue appealed is not eligible for further hearing based on the doctrine of issue preclusion.

(17) The appeal involves patient treatment interventions outlined in the patient handbook of the civil commitment unit for sexual offenders.

b. Either state or federal law requires automatic grant adjustment for classes of recipients. The director of the department shall decide whether to grant a hearing in these cases. When the reason for an individual appeal is incorrect grant computation in the application of these automatic adjustments, a hearing may be granted.

c. State or federal law or regulation provides for a different forum for appeals.

d. The appeal is filed prematurely as:

(1) There is no adverse action by the department, or

(2) The appellant has not exhausted the reconsideration process.

e. Upon review, it is determined that the appellant does not meet the criteria of an aggrieved person as defined in rule 441—7.1(17A).

f. The sole basis for denying, terminating or limiting assistance under 441—Chapter 47 or 441—Chapter 58 is that funds for the respective programs have been reduced, exhausted, eliminated or otherwise encumbered.

g. The appellant is an "aggrieved party" as defined in rule 441—22.1(225C) and is eligible for a compliance hearing with the mental health, mental retardation, developmental disabilities, and brain injury commission in accordance with rule 441—22.5(225C).

h. The issue appealed is moot.

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

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

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

a. *General standards.* In general, a hearing shall be held if the appeal is made within 30 days after official notification of an action or before the effective date of action. When the appeal is made more

than 30 days but less than 90 days after notification, the director shall determine whether a hearing shall be granted.

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

1. There was a serious illness or death of the appellant or a member of the appellant's family.

2. There was a family emergency or household disaster, such as a fire, flood, or tornado.

3. The appellant offers a good cause beyond the appellant's control, which can be substantiated.

4. There was a failure to receive the department's notification for a reason not attributable to the appellant. Lack of a forwarding address is attributable to the appellant. A hearing may be granted if an appellant provides proof that a forwarding address was not supplied due to fear of domestic violence, homelessness, or other good cause.

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

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

b. *Food assistance standard.* For appeals regarding food assistance, a hearing shall be held if the appeal is made within 90 days after official notification of an action.

c. *Offset standards.* For appeals regarding state or federal tax or debtor offsets, a hearing shall be held if the appeal is made within 15 days after official notification of the action. Counties have 30 days to appeal offsets, as provided in 441—paragraph 14.4(1)*"e."* When the appeal is made more than 15 days but less than 90 days after notification, the director shall determine whether a hearing shall be granted.

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

1. There was a serious illness or death of the appellant or a member of the appellant's family.

2. There was a family emergency or household disaster, such as a fire, flood, or tornado.

3. The appellant offers a good cause beyond the appellant's control, which can be substantiated.

4. There was a failure to receive the department's notification for a reason not attributable to the appellant. Lack of a forwarding address is attributable to the appellant. A hearing may be granted if an appellant provides proof that a forwarding address was not supplied due to fear of domestic violence, homelessness, or other good cause.

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

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

d. *Abuse standard.* For appeals regarding child and dependent adult abuse, a hearing shall be held if the appeal is made within six months after official notification of the action as provided in Iowa Code section 235A.19. The day after the official notice is mailed is the first day of the period within which an appeal must be filed. When the time limit for filing falls on a holiday or a weekend, the time will be extended to the next workday.

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

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

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

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

7.5(5) *Informal settlements.* The time limit for submitting an appeal is not extended while attempts at informal settlement are in progress. Prehearing conferences are provided for at subrules 7.7(4) and 7.8(4).

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

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

1. Form 470-2616, Demand Letter for FIP/RCA Agency Error Overissuance;
2. Form 470-3490, Demand Letter for FIP/RCA Client Error Overissuance;
3. Form 470-3990, Demand Letter for PROMISE JOBS Agency Error Overissuance;
4. Form 470-3991, Demand Letter for PROMISE JOBS Client Error Overissuance; or
5. Form 470-3992, Demand Letter for PROMISE JOBS Provider Error Overissuance.

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

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

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

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

(1) Form 470-2891, Notice of Medical Assistance Overpayment; or

(2) Form 470-3984, Notice of Healthy and Well Kids in Iowa (HAWK-I) Overpayment.

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

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

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

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

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

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

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

(1) Form 470-0338, Demand Letter for Food Assistance Agency Error Overissuance;

(2) Form 470-3486, Demand Letter for Food Assistance Intentional Program Violation Overissuance; or

(3) Form 470-3487, Demand Letter for Food Assistance Inadvertent Household Error Overissuance.

b. Subject to the time limits described in subrule 7.5(4), a person's right to appeal the recovery of an overpayment through benefit reduction, but not the existence, computation, or amount of an overpayment, begins when the person receives Form 470-0485, 470-0485(S), 470-0486, or

470-0486(S), Notice of Decision, informing the person that benefits will be reduced to recover a food assistance overpayment.
[**ARC 8003B**, IAB 7/29/09, effective 9/2/09; **ARC 8439B**, IAB 1/13/10, effective 3/1/10]

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

7.6(1) *Written and oral notification.* The department shall advise each applicant and recipient of the right to appeal any adverse decision affecting the person's status.

a. Written notification of the following shall be given at the time of application and at the time of any agency action affecting the claim for assistance:

(1) The right to request a hearing.

(2) The procedure for requesting a hearing.

(3) The right to be represented by others at the hearing unless otherwise specified by statute or federal regulation.

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

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

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

7.6(2) *Representation.* All persons shall be advised that they may be represented at hearings by others, including legal counsel, relatives, friends, or any other spokesperson of choice, unless otherwise specified by statute or federal regulations. The department shall advise the persons of any legal services which may be available and that the person may be represented by counsel at the person's own expense.
[**ARC 8003B**, IAB 7/29/09, effective 9/2/09]

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

7.7(1) *Notification.*

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

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

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

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

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

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

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

(1) A statement of what action is being taken,

(2) The reasons for the intended action,

(3) The manual chapter number and subheading supporting the action and the corresponding rule reference,

(4) An explanation of the appellant's right to appeal, and

(5) The circumstances under which assistance is continued when an appeal is filed.

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

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

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

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

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

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

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

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

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

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

j. Rescinded, effective 2/1/84.

k. The department terminates or reduces benefits or makes changes based on a completed Form 470-2881, 470-2881(S), 470-2881(M), or 470-4083(MS), Review/Recertification Eligibility Document, as described at 441—paragraph 40.27(1)*"b"*or rule 441—75.52(249A).

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

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

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

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

7.7(4) *Conference during the timely notice period.* During the timely notice period, the appellant may have a conference to discuss the situation and the agency shall provide a full explanation of the reasons for the pending action and give the recipient an opportunity to offer facts to support the contention that the pending action is not warranted. The appellant may be accompanied by a representative, legal counsel, friend or other person and this person may represent the appellant when the appellant is not able to be present unless otherwise specified by statute or federal regulation.

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

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

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

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

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

e. When services of the community self-sufficiency grant project are available to all PROMISE JOBS participants as specified in subrule 441—47.46(1).

7.7(6) *Reinstatement.*

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

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

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

[**ARC 8003B**, IAB 7/29/09, effective 9/2/09]

441—7.8(17A) Opportunity for hearing.

7.8(1) *Initiating an appeal.* To initiate an appeal, a person or the person's authorized representative must state in writing that the person disagrees with a decision, action, or failure to act on the person's case.

a. All appeals shall be made in writing, except for food assistance appeals, which may be made orally.

b. The written request may be sent or delivered by any means to the appeals section, to the local office, or to the office that took the adverse action.

c. The oral request may be made to the appeals section or to the department office that took the adverse action.

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

A written appeal is filed on the date postmarked on the envelope sent to the department, or, when the postmarked envelope is not available, on the date the appeal is stamped received by the agency. Receipt date of all appeals shall be documented by the office where the appeal is received.

7.8(3) Rescinded IAB 12/13/89, effective 2/1/90.

7.8(4) *Prehearing conference.* When desired by the appellant, a prehearing conference with a representative of the local office or the office which took the action appealed shall be held as soon as possible after the appeal has been filed. An appellant's representative shall be allowed to attend and participate in the conference, unless precluded by federal rule or state statute.

The purpose of the prehearing conference is to provide information as to the reasons for the intended adverse action, to answer questions, to explain the basis for the adverse action, to provide an opportunity for the appellant to explain the appellant's action or position, and to provide an opportunity for the appellant to examine the contents of the case record plus all documents and records to be used by the department at the hearing in accordance with 441—Chapter 9. A conference need not be requested for the appellant to have access to the records as provided in subrule 7.13(1) and 441—Chapter 9.

7.8(5) *Interference.* The prehearing conference shall not be used to discourage appellants from proceeding with their appeals. The right of appeal shall not be limited or interfered with in any way, even though the person's complaint may be without basis in fact, or because of the person's own misinterpretation of law, agency policy, or methods of implementing policy.

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

a. It has been withdrawn by the appellant in writing.

b. The sole issue is one of state or federal law requiring automatic grant adjustments for classes of recipients.

c. It has been abandoned.

d. The agency, by written notice, withdraws the action appealed and restores the appellant's status which existed before the action appealed was taken.

e. The agency implements action and issues a notice of decision to correct an error made by the agency which resulted in the appeal.

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

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

7.8(8) *Withdrawal.* When the appellant desires to voluntarily withdraw an appeal, the worker, the presiding officer, or the appeals section shall request a clear, written statement from the appellant to withdraw the appeal. The appellant may use Form 470-0492 or 470-0492(S), Request for Withdrawal of Appeal, for this purpose.

7.8(9) *Department's responsibilities.* Unless the appeal is voluntarily withdrawn, the department worker or agent responsible for representing the department at the hearing shall:

a. Within one working day of receipt, complete the worker information section of Form 470-0487 or 470-0487(S), Appeal and Request for Hearing, and forward that form, the written appeal, the postmarked envelope, if there is one, and a copy of the notification of the proposed adverse action to the appeals section.

b. Forward a summary and supporting documentation of the worker's factual basis for the proposed action to the appeals section within ten days of the receipt of the appeal.

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

[**ARC 8003B**, IAB 7/29/09, effective 9/2/09]

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

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

a. An appeal is filed within the timely notice period.

b. The appellant requests a hearing within ten days from the date adequate notice is issued for cancellation or reduction of food assistance, family investment program, or medical assistance benefits, based on the completed report form, including:

(1) Review/Recertification Eligibility Document, Form 470-2881, 470-2881(S), 470-2881(M), or 470-4083(MS).

(2) Transitional Medicaid Notice of Decision/Quarterly Income Report, Form 470-2663, 470-2663(S), 470-2663(M), or 470-2663(MS).

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

7.9(2) *When assistance does not continue.* The adverse action appealed to suspend, reduce, restrict, or cancel assistance; revoke a license, registration, certification, approval, or accreditation; or take other proposed action may be implemented pending a final decision on appeal when:

a. An appeal is not filed within the timely notice period.

b. The appellant does not request a hearing within ten days from the date adequate notice is issued based on the completed monthly report.

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

d. and *e.* Rescinded IAB 4/30/03, effective 7/1/03.

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

7.9(3) *Recovery of excess assistance paid pending a final decision on appeal.* Continued assistance is subject to recovery by the department if its action is affirmed, except as specified at subrule 7.9(5).

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

7.9(4) *Recovery of excess assistance paid when the appellant's benefits are changed prior to a final decision.* Recovery of excess assistance paid will be made to the date of change which affects the improper payment. The recovery shall be made when the appellant's benefits are changed due to one of the following reasons:

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

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

7.9(5) *Recovery of assistance when a new limited benefit plan is established.* Assistance issued pending the final decision of the appeal is not subject to recovery when a new limited benefit plan period is established. A new limited benefit plan period shall be established when the department is affirmed in a timely appeal of the establishment of the limited benefit plan. All of the following conditions shall exist:

a. The appeal is filed within the timely notice period of the notice of decision establishing the beginning date of the LBP.

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

c. The department's action is affirmed.

[**ARC 8003B**, IAB 7/29/09, effective 9/2/09]

441—7.10(17A) Procedural considerations. Upon receipt of the notice of appeal, the department shall:

7.10(1) *Registration.* Register the appeal.

7.10(2) *Acknowledgment.* Send an acknowledgment of receipt of the appeal to the appellant, representative, or both.

A copy of the acknowledgment of receipt of appeal will be sent to the appropriate departmental office.

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

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

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

7.10(4) *Hearing scheduled.* For those records certified for hearing, the department of inspections and appeals shall establish the date, time, method and place of the hearing, with due regard for the convenience of the appellant as set forth in department of inspections and appeals rules 481—Chapter 10 unless otherwise designated by federal or state statute or regulation.

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

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

c. In cases involving the determination of the community spouse resource allowance, the hearing shall be held within 30 days of the date of the appeal request.

d. In cases involving an appeal of a sex offender risk assessment, the hearing shall be held within 30 days of the date of the appeal request.

e. Emergency assistance appeals shall be expedited.

7.10(5) *Method of hearing.* The department of inspections and appeals shall determine whether the appeal hearing is to be conducted in person, by videoconference or by teleconference call. The parties to the appeal may participate from multiple sites for videoconference or teleconference hearings. Any appellant is entitled to an in-person hearing if the appellant requests one. All parties shall be granted the same rights during a teleconference hearing as specified in 441—7.13(17A). The appellant may request to have a presiding officer render a decision for attribution appeals through an administrative hearing.

7.10(6) *Reschedule requests.* Requests by the appellant or the department to set another date, time, method or place of hearing shall be made to the department of inspections and appeals directly except as otherwise noted. The granting of the requests will be at the discretion of the department of inspections and appeals.

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

b. All other requests concerning the scheduling of a hearing shall be made to the department of inspections and appeals directly.

7.10(7) *Notification.* For those appeals certified for hearing, the department of inspections and appeals shall send a notice to the appellant at least ten calendar days in advance of the hearing date.

a. The notice, as prescribed in Iowa Code section 17A.12(2), shall set forth:

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

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

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

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

c. Notices of hearing regarding an intentional program violation shall be served upon the appellant both by certified mail, return receipt requested, and by first-class mail, postage prepaid, addressed to the appellant at the last-known address. All other notices of hearing shall be mailed by first-class mail, postage prepaid, addressed to the appellant at the appellant's last-known address.

[**ARC 8003B**, IAB 7/29/09, effective 9/2/09]

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

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

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

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

7.13(2) *Conduct of hearing.* The hearing shall be conducted by an administrative law judge designated by the department of inspections and appeals. It shall be an informal rather than a formal judicial procedure, and shall be designed to serve the best interest of the appellant. The appellant shall have the right to introduce any evidence on points at issue believed necessary, and to challenge and cross-examine any statement made by others, and to present evidence in rebuttal. A verbatim record shall be kept of the evidence presented.

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

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

a. Where appropriate and not contrary to law, any party may move for a default decision or for a hearing and a proposed decision on the merits in the absence of a defaulting party.

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

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

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

7.13(5) *Proceedings after default decision.*

a. Default decisions become final agency action unless a motion to vacate the decision is filed within the time allowed for an appeal of a proposed decision by subrule 7.16(5).

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

(1) The appeals section shall be responsible for serving all parties with the motion to vacate. All parties to the appeal shall have ten days from service by the department to respond to the motion to vacate. If the department responds to any party's motion to vacate, all parties shall be allowed another ten days to respond to the department.

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

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

d. "Good cause" for purposes of this rule shall have the same meaning as "good cause" for setting aside a default judgment under Iowa Rule of Civil Procedure 1.977.

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

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

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

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

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

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

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

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

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

(1) The appeals section shall be responsible for serving all parties with the motion to vacate. All parties to the appeal shall have ten days from service by the department to respond to the motion to vacate. If the department responds to any party's motion to vacate, all parties shall be allowed another ten days to respond to the department.

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

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

e. "Good cause" for purposes of this rule shall have the same meaning as "good cause" for setting aside a default judgment under Iowa Rule of Civil Procedure 1.977.

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

g. Upon a final decision granting a motion to vacate, a new contested case hearing shall be held after proper service of notice to all parties. The situation shall be treated as the filing of a new appeal for purposes of calculating time limits, with the filing date being the date the decision granting the motion to vacate became final.

h. Upon a final decision denying a motion to vacate, the proposed decision on the merits in the absence of a defaulting party becomes final unless there is request for review on the merits by the director made pursuant to paragraph 7.13(6)*"a"* or *"j."*

i. Any review on the merits by the director requested pursuant to paragraph 7.13(6)*"a"* and stayed pursuant to paragraph 7.13(6)*"b"* pending a decision on a motion to vacate shall be conducted upon a final decision denying the motion to vacate.

j. Upon a final decision denying a motion to vacate a proposed decision issued in the absence of a defaulting party, any party to the contested case proceeding may request a review on the merits by the director pursuant to rule 441—7.16(17A), treating the date that the denial of the motion to vacate became final as the date of the proposed decision.

[**ARC 8003B**, IAB 7/29/09, effective 9/2/09]

441—7.14(17A) Limitation of persons attending. The hearing shall be limited in attendance to the following persons, unless otherwise specified by statute or federal regulations: appellant, appellant's representative, agency employees, agency's legal representatives, other persons present for the purpose of offering testimony pertinent to the issues in controversy, and others upon mutual agreement of the parties. The administrative law judge may sequester witnesses during the hearing.

Nothing in this rule shall be construed to allow members of the press, news media, or any other citizens' group to attend the hearing without the written consent of the appellant.

441—7.15(17A) Medical examination. When the hearing involves medical issues, a medical assessment or examination by a person or physician other than the one involved in the decision under question shall be obtained and the report made a part of the hearing record when the administrative law

judge or appellant considers it necessary. Any medical examination required shall be performed by a physician satisfactory to the appellant and the department at agency expense.

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

441—7.16(17A) The appeal decision.

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

a. The notice of appeal.

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

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

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

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

The appellant, appellant's representative, or the department may appeal for the director's review of the proposed decision.

When the appellant or the department has not appealed the proposed decision or an appeal for the director's review of the proposed decision is not granted, the proposed decision shall become the final decision.

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

7.16(5) *Time limit for appeal of a proposed decision.* Appeal for the director's review of the proposed decision must be made in writing to the director and postmarked or date-stamped within ten calendar days of the date on which the proposed decision was signed and mailed. The day after the proposed decision is mailed is the first day of the time period within which a request for review must be filed. When the time limit for filing falls on a holiday or a weekend, the time will be extended to the next workday.

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

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

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

7.16(7) *Appeal of the proposed decision by the appellant.* When the director grants a review of a proposed decision all other parties shall be so notified.

7.16(8) *Opportunity for oral presentation of appeal of the proposed decision.* In cases where there is an appeal of a proposed decision each party shall be afforded an opportunity to present oral arguments with the consent of the director. Any party wishing oral argument shall specifically request it. When granted, all parties shall be notified of the time and place.

7.16(9) *Time limits.* A final decision on the appeal shall be issued within 90 days from the date of the appeal on all decisions except food assistance and vendors. Food assistance-only decisions shall be rendered in 60 days. PROMISE JOBS displacement grievance decisions shall be rendered within 90 days from the date the displacement grievance was filed with the PROMISE JOBS contractee. Failure to reach a decision within these time frames shall not affect the merits of the appellant's appeal.

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

b. The department shall take prompt, definite and final administrative action to carry out the decision rendered within 7 calendar days of receipt of a copy of the final decision. When the final decision is favorable to the appellant, or when the department decides in favor of the appellant before the hearing, the department shall make any additional corrective payments due, retroactive to the date of the incorrect action.

7.16(10) *Final decision.* The department shall mail the final decision to the appellant at the appellant's last-known address by first-class mail, postage prepaid.

[**ARC 8003B**, IAB 7/29/09, effective 9/2/09]

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

441—7.18(17A) Ex parte communication.

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

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

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

c. For purposes of this rule:

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

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

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

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

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

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

7.18(6) *Disclosure of prohibited communications.* A presiding officer who receives a prohibited ex parte communication during the pendency of a contested case must initially determine if the effect of the communication is so prejudicial that the presiding officer should be disqualified from the case. If the presiding officer determines that disqualification is warranted, a copy of any prohibited written communication, all written responses to the communication, a written summary stating the substance of any prohibited oral or other communication not available in written form for disclosure, all responses made, and the identity of each person from whom the presiding officer received a prohibited ex parte communication shall be disclosed. If the presiding officer determines that disqualification is not warranted, such documents shall be submitted for inclusion in the record and served on all parties. Any party desiring to rebut the prohibited communication must be allowed the opportunity to do so upon written request filed within ten days after notice of communication.

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

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

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

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

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

7.20(2) *Stays of agency action.*

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

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

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

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

7.21(1) *Appeal hearings.* All appeal hearings in the food assistance program shall be conducted in accordance with federal regulation, Title 7, Section 273.15, as amended to January 1, 2008.

7.21(2) *Food assistance administrative disqualification hearings.* All food assistance administrative disqualification hearings shall be conducted in accordance with federal regulation, Title 7, Section 273.16, as amended to January 1, 2008.

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

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

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

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

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

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

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

7.21(5) *Attendance at hearing.* The household member shall be allowed 10 days from the scheduled hearing to present reasons indicating good cause for not attending the hearing.

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

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

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

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

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

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

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

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

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

[**ARC 8003B**, IAB 7/29/09, effective 9/2/09]

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

441—7.23(17A) Contested cases with no factual dispute. If the parties in a contested case agree that there is no dispute of material fact, the parties may present all admissible evidence either by stipulation, or as otherwise agreed, in lieu of an evidentiary hearing. If an agreement is reached, the parties shall jointly submit a schedule for submission of the record, briefs and oral arguments to the presiding officer for approval.

441—7.24(17A) Emergency adjudicative proceedings.

7.24(1) *Necessary emergency action.* To the extent necessary to prevent or avoid immediate danger to the public health, safety, or welfare, and consistent with the United States Constitution and the Iowa Constitution and other provisions of law, the department may issue a written order in compliance with Iowa Code section 17A.18 to suspend a license in whole or in part, order the cessation of any continuing activity, order affirmative action, or take other action within the jurisdiction of the department by emergency adjudicative order. Before issuing an emergency adjudicative order, the department shall consider factors including, but not limited to, the following:

a. Whether there has been sufficient factual investigation to ensure that the agency is proceeding on the basis of reliable information.

b. Whether the specific circumstances which pose immediate danger to the public health, safety or welfare have been identified and determined to be continuing.

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

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

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

7.24(2) *Issuance of order.*

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

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

(1) Personal delivery.

(2) Certified mail, return receipt requested, to the last address on file with the department.

(3) Certified mail to the last address on file with the department.

(4) First-class mail to the last address on file with the department.

(5) Fax. Fax may be used as the sole method of delivery if the person required to comply with the order has filed a written request that department orders be sent by fax and has provided a fax number for that purpose.

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

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

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

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

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◊ Two or more ARCs

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 as amended by 2010 Iowa Acts, Senate File 2088, section 347.

(1) For any drug requiring prior authorization, reimbursement will be made for a 72-hour or three-day supply dispensed in an emergency when a prior authorization request cannot be submitted.

(2) Unless the manufacturer or labeler of a mental health prescription drug that has a significant variation in therapeutic or side effect profile from other drugs in the same therapeutic class enters into a contract to provide the state with a supplemental rebate, the drug may be placed on the preferred drug list as nonpreferred, with prior authorization required. However, prior authorization shall not be required for such a drug for a member whose regimen on the drug was established before January 1, 2011, as verified by documented pharmacy claims.

(3) For mental health prescription drugs requiring prior authorization that have a significant variation in therapeutic or side effect profile from other drugs in the same therapeutic class, reimbursement will be made for up to a seven-day supply pending prior authorization. A request for prior authorization shall be deemed approved if the prescriber:

1. Has on file with the department current contact information, including a current fax number, and a signed Form 470-4914, Fax Confidentiality Certificate, and

2. Does not receive a notice of approval or disapproval within 48 hours of a request for prior authorization.

b. Payment is not made for:

(1) Drugs whose prescribed use is not for a medically accepted indication as defined by Section 1927(k)(6) of the Social Security Act.

(2) Drugs used 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; **ARC 9175B**, IAB 11/3/10, effective 1/1/11]

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		

ICD-9	CATEGORY I	ICD-9	CATEGORY II	ICD-9	CATEGORY III
		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		
		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. However, active pharmaceutical ingredients and excipients that are identified as preferred on the preferred drug list published by the department pursuant to Iowa Code section 249A.20A are covered. Medical supplies shall not be dispensed at any one time in quantities exceeding a 31-day supply for active pharmaceutical ingredients and excipients or a three-month supply for all other items. After the initial dispensing of medical supplies, the provider must document a refill request from the Medicaid member or the member's caregiver for each refill.

a. 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:

Active pharmaceutical ingredients and excipients identified as preferred on the preferred drug list published pursuant to Iowa Code section 249A.20A.

Catheter (indwelling Foley).

Colostomy and ileostomy appliances.

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

Diabetic 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; **ARC 9256B**, IAB 12/1/10, effective 1/1/11]

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.

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◊ 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 disability 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 disability 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 disability waivers: Fee schedule as determined by Medicare.	For elderly waiver: $80.85 per visit. For intellectual disability 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 disability 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 member 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 member 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 member 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 disability 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. 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 pursuant to paragraph 79.1(5)*"y"* and is an Iowa non-state-government-owned acute care teaching hospital located in a county with a population over 350,000.

(2) Amount of payment. The total amount of disproportionate share payments pursuant to paragraph 79.1(5)*"y"* and the Iowa non-state-government-owned acute care teaching hospital disproportionate share payments shall not exceed the amount of the state's allotment under Public Law 102-234. In addition, the total amount of all disproportionate share payments shall not exceed the hospital-specific disproportionate share limits under Public Law 103-666.

(3) Final disproportionate share adjustment. The department's total year-end disproportionate share obligations to a qualifying hospital will be calculated following completion of the desk review or audit of CMS 2552-96, Hospital and Healthcare Complex Cost Report. The department's total year-end disproportionate share obligation shall not exceed the difference between $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) For services rendered July 1, 2010, through June 30, 2011, 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, means the hospital's cost report with fiscal year end on or after January 1, 2007, and before January 1, 2008. Cost reports shall be reviewed using Medicare's cost reporting and cost reimbursement principles for those cost reporting periods.

"Blended base APC rate" shall mean the hospital-specific base APC rate, plus the statewide base APC rate, divided by two. The costs of hospitals receiving reimbursement as critical access hospitals during any of the period included in the base-year cost report shall not be used in determining the statewide base APC rate.

"Case-mix index" shall mean an arithmetical index measuring the relative average costliness of outpatient cases treated in a hospital, compared to the statewide average.

"Cost outlier" shall mean services provided during a single visit that have an extraordinarily high cost as established in paragraph *"g"* and are therefore eligible for additional payments above and beyond the base APC payment.

"Current procedural terminology—fourth edition (CPT-4)" is the systematic listing and coding of procedures and services provided by physicians or other related health care providers. The CPT-4 coding is maintained by the American Medical Association and is updated yearly.

"Diagnostic service" means an examination or procedure performed to obtain information regarding the medical condition of an outpatient.

"Direct medical education costs" shall mean costs directly associated with the medical education of interns and residents or other medical education programs, such as a nursing education program or allied health programs, conducted in an outpatient setting, that qualify for payment as medical education costs under the Medicare program. The amount of direct medical education costs is determined from the hospital base-year cost reports and is inflated in determining the direct medical education rate.

"Direct medical education rate" shall mean a rate calculated for a hospital reporting medical education costs on the Medicare cost report (CMS 2552). The rate is calculated using the following

formula: Direct medical education costs are multiplied by the percentage of valid claims to total claims, further multiplied by inflation factors, then divided by outpatient visits.

"Discount factor" means the percentage discount applied to additional APCs when more than one APC is provided during the same visit (including the same APC provided more than once). Not all APCs are subject to a discount factor.

"GME/DSH fund apportionment claim set" means the hospital's applicable Medicaid claims paid from July 1, 2008, through June 30, 2009. The claim set is updated every three years in July.

"GME/DSH fund implementation year" means 2009.

"Graduate medical education and disproportionate share fund" or *"GME/DSH fund"* means a reimbursement fund developed as an adjunct reimbursement methodology to directly reimburse qualifying hospitals for the direct costs of interns and residents associated with the operation of graduate medical education programs for outpatient services.

"Healthcare common procedures coding system" or *"HCPCS"* means the national uniform coding method that is maintained by the Centers for Medicare and Medicaid Services (CMS) and that incorporates the American Medical Association publication Physicians Current Procedural Terminology (CPT) and the three HCPCS unique coding levels I, II, and III.

"Hospital-based clinic" means a clinic that is owned by the hospital, operated by the hospital under its hospital license, and on the premises of the hospital.

"International classifications of diseases—fourth edition, ninth revision (ICD-9)" is a systematic method used to classify and provide standardization to coding practices which are used to describe the diagnosis, symptom, complaint, condition or cause of a person's injury or illness.

"Medicaid claim set" means the hospital's applicable Medicaid claims for the period of January 1, 2006, through December 31, 2007, and paid through March 31, 2008.

"Modifier" means a two-character code that is added to the procedure code to indicate the type of service performed. The modifier allows the reporting hospital to indicate that a performed service or procedure has been altered by some specific circumstance. The modifier may affect payment or may be used for information only.

"Multiple significant procedure discounting" means a reduction of the standard payment amount for an APC to recognize that the marginal cost of providing a second APC service to a patient during a single visit is less than the cost of providing that service by itself.

"Observation services" means a set of clinically appropriate services, such as ongoing short-term treatment, assessment, and reassessment, that is provided before a decision can be made regarding whether a patient needs further treatment as a hospital inpatient or is able to be discharged from the hospital.

"Outpatient hospital services" means preventive, diagnostic, therapeutic, observation, rehabilitation, or palliative services provided to an outpatient by or under the direction of a physician, dentist, or other practitioner by an institution that:

1. Is licensed or formally approved as a hospital by the officially designated authority in the state where the institution is located; and
2. Meets the requirements for participation in Medicare as a hospital.

"Outpatient prospective payment system" or *"OPPS"* means the payment methodology for hospital outpatient services established by this subrule and based on Medicare's outpatient prospective payment system mandated by the Balanced Budget Refinement Act of 1999 and the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000.

"Outpatient visit" shall mean those hospital-based outpatient services which are billed on a single claim form.

"Packaged service" means a service that is secondary to other services but is considered an integral part of another service.

"Pass-through" means certain drugs, devices, and biologicals for which providers are entitled to payment separate from any APC.

"Quality improvement organization" or *"QIO"* shall mean the organization that performs medical peer review of Medicaid claims, including review of validity of hospital diagnosis and procedure coding

information; completeness, adequacy and quality of care; and appropriateness of prospective payments for outlier cases and nonemergent use of the emergency room. These activities undertaken by the QIO may be included in a contractual relationship with the Iowa Medicaid enterprise.

"Rebasing" shall mean the redetermination of the blended base APC rate using more recent Medicaid cost report data.

"Significant procedure" shall mean the procedure, therapy, or service provided to a patient that constitutes the primary reason for the visit and dominates the time and resources expended during the visit.

"Status indicator" or *"SI"* means a payment indicator that identifies whether a service represented by a CPT or HCPCS code is payable under the 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 hospital services established pursuant to 79.1(1)*"c."* For items not covered by Iowa Medicaid as an outpatient hospital service, the item is not paid as an outpatient hospital service, but may be paid by Iowa Medicaid under the specific rate or methodology established by other rules (other than outpatient hospital).

d. Calculation of case-mix indices. Hospital-specific and statewide case-mix indices shall be calculated using the Medicaid claim set.

(1) Hospital-specific case-mix indices are calculated by summing the relative weights for each APC service at that hospital and dividing the total by the number of APC services for that hospital.

(2) The statewide case-mix index is calculated by summing the relative weights for each APC service for all claims and dividing the total by the statewide total number of APC services. Claims for hospitals receiving reimbursement as critical access hospitals during any of the period included in the base-year cost report are not used in calculating the statewide case-mix index.

e. Calculation of the hospital-specific base APC rates.

(1) Using the hospital's base-year cost report, hospital-specific outpatient cost-to-charge ratios are calculated for each ancillary and outpatient cost center of the Medicare cost report, Form CMS 2552-96.

(2) The cost-to-charge ratios are applied to each line item charge reported on claims from the Medicaid claim set to calculate the Medicaid cost per service. The hospital's total outpatient Medicaid cost is the sum of the Medicaid cost per service for all line items.

(3) The following items are subtracted from the hospital's total outpatient Medicaid costs:

1. The total calculated Medicaid direct medical education cost for interns and residents based on the hospital's base-year cost report.

2. The total calculated Medicaid cost for services listed at 441—subrule 78.31(1), paragraphs *"g"* to *"n."*

3. The total calculated Medicaid cost for ambulance services.

4. The total calculated Medicaid cost for services paid based on the Iowa Medicaid fee schedule.

(4) The remaining amount is multiplied by a factor to limit aggregate expenditures to available funding, divided by the hospital-specific case-mix index, and then divided by the total number of APC services for that hospital from the Medicaid claim set.

(5) Hospital-specific base APC rates are not computed for hospitals receiving reimbursement as critical access hospitals during any of the period included in the base-year cost report.

f. Calculation of statewide base APC rate.

(1) The statewide average base APC rate is calculated by summing the outpatient Medicaid cost for all hospitals and subtracting the following:

1. The total calculated Medicaid direct medical education cost for interns and residents for all hospitals.

2. The total calculated Medicaid cost for services listed at 441—subrule 78.31(1), paragraphs *"g"* to *"n,"* for all hospitals.

3. The total calculated Medicaid cost for ambulance services for all hospitals.

4. The total calculated Medicaid cost for services paid based on the Iowa Medicaid fee schedule for all hospitals.

(2) The resulting amount is multiplied by a factor to limit aggregate expenditures to available funding, divided by the statewide case-mix index, and then divided by the statewide total number of APC services from the Medicaid claim set.

(3) Data for hospitals receiving reimbursement as critical access hospitals during any of the period included in the base-year cost report is not used in calculating the statewide average base APC rate.

g. *Cost outlier payment policy.* Additional payment is made for services provided during a single visit that exceed the following Medicaid criteria of cost outliers for each APC. Outlier payments are determined on an APC-by-APC basis.

(1) An APC qualifies as a cost outlier when the cost of the service exceeds both the multiple threshold and the fixed-dollar threshold.

(2) The multiple threshold is met when the cost of furnishing an APC service exceeds 1.75 times the APC payment amount.

(3) The fixed-dollar threshold is met when the cost of furnishing an APC service exceeds the APC payment amount plus $2,000.

(4) If both the multiple threshold and the fixed-dollar threshold are met, the outlier payment is calculated as 50 percent of the amount by which the hospital's cost of furnishing the APC service or procedure exceeds the multiple threshold.

(5) The cost of furnishing the APC service or procedure is calculated using a single overall hospital-specific cost-to-charge ratio determined from the base-year cost report. Costs appearing on a claim that are attributable to packaged APC services for which no separate payment is made are allocated to all nonpackaged APC services that appear on that claim. The amount allocated to each nonpackaged APC service is based on the proportion the APC payment rate for that APC service bears to the total APC rates for all nonpackaged APC services on the claim.

h. *Payment to critical access hospitals.* Initial, interim payments to critical access hospitals as defined in paragraph 79.1(5)*"a"* shall be the hospital's line-item charge multiplied by the hospital's Medicaid outpatient cost-to-charge ratio. These interim payments are subject to annual retrospective adjustment equal to the difference between the reasonable costs of covered services provided to eligible fee-for-service Medicaid members (excluding members in managed care) and the Medicaid reimbursement received. The department shall determine the reasonable costs of services based on the hospital's annual cost reports and Medicare cost principles. When the interim amounts paid exceed reasonable costs, the department shall recover the difference.

(1) After any retrospective adjustment, the department shall update the cost-to-charge ratio to reflect as accurately as is possible the reasonable costs of providing the covered service to eligible fee-for-service Medicaid members for the coming year. The department shall base these changes on the most recent utilization as submitted to the Iowa Medicaid enterprise provider cost audit and rate-setting unit and Medicare cost principles.

(2) Once a hospital begins receiving reimbursement as a critical access hospital, the cost-to-charge ratio is not subject to rebasing as provided in paragraph 79.1(16)*"j."*

i. *Cost-reporting requirements.* Hospitals shall prepare annual cost reports in accordance with generally accepted accounting principles as defined by the American Institute of Certified Public Accountants and in accordance with Medicare Provider Reimbursement Manual, CMS Publication 15, subject to the exceptions and limitations provided in this rule.

(1) Using electronic media, each hospital shall submit the following:

1. The hospital's Medicare cost report (Form CMS 2552-96, Hospitals and Healthcare Complex Cost Report);

2. Either Form 470-4515, Critical Access Hospital Supplemental Cost Report, or Form 470-4514, Hospital Supplemental Cost Report; and

3. A copy of the revenue code crosswalk used to prepare the Medicare cost report.

(2) The cost reports and supporting documentation shall be sent to the Iowa Medicaid Enterprise, Provider Cost Audit and Rate Setting Unit, 100 Army Post Road, P.O. Box 36450, Des Moines, Iowa 50315.

(3) The cost reports shall be submitted on or before the last day of the fifth calendar month following the close of the period covered by the report. For fiscal periods ending on a day other than the last day of the month, cost reports are due 150 days after the last day of the cost-reporting period. Extensions of the due date for filing a cost report granted by the Medicare fiscal intermediary shall be accepted by Iowa Medicaid.

j. Rebasing.

(1) Effective January 1, 2009, and annually thereafter, the department shall update the OPPS APC relative weights using the most current calendar update as published by the Centers for Medicare and Medicaid Services.

(2) Effective January 1, 2009, and every three years thereafter, blended base APC rates shall be rebased. Cost reports used in rebasing shall be the hospital fiscal year-end Form CMS 2552-96, Hospital and Healthcare Complex Cost Report, as submitted to Medicare in accordance with Medicare cost report submission time lines for the hospital fiscal year ending during the preceding calendar year. If a hospital does not provide this cost report, including the Medicaid cost report and revenue code crosswalk, to the Iowa Medicaid enterprise provider cost audit and rate-setting unit by May 31 of a year in which rebasing occurs, the most recent submitted cost report will be used.

(3) Effective January 1, 2009, and every three years thereafter, case-mix indices shall be recalculated using valid claims most nearly matching each hospital's fiscal year end.

(4) The graduate medical education and disproportionate share fund shall be updated as provided in subparagraph 79.1(16)*"v"*(3).

k. Payment to out-of-state hospitals. Out-of-state hospitals providing care to members of Iowa's Medicaid program shall be reimbursed in the same manner as Iowa hospitals, except 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; **ARC 9176B**, IAB 11/3/10, effective 12/8/10]

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 2and 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) Electronic health record incentive program. The department has elected to participate in the electronic health record (EHR) incentive program authorized under Section 4201 of the American Recovery and Reinvestment Act of 2009 (ARRA), Public Law No. 111-5. The electronic health record incentive program provides incentive payments to eligible hospitals and professionals participating in the Iowa Medicaid program that adopt and successfully demonstrate meaningful use of certified electronic health record technology.

79.16(1) *State elections.* In addition to the statutory provisions in Section 4201 of the ARRA, the electronic health record incentive program is governed by federal regulations at 42 CFR Part 495 as published in the Federal Register, Vol. 75, No. 144, on July 28, 2010. In compliance with the requirements of federal law, the department establishes the following state options under the Iowa electronic health record incentive program:

a. For purposes of the term "hospital-based eligible professional (EP)" as set forth in 42 CFR Section 495.4 as amended to July 28, 2010, the department elects the calendar year preceding the payment year as the period used to calculate whether or not an eligible professional is "hospital-based" for purposes of the regulation.

b. For purposes of calculating patient volume as required by 42 CFR Section 495.306 as amended to July 28, 2010, eligible providers may elect to use either:

(1) The methodology found in 42 CFR Section 495.306(c) as amended to July 28, 2010, or

(2) The methodology found in 42 CFR Section 495.306(d) as amended to July 28, 2010.

c. For purposes of 42 CFR Section 495.310(g)(1)(i)(B) as amended to July 28, 2010, the "12-month period selected by the state" shall mean the state fiscal year.

79.16(2) *Eligible providers.* To be deemed an "eligible provider" for the electronic health record incentive program, a provider must satisfy the following criteria:

a. The provider must be currently enrolled as an Iowa Medicaid provider.

b. The provider must be one of the following:

(1) An eligible professional, listed as:

1. A physician,
2. A dentist,
3. A certified nurse midwife,
4. A nurse practitioner, or
5. A physician assistant practicing in a federally qualified health center or a rural health clinic when the physician assistant is the primary provider, clinical or medical director, or owner of the site.

(2) An acute care hospital, defined as a health care facility where the average length of stay is 25 days or fewer, which has a CMS certification number with the last four digits in the series 0001-0879 or 1300-1399.

(3) A children's hospital, defined as a separately certified children's hospital, either freestanding or a hospital-within-hospital, that predominately treats individuals under 21 years of age and has a CMS certification number with the last four digits in the series 3300-3399.

c. For the year for which the provider is applying for an incentive payment:

(1) An acute care hospital must have 10 percent Medicaid patient volume.

(2) An eligible professional must have at least 30 percent of the professional's patient volume covered by Medicaid, except that:

1. A pediatrician must have at least 20 percent Medicaid patient volume.
2. When a professional has at least 50 percent of patient encounters in a federally qualified health center or rural health clinic, patients who were furnished services either at no cost or at a reduced cost based on a sliding scale or ability to pay, patients covered by the HAWK-I program, and Medicaid members may be counted to meet the 30 percent threshold.

79.16(3) *Application and agreement.* Any eligible provider who wants to participate in the Iowa electronic health record incentive program must declare the intent to participate by registering with the National Level Repository, as developed by the Centers for Medicare and Medicaid Services (CMS). CMS will notify the department of an eligible provider's application for the incentive payment.

a. Upon receipt of an application for participation in the program, the department will contact the applicant with instructions for accessing the EHR incentive payment program section of the Iowa Medicaid portal access (IMPA) Web site at https://secureapp.dhs.state.ia.us/impa/. The applicant shall use the Web site to:

(1) Attest to the applicant's qualifications to receive the incentive payment, and

(2) Digitally sign Form 470-4976, Iowa Electronic Health Record Incentive Program Provider Agreement.

b. For the second year of participation, the eligible provider must submit meaningful use and clinical quality measures to the department, either through attestation or electronically as required by the department.

c. The department shall verify the applicant's eligibility, including patient volume and practice type, and the applicant's use of certified electronic health record technology.

79.16(4) *Payment.* The department shall issue the incentive payment only after confirming that all eligibility and performance criteria have been satisfied. Payments will be processed and paid to the tax identification number designated by the applicant. The department will communicate the payment or denial of payment to the National Level Repository.

a. The primary communication channel from the department to the provider will be the IMPA Web site. If the department finds that the applicant is ineligible or has failed to achieve the criteria necessary for the payment, the department shall notify the provider through the Web site. Providers shall access the Web site to determine the status of their payment, including whether the department denied payment and the reason for the denial.

b. Providers must retain records supporting their eligibility for the incentive payment for a minimum of six years. The department will select providers for audit after issuance of an incentive payment. Incentive recipients shall cooperate with the department by providing proof of:

(1) Eligibility,

(2) Purchase of certified electronic health record technology, and

(3) Meaningful use of electronic health record technology.

79.16(5) *Administrative appeal.* Any eligible provider or any provider that claims to be an eligible provider and who has been subject to an adverse action related to the Iowa electronic health record incentive program may seek review of the department's action pursuant to 441—Chapter 7. Appealable issues include:

a. Provider eligibility determination.

b. Incentive payments.

c. Demonstration of adopting, implementing, upgrading and meaningful use of technology.

This rule is intended to implement Iowa Code section 249A.4 and Public Law No. 111-5.

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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 118
CHILD CARE QUALITY RATING SYSTEM

PREAMBLE

This chapter establishes rules for the child care quality rating system, which is designed for child care programs that primarily serve children between birth and the age of 12. Participation in the quality rating system is voluntary. The chapter includes application procedures and standards for the quality rating.
[**ARC 9257B**, IAB 12/1/10, effective 2/1/11]

441—118.1(237A) Definitions.

"Aim4Excellence credential" means the national director credential for early childhood administrators that is administered by the McCormick Center for Early Childhood Leadership.

"Apprenticeship certificate" means a nationally recognized Child Care Development Specialist Registered Apprenticeship Certificate awarded by the U.S. Department of Labor. The certificate requires two years of full-time employment with on-the-job training and 288 hours (at least 19 credits) of approved, related college education or training.

"Child care facility" means a licensed child care center, a preschool, or a registered child development home.

"Child care nurse consultant" means a registered nurse licensed in the state of Iowa who has completed training using a nationally approved curriculum for health and safety in child care and early education. The child care nurse consultant provides on-site consultation, technical assistance, and training to child care and early education providers regarding health and safety. The child care nurse consultant is employed by or has a written agreement with the local Title V maternal and child health agency or contracts for service delivery directly through the state-level Title V maternal and child health program administered by the Iowa department of public health, bureau of family health.

"Child development associate credential (CDA)" means a credential awarded by the Council for Professional Recognition to individuals working in child care settings who demonstrate proficiency in specific competency standards. The credential requires 120 hours of approved training over the past five years.

"ChildNet certification" means verified completion of the 25-hour ChildNet training series in areas specifically designed for child development home providers and completion of the certification process.

"Department" means the department of human services.

"Eligible applicants" means programs meeting the definition of "child care facility" or programs operating under the authority of an accredited school district or nonpublic school.

"Environment rating scale" means a child care program assessment instrument (scale) developed through the auspices of the Frank Porter Graham Child Development Center of the University of North Carolina at Chapel Hill. The scale is the measurement tool used by an assessor during an on-site observation of a child care classroom to evaluate and provide a score to a child care program. Scales must be administered by entities approved by the department of human services or the department's designee. Four scales are available, based on the type of program being assessed:

1. Family child care environment rating scale for programs conducted in a provider's own home for children from infancy through school age.
2. Infant/toddler environment rating scale for group programs for children from birth to 2½ years of age.
3. Early childhood environment rating scale for group programs for children of preschool through kindergarten age, 2½ to 5 years.
4. School-age care environment rating scale for group programs for children of school age, 5 to 12 years.

"Head Start program performance standards" means the standards that define the services that Head Start programs are required to provide to the children and families they serve. The standards constitute the expectations and requirements that Head Start grantees must meet.

"Iowa quality preschool program standards" means standards developed by the Iowa department of education, based on the ten standards of the National Association for the Education of Young Children accreditation.

"National administrator credential (NAC)" means the 40-hour comprehensive training for child care and education administrators and successful completion of the certification process.

"Staff in the classroom" means staff responsible for care of children in the classroom.

[**ARC 9257B**, IAB 12/1/10, effective 2/1/11]

441—118.2(237A) Application for quality rating. Eligible applicants shall apply for a quality rating by submitting the specified application form and any required supporting documentation to the department. Applications for a Level 1 rating will not be accepted from programs that have previously been rated at Level 1.

118.2(1) *Transition period.* For the period February 1, 2011, through July 31, 2011, eligible applicants may apply for a quality rating either under this subrule or under subrule 118.2(2).

a. A child care center or preschool applying under this subrule shall complete Form 470-4229, Application for Quality Rating—Center/Preschool. The quality rating will be based on the standards in rule 441—118.3(237A).

b. A child development home applying under this subrule shall complete Form 470-4302, Application for Quality Rating—Child Development Home. The quality rating will be based on the standards in rule 441—118.4(237A).

118.2(2) *Ongoing standards.* Until August 1, 2011, eligible applicants have the choice of applying under this subrule or under subrule 118.2(1). Effective August 1, 2011, all eligible applicants must apply for a quality rating under this subrule.

a. A child care center, preschool, or program operating under the authority of an accredited school district or nonpublic school applying under this subrule shall complete Form 470-4902, Quality Rating System Application for Licensed Centers, Preschools, and School-Based Programs. The quality rating will be based on the standards in rule 441—118.5(237A).

b. A child development home applying under this subrule shall complete Form 470-4901, Quality Rating System Application for Child Development Homes. The quality rating will be based on the standards in rule 441—118.6(237A).

118.2(3) *Change in location of facility.* If the location of a rated program changes, the program must notify the department and complete a new application form as specified in subrule 118.2(1) or 118.2(2). The department shall make a new determination of the appropriate rating.

[**ARC 9257B**, IAB 12/1/10, effective 2/1/11]

441—118.3(237A) Rating standards for child care centers and preschools (sunsetting on July 31, 2011). For applications submitted under subrule 118.2(1), to participate in the quality rating system, a child care center or preschool shall certify that its facility meets the applicable criteria as defined in subrule 118.3(1).

118.3(1) *Criteria.* Criteria for each rating level are defined as follows.

a. *Level 1.* To be rated at Level 1, a facility must either:

(1) Have a full or provisional license from the department of human services with no action pending to revoke or deny the license; or

(2) Operate under the authority of an accredited school district or nonpublic school.

b. *Level 2.* To be rated at Level 2, a facility must meet the following criteria:

(1) The facility must have a full license from the department of human services with no action pending to revoke or deny the license, or operate under the authority of an accredited school district or nonpublic school.

(2) The facility must complete the Iowa department of public health's Form HCCI-BPA2006, Child Care Business—Partnership Agreement.

(3) The facility must complete the Iowa department of public health's provider health and safety questionnaire, Form HCCI-CDOS2006, Child Care Center Director/Owner Survey.

(4) If eligible, the facility must participate in the child and adult care food program (CACFP), unless children are in attendance less than four hours per day and the program does not serve meals.

(5) The facility must have on duty in each room at all times at least one staff member who has completed training in mandatory reporting of child abuse, universal precautions and infectious disease control, cardiopulmonary resuscitation, and first aid as specified in 441—subrule 109.7(1) and subparagraphs 109.7(2)*"a"*(1) and (2).

(6) The facility must provide basic orientation for all staff before they begin work.

(7) All staff, including the facility's director, must complete Form 470-4234, Child Care Center Staff Self-Assessment, no more than 12 months before application for quality rating. The director must also complete Form 470-4233, Child Care Center Self-Assessment.

c. *Level 3.* To be rated at Level 3, a facility must meet the following criteria in addition to meeting the criteria for Level 2:

(1) The facility must earn a minimum of 10 points from the categories listed in subrules 118.3(2) through 118.3(6).

(2) The facility must earn at least one point from each category.

d. *Level 4.* To be rated at Level 4, a facility must meet the following criteria in addition to meeting the criteria for Level 2:

(1) The facility must earn a minimum of 18 points from the categories listed in subrules 118.3(2) through 118.3(6).

(2) The facility must earn at least one point from each category.

e. *Level 5.* To be rated at Level 5, a facility must meet the following criteria in addition to meeting the criteria for Level 2:

(1) The facility must earn a minimum of 26 points from the categories listed in subrules 118.13(2) through 118.13(6).

(2) The facility must earn at least one point from each category.

118.3(2) *Professional development.* A child care center or preschool may earn a maximum of 12 points in the professional development category. Points are awarded as follows:

a. *Credential.* Two points are awarded if the facility director:

(1) Has a current national administrator credential; or

(2) Is a school principal licensed by the Iowa board of educational examiners.

b. *Related degree.* One point is awarded if at least one staff member at the facility has at least a bachelor's degree in education specific to the age group for whom the person provides care.

c. *Education and experience.* A facility may earn a maximum of nine points for staff education and experience. Programs may select up to two of the following options:

(1) Five points are awarded if at least 50 percent of staff in each classroom have a minimum of a bachelor's degree in education specific to the age group for whom they provide care.

(2) Four points are awarded if at least 50 percent of staff in each classroom have a minimum of an associate's degree in education specific to the age group for whom they provide care.

(3) Three points are awarded if at least 50 percent of staff in each classroom have a minimum of a child development associate credential or apprenticeship certificate.

(4) Two points are awarded if at least 50 percent of staff in each classroom have a minimum of either six college credit hours in education specific to the age group for whom they provide care or have a paraeducator certificate from the Iowa board of educational examiners.

(5) Two points are awarded if at least 50 percent of staff in each classroom have received a minimum of 30 hours of training beyond regulatory requirements in the last 12 months and have at least five years of experience working in a child care facility or a program operating under the authority of an accredited school district or nonpublic school.

(6) One point is awarded if at least 50 percent of staff in each classroom have received a minimum of 15 hours of training beyond regulatory requirements in the last 12 months.

118.3(3) *Health and safety.* A child care center or preschool may earn a maximum of eight points in the health and safety category. Points are awarded as follows:

a. *Injury prevention.* A facility may earn a maximum of three points for injury prevention. Points are awarded as follows:

(1) One point is awarded if the facility completes the Iowa department of public health's Form HCCI-IP2006, Injury Prevention Summary Report, during a visit with a child care nurse consultant.

(2) Two points are awarded if the child care nurse consultant verifies that the facility has started the process of making recommended corrections.

(3) Three points are awarded if the child care nurse consultant verifies that the facility has completed all corrections.

b. *Child record review.* A facility may earn a maximum of two points for child record review. Points are awarded as follows:

(1) One point is awarded if the facility completes the Iowa department of public health's Form HCCI-CRR2006, Child Record Review, during a visit with a child care nurse consultant.

(2) Two points are awarded if the child care nurse consultant verifies that the facility has worked with the child care nurse consultant to refer families to health care providers.

c. *Health and safety assessment.* A facility may earn a maximum of three points for health and safety assessment. Points are awarded as follows:

(1) One point is awarded if the facility completes the Iowa department of public health's Form HCCI-HSA2006, Health and Safety Assessment, during a visit with the child care nurse consultant.

(2) Two points are awarded if the child care nurse consultant verifies that the facility has developed a plan of action to correct deficiencies.

(3) Three points are awarded if the child care nurse consultant verifies that the facility has completed all corrections.

118.3(4) *Environment.* A child care center or preschool may earn a maximum of 11 points in the environment category. Points are awarded as follows:

a. *Environment rating scale training and self-assessment.*

(1) One point is awarded if the facility director or assistant director completes approved training on using the infant/toddler environment rating scale, the early childhood environment rating scale, or the school-age care environment rating scale to evaluate and improve the facility before outside evaluation.

(2) One point is awarded if, after completing training on how to use the infant/toddler environment rating scale, the early childhood environment rating scale, or the school-age care environment rating scale, the facility director or assistant director completes a self-assessment of at least one-third of the facility's classrooms, including at least one classroom in each age group served by the facility using the appropriate environment rating scale.

(3) One point is awarded if, after completing training on how to use the infant/toddler environment rating scale, the early childhood environment rating scale, or the school-age care environment rating scale, the facility director or assistant director completes Form 470-4288, Child Care Center Improvement Plan, based on the environment rating scale self-assessment. Form 470-4288 must be completed for each room for which a self-assessment was completed.

b. *Environment rating scale.* A facility may earn a maximum of three points on the environment rating scale. The facility director or assistant director must complete training on the use of one of the environment rating scales before requesting assessment. An assessor approved by the department of human services or the department's designee must perform the environment rating assessment. At least one-third of the facility's classrooms must be assessed, including at least one classroom in each age group served by the facility. Points are awarded as follows:

(1) One point is awarded if the facility receives an average score of 3 on a scale of 7 (with no subscale scores lower than 2) on the infant/toddler environment rating scale, the early childhood environment rating scale, or the school-age care environment rating scale.

(2) Two points are awarded if the facility receives an average score of 4 on a scale of 7 (with no subscale scores lower than 2) on the infant/toddler environment rating scale, the early childhood environment rating scale, or the school-age care environment rating scale.

(3) Three points are awarded if the facility receives an average score of 5 on a scale of 7 (with no subscale scores lower than 2) on the infant/toddler environment rating scale, the early childhood environment rating scale, or the school-age care environment rating scale.

c. *Iowa quality preschool program standards.* A facility may earn a maximum of two points on the Iowa quality preschool program standards. Points are awarded as follows:

(1) One point is awarded if the facility completes training on Iowa quality preschool program standards.

(2) One point is awarded if the facility completes the Iowa quality preschool program standards self-assessment and develops a quality improvement plan.

d. *Accreditation.* A facility may earn a maximum of three points for accreditation. Points are awarded as follows:

(1) One point is awarded if the facility meets accreditation standards for group or class size from an accrediting body identified in subparagraph (2) that is appropriate to the child care setting.

(2) Three points are awarded if the facility is accredited by the National Association for the Education of Young Children, the National Afterschool Association, or another accrediting body approved by the department of human services or if a Head Start program demonstrates compliance with Head Start program performance standards.

118.3(5) *Family and community partnerships.* A child care center or preschool may earn a maximum of two points in the family and community partnerships category. Points are awarded as follows:

a. One point is awarded if the facility or the facility director is a member of a professional organization specific to the age group for whom care is provided.

b. One point is awarded if the facility provides orientation for new parents and holds annual conferences with parents.

118.3(6) *Leadership and administration.* A child care center or preschool may earn a maximum of four points in the leadership and administration category. Points are awarded as follows:

a. One point is awarded if the facility completes yearly written evaluations for all staff.

b. One point is awarded if the facility develops and updates Form 470-4235, Child Care Center Improvement Plan, annually.

c. One point is awarded if all staff complete Form 470-4236, Professional Development Plan.

d. One point is awarded if all staff who have direct contact with children have a full, facility-based orientation within four months of beginning employment with the facility.

[**ARC 9257B**, IAB 12/1/10, effective 2/1/11]

441—118.4(237A) Rating criteria for child development homes (sunsetting on July 31, 2011). For applications submitted under subrule 118.2(1), to participate in the quality rating system, a child development home provider shall certify that the home meets the applicable criteria as defined in subrule 118.4(1).

118.4(1) *Criteria for each rating level.*

a. To be rated at Level 1, the home must be a registered child development home.

b. To be rated at Level 2, the home must meet the following criteria in addition to meeting the criterion for Level 1:

(1) The provider completes and maintains ChildNet certification.

(2) The provider participates in the child and adult care food program (CACFP).

(3) The provider completes the Iowa department of public health's Form HCCI-BPA2006, Child Care Business—Partnership Agreement.

(4) The provider completes the Iowa department of public health's provider health and safety questionnaire, Form HCCI-HDOS2006, Home Child Care Center Director/Owner Survey.

(5) The provider completes Form 470-4231, Child Development Home Professional Development Self-Assessment.

(6) The provider completes Form 470-4236, Professional Development Plan.

c. To be rated at Level 3, the home must meet the following criteria in addition to meeting the criteria for Levels 1 and 2:

(1) The home must earn a minimum of seven points from the categories listed in subrules 118.4(2) through 118.4(5).

(2) The home must earn at least one point from each category.

d. To be rated at Level 4, the home must meet the following criteria in addition to meeting the criteria for Levels 1 and 2:

(1) The home must earn a minimum of 12 points from the categories listed in subrules 118.4(2) through 118.4(5).

(2) The home must earn at least one point from each category.

e. To be rated at Level 5, the home must meet the following criteria in addition to meeting the criteria for Levels 1 and 2:

(1) The home must earn a minimum of 16 points from the categories listed in subrules 118.4(2) through 118.4(5).

(2) The home must earn at least one point from each category.

118.4(2) *Professional development.* A child development home may earn a maximum of six points in the professional development category. Points are awarded as follows:

a. *Experience and training.* A home may earn a maximum of two points for experience and training. Points are awarded as follows:

(1) One point is awarded if the provider has at least two years of experience working in a child care facility or a program operating under the authority of an accredited school district or nonpublic school and 10 hours of additional training per year beyond regulatory requirements.

(2) Two points are awarded if the provider has at least five years of experience working in a child care facility or a program operating under the authority of an accredited school district or nonpublic school and 20 hours of additional training per year beyond regulatory requirements.

b. *Education.* A home may earn a maximum of four points for education. Points are awarded as follows:

(1) Two points are awarded if the provider has completed an apprenticeship certificate, child development associate credential, or at least nine college credit hours in education specific to the age group for whom care is provided.

(2) Three points are awarded if the provider has completed an associate's degree in education specific to the age group for whom care is provided.

(3) Four points are awarded if the provider has completed a bachelor's degree or higher in education specific to the age group for whom care is provided.

118.4(3) *Health and safety.* A child development home may earn a maximum of eight points in the health and safety category. Points are awarded as follows:

a. *Injury prevention.* A home may earn a maximum of three points for injury prevention. Points are awarded as follows:

(1) One point is awarded if the provider completes the Iowa department of public health's Form HCCI-IP2006, Injury Prevention Summary Report, during a visit with a child care nurse consultant.

(2) Two points are awarded if the child care nurse consultant verifies that the provider has started the process of making recommended corrections.

(3) Three points are awarded if the child care nurse consultant verifies that the provider has completed all corrections.

b. *Child record review.* A home may earn a maximum of two points for child record review. Points are awarded as follows:

(1) One point is awarded if the provider completes the Iowa department of public health's Form HCCI-CRR2006, Child Record Review, during a visit with a child care nurse consultant.

(2) Two points are awarded if the child care nurse consultant verifies that the provider has worked with the child care nurse consultant to refer families to health care providers.

c. *Health and safety assessment.* A home may earn a maximum of three points in the health and safety assessment category. Points are awarded as follows:

(1) One point is awarded if the provider completes the Iowa department of public health's Form HCCI-HSA2006, Health and Safety Assessment, during a visit with the child care nurse consultant.

(2) Two points are awarded if the child care nurse consultant verifies that the provider has developed a plan of action to correct deficiencies.

(3) Three points are awarded if the child care nurse consultant verifies that the provider has completed all corrections.

118.4(4) *Environment.* A child development home may earn a maximum of eight points in the environment category. Points are awarded as follows:

a. *Environment rating scale training and self-assessment.* A home may earn a maximum of three points for environment rating scale training and self-assessment. Points are awarded as follows:

(1) One point is awarded if the provider completes approved training on how to use the family day care rating scale to assess the child development home environment.

(2) One point is awarded if, after completing training on how to use the family day care rating scale, the provider completes a self-assessment using the family day care rating scale.

(3) One point is awarded if, after completing training on how to use the family day care rating scale, the provider completes Form 470-4232, Child Development Home Improvement Plan, based on the family day care rating scale self-assessment.

b. *Environment rating scale.* A home may earn a maximum of two points on the environment rating scale. An assessor approved by the department of human services or the department's designee must perform the environment rating assessment. The provider must complete training on the family day care rating scale before requesting assessment. Points are awarded as follows:

(1) One point is awarded if the home receives an average score of 4 on a scale of 7, with no subscale scores lower than 2.

(2) Two points are awarded if the home receives an average score of 5 on a scale of 7, with no subscale scores lower than 2.

c. *Accreditation.* Three points are awarded if the home is accredited by the National Association for Family Child Care or another accrediting body approved by the department of human services.

118.4(5) *Family and community partnerships.* A child development home may earn a maximum of two points in the family and community partnerships category. Points are awarded as follows:

a. One point is awarded if the provider is a member of a professional organization specific to the age group for whom care is provided.

b. One point is awarded if the provider offers an orientation for new parents and holds annual conferences with parents.

[**ARC 9257B**, IAB 12/1/10, effective 2/1/11]

441—118.5(237A) Rating standards for child care centers, preschools, and programs operating under the authority of an accredited school district or nonpublic school. To participate in the quality rating system, a child care center, preschool, or program operating under the authority of an accredited school district or nonpublic school applying under subrule 118.2(2) shall certify that its facility meets the applicable criteria as defined in subrule 118.5(1).

118.5(1) *Criteria.* Criteria for each rating level are defined as follows:

a. *Level 1.* To be rated at Level 1, a facility must either:

(1) Have a full or provisional license from the department with no action pending to revoke or deny the license; or

(2) Operate under the authority of an accredited school district or nonpublic school.

b. *Level 2.* To be rated at Level 2, a facility must meet the following criteria:

(1) The facility must have a full license from the department with no action pending to revoke or deny the license or must operate under the authority of an accredited school district or nonpublic school.

(2) If eligible, the facility must participate in the child and adult care food program (CACFP), unless children are in attendance less than four hours per day and the program does not serve meals.

(3) The facility must have on duty in each room at all times at least one staff member who has completed training in mandatory reporting of child abuse, universal precautions and infectious disease control, cardiopulmonary resuscitation, and first aid as specified in 441—subrule 109.7(1) and subparagraphs 109.7(2)*"a"*(1) and (2).

(4) The facility must provide basic orientation for all staff before they begin work.

(5) All staff, including the facility's director, must complete Form 470-4234, Child Care Center Staff Self-Assessment, no more than 12 months before application for quality rating. The director must also complete Form 470-4233, Child Care Center Self-Assessment.

c. *Level 3.* To be rated at Level 3, a facility must meet the following criteria in addition to meeting the criteria for Level 2:

(1) The facility must earn a minimum of 17 points from the categories listed in subrules 118.5(2) through 118.5(6).

(2) The facility must earn at least one point from each category.

d. *Level 4.* To be rated at Level 4, a facility must meet the following criteria in addition to meeting the criteria for Level 2:

(1) The facility must earn a minimum of 27 points from the categories listed in subrules 118.5(2) through 118.5(6).

(2) The facility must earn at least one point from each category.

e. *Level 5.* To be rated at Level 5, a facility must meet the following criteria in addition to meeting the criteria for Level 2:

(1) The facility must earn a minimum of 34 points from the categories listed in subrules 118.5(2) through 118.5(6).

(2) The facility must earn at least one point from each category.

(3) The facility must earn a minimum score of 5.0 in each assessed classroom on the appropriate environment rating scale. An assessor approved by the department or the department's designee must perform the environment rating assessment. At least one-third of the facility's classrooms must be assessed, including at least one classroom in each age group served by the facility.

118.5(2) *Professional development.* A maximum of 30 points may be earned in the professional development category. Points are awarded as follows:

a. *Credential.* A maximum of five points may be earned in the credential category.

(1) Five points are awarded if the facility director has a current national administrator credential or Aim4Excellence credential.

(2) Five points are awarded if the facility director is a school principal licensed by the Iowa board of educational examiners.

(3) Five points are awarded if a staff member has completed the two-year Head Start management acceleration program covering all aspects of Head Start management, services and systems.

b. *Education and experience.* A maximum of 25 points may be earned for education and experience. To arrive at the total number of points earned, each staff member shall indicate the highest applicable education and experience qualification. Points will be assigned for each staff member based on the following criteria, and the total points will be divided by the number of staff. Only one criterion may be scored for each staff member.

(1) Has a master's degree in education appropriate to the age group for whom care is provided: 25 points.

(2) Has a bachelor's degree in education appropriate to the age group for whom care is provided: 20 points.

(3) Has an associate's degree in education appropriate to the age group for whom care is provided: 10 points.

(4) Has a one-year diploma in education appropriate to the age group for whom care is provided: 8 points.

(5) Has an apprenticeship certificate: 7 points.

(6) Has a child development associate credential: 6 points.

(7) Has an Iowa board of educational examiners paraeducator certificate at Level 2, early childhood, plus two years of experience in early childhood education under the supervision of a licensed early childhood teacher: 6 points.

(8) Has nine college credit hours in education specific to the age group for whom care is provided: 5 points.

(9) Has 30 hours of annual approved training beyond regulatory requirements and at least five years of experience working in a child care facility or a program operating under the authority of an accredited school district or nonpublic school: 4 points.

(10) Has 15 hours of annual approved training beyond regulatory requirements: 2 points.

118.5(3) *Health and safety.* A maximum of 19 points may be earned in the health and safety category. Points are awarded as follows:

a. Five points are awarded if within the five-year period before the application date the center director, assistant director, or on-site supervisor has successfully completed a three-semester-hour health, safety, and nutrition class through an approved community college or four-year college.

b. Two points are awarded if within the two-year period before the application date the center director, assistant director, or on-site supervisor has successfully completed a health and safety training approved by the department for the specific purpose of awarding points in the quality rating system.

c. Two points are awarded if the provider develops and implements an emergency preparedness plan in a format prescribed by the department.

d. Two points are awarded if the provider develops and implements enhanced health and safety policies in a format prescribed by the department.

e. Up to three points may be awarded for injury prevention.

(1) One point is awarded if the facility completes the Iowa department of public health's Form HCCI-IP2006, Injury Prevention Summary Report, during a visit with a child care nurse consultant.

(2) Two points are awarded if the child care nurse consultant verifies that the facility has started the process of making recommended corrections.

(3) Three points are awarded if the child care nurse consultant verifies that the facility has completed all corrections.

f. Up to two points may be awarded for child record review.

(1) One point is awarded if the facility completes the Iowa department of public health's Form HCCI-CRR2006, Child Record Review, during a visit with a child care nurse consultant.

(2) Two points are awarded if the child care nurse consultant verifies that the facility has worked with the child care nurse consultant to refer families to health care providers.

g. Up to three points may be awarded for health and safety assessment.

(1) One point is awarded if the facility completes the Iowa department of public health's Form HCCI-HSA2006, Health and Safety Assessment, during a visit with the child care nurse consultant.

(2) Two points are awarded if the child care nurse consultant verifies that the facility has developed a plan of action to correct deficiencies.

(3) Three points are awarded if the child care nurse consultant verifies that the facility has completed all corrections.

118.5(4) *Environment.* A maximum of 27 points may be earned in the environment category. Points are awarded as follows:

a. *Training and self-assessment.* A maximum of nine points may be earned in training and self-assessment.

(1) Two points are awarded if the facility director or assistant director completes approved training on the use of the infant/toddler environment rating scale, the early childhood environment rating scale, or the school-age care environment rating scale to evaluate and improve the facility before outside evaluation.

(2) Two points are awarded if, after completing approved training on how to use the environment rating scale, the facility director or assistant director completes a self-assessment and score sheet of at least one-third of the facility's classrooms, including at least one classroom in each age group served by the facility using the applicable environment rating scale.

(3) Two points are awarded if, after completing approved training on how to use the environment rating scale, the facility director or assistant director completes Form 470-4288, Child Care Center Improvement Plan, based on the environment rating scale self-assessment. Form 470-4288 must be completed for each room for which a self-assessment was completed.

(4) Three points are awarded if, after completing approved training on Iowa quality preschool program standards, the facility director or assistant director completes the Iowa quality preschool program standards self-assessment and develops a quality improvement plan.

b. *Enhanced ratios.* A facility may earn a maximum of three points for enhanced staff-to-child ratios. Three points are awarded if the facility meets accreditation standards for group or class size and staff-to-child ratio from an accrediting body identified at subparagraph 118.5(4)*"d"*(3) that is appropriate to the child care setting. These points may not be awarded to programs receiving points under subparagraph 118.5(4)*"d"*(3).

c. *Accreditation preparation.* A facility may earn a maximum of five points for accreditation preparation. Five points are awarded if the facility's accreditation self-assessment is approved by the National Association for the Education of Young Children. These points may not be awarded to programs receiving points under subparagraph 118.5(4)*"d"*(3).

d. *Accreditation.* A facility may earn a maximum of 18 points for accreditation. Points are awarded for one of the following criteria:

(1) Five points are awarded if the program is verified by the Iowa quality preschool program standards.

(2) Six points are awarded if a Head Start program demonstrates compliance with Head Start program performance standards.

(3) Eighteen points are awarded if the facility is accredited by the National Association for the Education of Young Children, the National Afterschool Association, or another accrediting body approved by the department.

118.5(5) *Family and community partnerships.* A maximum of eight points may be earned in the family and community partnership category. Points are awarded as follows:

a. One point is awarded if the facility or the facility director is a member of a professional organization specific to the age group for whom care is provided.

b. One point is awarded if the facility provides orientation for new parents.

c. One point is awarded if the facility holds annual conferences with parents.

d. One point is awarded if the facility holds at least one parent meeting annually.

e. Two points are awarded if a parent advisory board coordinated by the facility meets quarterly.

f. Two points are awarded if the facility collects annual parent surveys and uses the results to inform program practices.

118.5(6) *Leadership and administration.* A maximum of seven points may be earned in the leadership and administration category. Points are awarded as follows:

a. Two points are awarded if the facility completes yearly written evaluations for all staff.

b. One point is awarded if the facility develops an improvement plan using Form 470-4235, Child Care Center Improvement Plan, and updates the form annually.

c. One point is awarded if all staff complete Form 470-4236, Professional Development Plan.

d. Three points are awarded if all staff who have direct contact with children complete one of the following within four months of beginning employment with the facility:

(1) The new staff orientation training delivered by Iowa state university that provides new center and preschool staff a full, program-based orientation, or

(2) Another curriculum approved by the department.

[**ARC 9257B**, IAB 12/1/10, effective 2/1/11]

441—118.6(237A) Rating criteria for child development homes. To participate in the quality rating system, a child development home provider applying under subrule 118.2(2) shall certify that the home meets the applicable criteria as defined in subrule 118.6(1).

118.6(1) *Criteria for each rating level.*

a. *Level 1.* To be rated at Level 1, the home must be a registered child development home.

b. *Level 2.* To be rated at Level 2, the home must meet the following criteria in addition to meeting the criterion for Level 1:

(1) The provider completes and maintains ChildNet certification.

(2) The provider participates in the child and adult care food program (CACFP).

(3) The provider completes Form 470-4231, Child Development Home Professional Development Self-Assessment.

(4) The provider completes Form 470-4236, Professional Development Plan.

c. *Level 3.* To be rated at Level 3, the home must meet the following criteria in addition to meeting the criteria for Levels 1 and 2:

(1) The home must earn a minimum of 14 points from the categories listed in subrules 118.6(2) through 118.6(5).

(2) The home must earn at least one point from each category.

d. *Level 4.* To be rated at Level 4, the home must meet the following criteria in addition to meeting the criteria for Levels 1 and 2:

(1) The home must earn a minimum of 19 points from the categories listed in subrules 118.6(2) through 118.6(5).

(2) The home must earn at least one point from each category.

e. *Level 5.* To be rated at Level 5, the home must meet the following criteria in addition to meeting the criteria for Levels 1 and 2:

(1) The home must earn a minimum of 25 points from the categories listed in subrules 118.6(2) through 118.6(5).

(2) The home must earn at least one point from each category.

(3) The home must earn a minimum score of 5.0 on the family child care environment rating scale. An assessor approved by the department or the department's designee must perform the assessment.

118.6(2) *Professional development.* A child development home may earn a maximum of 34 points in the professional development category. For child development homes registered as Category C, points will be awarded only to the coprovider who has earned the most points. Points are awarded as follows:

a. *Experience and training.* A home may earn a maximum of four points for experience and training. Points are awarded as follows:

(1) Two points are awarded if the provider has at least two years of experience working in a child care facility or a program operating under the authority of an accredited school district or nonpublic school and 10 hours of additional training per year beyond regulatory requirements.

(2) Four points are awarded if the provider has at least five years of experience working in a child care facility or a program operating under the authority of an accredited school district or nonpublic school and 20 hours of additional training per year beyond regulatory requirements.

b. *Additional professional development.* A home may earn a maximum of five points for additional professional development. Points are awarded as follows:

(1) Two points are awarded if the provider successfully completes approved modules 1 and 2 of positive behavior and intervention support training developed by the Center on Social and Emotional Foundations for Learning (CSEFEL). Modules 1 and 2 total a minimum of 12 hours of training which focuses on promoting effective classroom and center practices that enhance the social and emotional competency of young children.

(2) Three points are awarded if the provider successfully completes modules 1 through 4 of the program for infant and toddler care developed by WestEd and the California Department of Education, covering social-emotional growth and socialization, group care, learning and development, culture, and family and providers.

c. *Education.* A home may earn a maximum of 25 points for education. Points are awarded for one of the following criteria:

(1) Twenty-five points are awarded if the provider has completed a master's degree in education appropriate to the age group for whom care is provided.

(2) Twenty points are awarded if the provider has completed a bachelor's degree in education appropriate to the age group for whom care is provided.

(3) Ten points are awarded if the provider has completed an associate's degree in education appropriate to the age group for whom care is provided.

(4) Eight points are awarded if the provider has completed a one-year diploma in education appropriate to the age group for whom care is provided.

(5) Seven points are awarded if the provider has a current apprenticeship certificate.

(6) Six points are awarded if the provider has a current child development associate credential.

(7) Five points are awarded if the provider has completed at least nine college credit hours in education specific to the age group for whom care is provided.

118.6(3) *Health and safety.* A child development home may earn a maximum of 19 points in the health and safety category. Points are awarded as follows:

a. Five points are awarded if within the five-year period before the application date the provider successfully completes a three-semester-hour health, safety, and nutrition class through an approved community college or four-year college.

b. Two points are awarded if within the two-year period before the application date the provider successfully completes a health and safety training approved by the department for the specific purpose of awarding points in the quality rating system.

c. Two points are awarded if the provider develops and implements an emergency preparedness plan in a format prescribed by the department.

d. Two points are awarded if the provider develops and implements enhanced health and safety policies in a format prescribed by the department.

e. Up to three points may be awarded for injury prevention.

(1) One point is awarded if the facility completes the Iowa department of public health's Form HCCI-IP2006, Injury Prevention Summary Report, during a visit with a child care nurse consultant.

(2) Two points are awarded if the child care nurse consultant verifies that the facility has started the process of making recommended corrections.

(3) Three points are awarded if the child care nurse consultant verifies that the facility has completed all corrections.

f. Up to two points may be awarded for child record review.

(1) One point is awarded if the facility completes the Iowa department of public health's Form HCCI-CRR2006, Child Record Review, during a visit with a child care nurse consultant.

(2) Two points are awarded if the child care nurse consultant verifies that the facility has worked with the child care nurse consultant to refer families to health care providers.

g. Up to three points may be awarded for health and safety assessment.

(1) One point is awarded if the facility completes the Iowa department of public health's Form HCCI-HSA2006, Health and Safety Assessment, during a visit with the child care nurse consultant.

(2) Two points are awarded if the child care nurse consultant verifies that the facility has developed a plan of action to correct deficiencies.

(3) Three points are awarded if the child care nurse consultant verifies that the facility has completed all corrections.

118.6(4) *Environment.* A child development home may earn a maximum of 23 points in the environment category. Points are awarded as follows:

a. *Environment rating scale training and self-assessment.* A home may earn a maximum of six points for environment rating scale training and self-assessment. Points are awarded as follows:

(1) Two points are awarded if the provider completes approved training on how to use the family child care environment rating scale to assess the child development home environment.

(2) Two points are awarded if, after completing training on how to use the environment rating scale, the provider completes a self-assessment and score sheet using the environment rating scale.

(3) Two points are awarded if, after completing training on how to use the environment rating scale and completion of the environment rating scale self-assessment and score sheet, the provider completes Form 470-4232, Child Development Home Improvement Plan, based on the environment rating scale self-assessment.

b. *Enhanced ratios.* A home may earn a maximum of two points for enhanced staff-to-child ratios. Two points are awarded if no more than two children under the age of two are in care at any one time

and no more than six children total are in care at any one time, including the provider's own children under school age.

c. *Accreditation.* A home may earn a maximum of 15 points for accreditation. Fifteen points are awarded if the home is accredited by the National Association for Family Child Care or another accrediting body approved by the department.

118.6(5) *Family and community partnerships.* A child development home may earn a maximum of six points in the family and community partnership category. Points are awarded as follows:

a. One point is awarded if the provider is a member of a professional organization specific to the age group for whom care is provided.

b. One point is awarded if the provider offers an orientation for new parents.

c. One point is awarded if the provider holds annual conferences with parents.

d. One point is awarded if the provider holds at least one parent meeting annually.

e. Two points are awarded if the provider collects annual parent surveys and uses the results to inform program practices.

[**ARC 9257B**, IAB 12/1/10, effective 2/1/11]

441—118.7(237A) Award of quality rating.

118.7(1) The facility shall display Form 470-4230, Quality Rating Certificate, in a conspicuous place.

118.7(2) Achievement bonuses may be awarded as funds are available.

118.7(3) Participants may request another quality rating for the purpose of increasing their rating no sooner than 12 months after issuance of a quality rating certificate.

118.7(4) Ratings are effective for 24 months from the date of issuance.

[**ARC 9257B**, IAB 12/1/10, effective 2/1/11]

441—118.8(237A) Adverse actions.

118.8(1) An eligible applicant must be notified of the right to appeal the rating decision in accordance with 441—Chapter 7.

118.8(2) A participant's quality rating shall be revoked if the facility no longer meets the definition of "eligible applicants."

118.8(3) Form 470-4230, Quality Rating Certificate, shall be returned to the department of human services if:

a. The certificate is revoked;

b. The certificate is not renewed; or

c. The provider voluntarily withdraws from the program.

118.8(4) Ratings are effective for 24 months from the date of issuance.

[**ARC 9257B**, IAB 12/1/10, effective 2/1/11]

These rules are intended to implement Iowa Code section 237A.30.

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CHAPTER 176
DEPENDENT ADULT ABUSE

[Prior to 7/1/83, Social Services[770] Ch 156]
[Previously appeared as Ch 156—renumbered IAB 2/29/84]
[Prior to 2/11/87, Human Services[498]]

441—176.1(235B) Definitions.

"Adult abuse" means either:

1. Any of the following as a result of the willful or negligent acts or omissions of a caretaker:

- Physical injury to, or injury which is at variance with the history given of the injury, or unreasonable confinement, unreasonable punishment, or assault of a dependent adult.
- The commission of a sexual offense under Iowa Code chapter 709 or Iowa Code section 726.2 with or against a dependent adult.
- Exploitation of a dependent adult, which means the act or process of taking unfair advantage of a dependent adult or the adult's physical or financial resources for one's own personal or pecuniary profit, without the informed consent of the dependent adult, including theft, by the use of undue influence, harassment, duress, deception, false representation, or false pretenses.
- The deprivation of the minimum food, shelter, clothing, supervision, physical or mental health care, and other care necessary to maintain a dependent adult's life or health.
- Sexual exploitation of a dependent adult by a caretaker. "Sexual exploitation" means any consensual or nonconsensual sexual contact with a dependent adult which includes but is not limited to kissing; touching of the clothed or unclothed inner thigh, breast, groin, buttock, anus, pubes, or genitals; or a sex act, as defined in Iowa Code section 702.17. "Sexual exploitation" includes the transmission, display, taking of electronic images of the unclothed breast, groin, buttock, anus, pubes, or genitals of a dependent adult by a caretaker for a purpose not related to treatment or diagnosis or as part of an ongoing assessment, evaluation or investigation. "Sexual exploitation" does not include touching which is part of a necessary examination, treatment, or care by a caretaker acting within the scope of the practice or employment of the caretaker; the exchange of a brief touch between the dependent adult and a caretaker for the purpose of reassurance, comfort, or casual friendship; or touching between spouses.

2. The deprivation of the minimum food, shelter, clothing, supervision, physical or mental health care, and other care necessary to maintain a dependent adult's life or health as a result of the acts or omissions of the dependent adult.

"Appropriate evaluation or assessment" means that evaluation or assessment reasonably believed by the department to be warranted by the facts and circumstances of the case as reported.

"Assault" means "assault" as defined in Iowa Code section 708.1.

"At-risk adult" means an adult who, because of a significant impairment due to a physical or mental disability or both, is unable to meet essential daily needs without assistance and whose personal health or safety is at risk due to such impairments, the environment, substance abuse problems, a lack of services or social supports, a refusal to accept services, or other risk factors identified through an assessment.

"Caretaker" means a related or nonrelated person who has the responsibility for the protection, care, or custody of a dependent adult as a result of assuming the responsibility voluntarily, by contract, through employment, or by order of the court.

"Collateral sources" means any person or agency who is presently providing, either in a professional or paraprofessional capacity, service to the dependent adult, including, but not limited to, doctors, counselors, and public health nurses.

"Confidentiality" means the withholding of information from any manner of communication, public or private.

"Denial of critical care" exists when the dependent adult's basic needs are denied or ignored to such an extent that there is immediate or potential danger of the dependent adult suffering injury or death, or is a denial of, or a failure to provide the mental health care necessary to adequately treat the dependent adult's serious social maladjustment, or is a gross failure of the caretaker to meet the emotional needs of the dependent adult necessary for normal functioning, or is a failure of the caretaker to provide for the proper supervision of the dependent adult.

"Department" means the department of human services and includes the county and central offices of the department, unless otherwise specified.

"Dependent adult" means a person 18 years of age or older who is unable to protect the person's own interests or unable to adequately perform or obtain services necessary to meet essential human needs, as a result of a physical or mental condition which requires assistance from another.

"Expungement" means the process of destroying dependent adult abuse information.

"Immediate danger to health or safety" means a situation in which death or severe bodily injury could reasonably be expected to occur without intervention.

"Immediately" means within 24 hours when referring to mandatory reporters reporting suspected abuse of a dependent adult.

"Individual employed as an outreach person" means a person who, in the course of employment, makes regular contacts with dependent adults regarding available community resources.

"Informed consent" (as used in Iowa Code paragraph 235B.2(5)*"c"*) means a dependent adult's agreement to allow something to happen that is based on a full disclosure of known facts and circumstances needed to make the decision intelligently, i.e., knowledge of risks involved or alternatives.

"Minimum food, shelter, clothing, supervision, physical and mental health care, and other care" means that food, shelter, clothing, supervision, physical and mental health care, and other care which, if not provided, would constitute denial of critical care.

"Multidisciplinary team" shall mean a membership of individuals who possess knowledge and skills related to the diagnosis, assessment, and disposition of dependent adult abuse cases and who are professionals practicing in the disciplines of medicine, public health, social work, law, law enforcement and other disciplines relative to dependent adults. Members of the team shall include, but are not limited to, persons representing the area agencies on aging, county attorneys, health care providers, and others involved in advocating or providing services for dependent adults.

"Physical injury" means damage to any bodily tissue to the extent that the tissue must undergo a healing process in order to be restored to a sound and healthy condition, or damage to any bodily tissue to the extent that the tissue cannot be restored to a sound and healthy condition, or damage to any bodily tissue which results in the death of the person who has sustained the damage, or physical injury which is at variance with the history given of it.

"Preponderance of evidence" shall mean evidence which is of greater weight or more convincing than the evidence which is offered in opposition to it.

"Proper supervision" means that supervision which a reasonable and prudent person would exercise under similar facts and circumstances, but in no event shall a person place a dependent adult in a situation that may endanger the dependent adult's life or health or cruelly punish or unreasonably confine the dependent adult.

"Registry" means the central registry for dependent adult abuse information established in Iowa Code Supplement section 235B.5.

"Report" means a verbal or written statement, made to the department, which alleges that dependent adult abuse has occurred.

[**ARC 8099B**, IAB 9/9/09, effective 8/13/09; **ARC 9258B**, IAB 12/1/10, effective 2/1/11]

441—176.2(235B) Denial of critical care. The failure on the part of the caretaker or dependent adult to provide for minimum food, shelter, clothing, supervision, physical or mental care, and other care necessary for the dependent adult's health and welfare when financially able to do so or when offered financial and other reasonable means to do so shall constitute denial of critical care to that dependent adult.

441—176.3(235B) Appropriate evaluation. Immediately upon receipt of a dependent adult abuse report the worker shall conduct an intake sufficient to determine whether the allegation constitutes a report of dependent adult abuse.

176.3(1) Dependent adult abuse reports shall be evaluated when all of the following criteria are alleged to be met:

a. The person is a dependent adult.

b. Dependent adult abuse exists as defined in Iowa Code section 235B.2.

c. A caretaker exists in reports of physical injury to or unreasonable confinement or cruel punishment of a dependent adult; commission of a sexual offense; exploitation; and deprivation by another person of food, shelter, clothing, supervision, physical and mental health care and other care necessary to maintain life or health.

176.3(2) Nondependent adult abuse situations. The following are not dependent adult abuse situations:

a. A report of domestic abuse under Iowa Code chapter 236, Domestic Abuse, does not in and of itself constitute a report of dependent adult abuse.

b. Circumstances in which the dependent adult declines medical treatment if the dependent adult holds a belief or is an adherent of a religion whose tenets and practices call for reliance on spiritual means in place of reliance on medical treatment.

c. Circumstances in which the dependent adult's caretaker, acting in accordance with the dependent adult's stated or implied consent, declines medical treatment if the dependent adult holds a belief or is an adherent of a religion whose tenets and practices call for reliance on spiritual means in place of reliance on medical treatment.

d. Withholding and withdrawing of health care from a dependent adult who is terminally ill in the opinion of a licensed physician when the withholding and withdrawing of health care is done at the request of the dependent adult or at the request of the dependent adult's next-of-kin or guardian pursuant to the applicable procedures under Iowa Code chapter 125, 144A, 222, 229, or 633.

e. All persons legally incarcerated in a penal setting, either in a local jail or confined to the custody of the director of the department of corrections.

176.3(3) Reports of dependent adult abuse which are the result of the acts or omissions of the dependent adult shall be collected and maintained in the files of the dependent adult as assessments only and shall not be included on the central registry. The central registry shall be notified as to the disposition of the assessment.

176.3(4) Confirmed, not registered. Reports of physical abuse or denial of critical care by a caretaker that would otherwise be founded reports shall be considered confirmed, not registered reports if the abuse is determined to be minor, isolated, and unlikely to reoccur. These reports shall be assessments and shall not be included on the central abuse registry. The assessment shall be maintained in the local office as directed in subrule 176.13(4).

441—176.4(235B) Reporters. The central registry and county office shall accept reports from mandatory reporters or any other person who believes dependent adult abuse has occurred.

176.4(1) Mandatory reporters shall:

a. Report suspected abuse of a dependent adult within 24 hours of becoming aware of an abusive incident.

b. Make a written report within 48 hours after an oral report.

176.4(2) The reporter may use the department's Form 470-2441, Suspected Dependent Adult Abuse Report, or may use a form developed by the reporter that meets the requirements of Iowa Code section 235B.3.

441—176.5(235B) Reporting procedure.

176.5(1) Each report made by someone other than a mandatory reporter may be oral or written.

176.5(2) The report shall be made by telephone or otherwise to the department of human services. When the person making the report has reason to believe that immediate protection for the dependent adult is advisable, that person shall also make an oral report to an appropriate law enforcement agency.

176.5(3) The department of human services shall:

a. Immediately, upon receipt of a report, make an oral report to the registry;

b. Forward a copy of the report to the registry; and

c. Promptly notify the appropriate county attorney of the receipt of any report.

176.5(4) The report shall contain the following information, or as much thereof as the person making the report is able to furnish:

a. The names and home addresses of the dependent adult, appropriate relatives, caretakers, and other persons believed to be responsible for the care of the dependent adult.

b. The dependent adult's present whereabouts if not the same as the address given.

c. The reason the adult is believed to be dependent. Dependency is the first criterion to be considered before beginning an evaluation.

d. The dependent adult's age.

e. The nature and extent of the adult abuse, including evidence of previous adult abuse. The existence of alleged adult abuse is the second criterion to be considered before beginning an evaluation.

f. Information concerning the suspected adult abuse of other dependent adults in the same residence.

g. Other information which the person making the report believes might be helpful in establishing the cause of the abuse or the identity of the person or persons responsible for the abuse, or helpful in providing assistance to the dependent adult.

h. The name and address of the person making the report.

176.5(5) A report shall be accepted whether or not it contains all of the information requested in 176.5(4), and may be made to the department, county attorney, or law enforcement agency. When the report is made to any agency other than the department of human services, that agency shall promptly refer the report to the department.

441—176.6(235B) Duties of the department upon receipt of report.

176.6(1) When a report is received, the department shall promptly commence an appropriate evaluation or assessment, except that the department of inspections and appeals is responsible for the evaluation and disposition of a case of adult abuse in a health care facility, including hospitals as defined in Iowa Code section 135B.1 and facilities as defined in Iowa Code section 135C.1. The department shall forward all reports and other information concerning adult abuse in a health care facility to the department of inspections and appeals on the first working day following the submitting of the report. The department of inspections and appeals shall inform the registry of all actions taken or contemplated concerning the evaluation or disposition of a case of adult abuse in a health care facility. The primary purpose of the evaluation or assessment by the department shall be the protection of the dependent adult named in the report.

176.6(2) The evaluation or assessment shall include all of the following:

a. Identification of the nature, extent, and cause of the adult abuse, if any, to the dependent adult named in the report.

b. The identification of the person or persons responsible for the adult abuse.

c. A determination of whether other dependent adults in the same residence have been subjected to adult abuse.

d. A critical examination of the residential environment of the dependent adult named in the report, and the dependent adult's relationship with caretakers and other adults in the same residence.

e. A critical explanation of all other pertinent matters.

176.6(3) The evaluation or assessment, with the consent of the dependent adult or caretaker, when appropriate, may include a visit to the residence of the dependent adult named in the report and an examination of the dependent adult. If permission to enter the residence and to examine the dependent adult is refused, the district court, upon a showing of probable cause that a dependent adult has been abused, may authorize a person, authorized by the department, to make an evaluation or assessment, to enter the residence of, and to examine the dependent adult.

Upon a showing of probable cause that a dependent adult has been financially exploited, a court may authorize a person, also authorized by the department, to gain access to the financial records of the dependent adult.

176.6(4) County attorneys, law enforcement agencies, multidisciplinary teams as defined in Iowa Code section 235B.1, subsection 1, and social services agencies in the state shall cooperate and assist in

the evaluation or assessment upon the request of the department. County attorneys and appropriate law enforcement agencies shall also take any other lawful action necessary or advisable for the protection of the dependent adult.

176.6(5) Completion of evaluation or assessment report. Upon completion of its evaluation or assessment, the department shall complete a report that describes its findings and includes all actions taken or contemplated.

a. The department shall complete its report within 20 working days of the receipt of the abuse allegations, unless the worker's supervisor grants an extension of time for good cause shown. The worker's supervisor may grant an extension for a maximum of 30 working days. No more than three extensions shall be granted.

b. Upon completion of an evaluation, the department shall enter its report into the system on dependent adults (SODA).

c. Upon completion of an assessment when the alleged abuse is the result of the acts or omissions of the dependent adult, the department shall place the report in the case file of the dependent adult and on SODA.

176.6(6) Report to county attorney. The department shall transmit a copy of the report of its evaluation or assessment to the appropriate county attorney. The county attorney shall notify the local office of the department of any actions or contemplated actions with respect to a suspected case of adult abuse.

176.6(7) Based on the evaluation, the department shall complete an assessment of services needed by a dependent adult believed to be the victim of abuse, the dependent adult's family, or a caretaker. The department shall explain that the department does not have independent legal authority to compel the acceptance of protective services. Upon voluntary acceptance of the offer of services, the department shall make referrals or may provide necessary protective services to eligible dependent adults, their family members, and caretakers.

176.6(8) Court action. When, upon completion of the evaluation or assessment or upon referral from the state department of inspections and appeals, the department determines that the best interests of the dependent adult require court action, the department shall initiate action for the appointment of a guardian or conservator, or for admission or commitment to an appropriate institution or facility, pursuant to the applicable procedures under Iowa Code chapter 125, 222, 229, or 633. The department may pursue other remedies provided by law pursuant to the applicable procedures under Iowa Code sections 235B.17, 235B.18, 235B.19, and 235B.20 or any other legal remedy which provides protection to a dependent adult. The appropriate county attorney shall assist the department in the preparation of the necessary papers to initiate the action, and shall appear and represent the department at all district court proceedings.

176.6(9) The department shall assist the district court during all stages of court proceedings involving a suspected case of adult abuse.

176.6(10) In every case involving adult abuse which is substantiated by the department and which results in a judicial proceeding on behalf of the dependent adult, legal counsel shall be appointed by the court to represent the dependent adult in the proceedings. The court may also appoint a guardian ad litem to represent the dependent adult when necessary to protect the dependent adult's best interests. The same attorney may be appointed to serve both as legal counsel and as guardian ad litem. Before legal counsel or a guardian ad litem is appointed pursuant to Iowa Code section 235B.3, subsection 7, paragraph *"c,"* the court shall require the dependent adult and any person legally responsible for the support of the dependent adult to complete under oath a detailed financial statement. If, on the basis of that financial statement, the court deems that the dependent adult or the legally responsible person is able to bear all or a portion of the cost of the legal counsel or guardian ad litem, the court shall so order. In cases where the dependent adult or the legally responsible person is unable to bear the cost of the legal counsel or guardian ad litem, the expense shall be paid by the county.

176.6(11) Notification of licensing authority. Based on information discovered during an evaluation of dependent adult abuse in a program providing care to a dependent adult, the department shall notify

the licensing or accrediting authority for the program, the governing body of the program, and the administrator in charge of the program of any of the following:

a. A violation of program policy noted in the evaluation.

b. An instance in which program policy or lack of program policy may have contributed to the dependent adult abuse.

c. An instance in which general practice in the program appears to differ from the program's policy.

The licensing or accrediting authority, the governing body, and the administrator in charge of the program shall take any lawful action which may be necessary or advisable to protect dependent adults receiving care in the program.

176.6(12) Assessments by other agencies. The department may approve agencies considered capable and appropriate to complete assessments of dependent adults who are suspected of being abused.

a. The department may make a referral to an approved agency to complete an assessment of a dependent adult who is suspected of being abused, in conjunction with a department abuse evaluation or assessment on the dependent adult.

b. The department may use information obtained from the assessment completed by the approved agency in the abuse evaluation or assessment. The department has complete authority in determining the conclusions of the abuse evaluation or assessment.

176.6(13) Referrals to other agencies. During an assessment or evaluation of suspected abuse of a dependent adult, the department shall:

a. Make a referral to the division of labor services of the department of workforce development if an issue is discovered that concerns wages, workplace safety, or labor and employment matters under the jurisdiction of that agency.

b. Make a referral to the civil rights commission if an issue is discovered that involves discrimination under the jurisdiction of that agency.

176.6(14) Assessment of dependency and risk. After the first visit to a dependent adult who is alleged to be abused, the department shall complete an assessment of the adult using Form 470-3246, Dependent Adult Assessment Tool. The department shall assess:

a. The adult's dependency,

b. The risk to the adult's health or safety, and

c. The areas in which the adult is either dependent or independent.

176.6(15) Follow-up for at-risk adults. When it has not been possible or necessary to obtain a court order for services to an at-risk adult, the department shall attempt to persuade the at-risk adult to agree to accept services and to participate in preparing a safety plan. If the adult refuses to sign Form 470-4835, Safety Plan for At-Risk Adult, and to accept services, the department shall provide periodic visits.

a. *Purpose.* The purpose of the visits shall be to:

(1) Assess the adult for increased risk or impairment,

(2) Monitor the adult's situation to determine the feasibility of intervening with protective services, and

(3) Persuade the adult to accept services and to sign Form 470-4835, Safety Plan for At-Risk Adult.

b. *Exemption.* If it has been determined there is a physical threat to the safety of the department employee who is attempting to visit an at-risk adult, the department shall not attempt a periodic visit unless the physical threat to safety has been removed.

c. *Criteria to continue visits.* Periodic visits shall continue if:

(1) The adult's health or safety has deteriorated somewhat but not to the point that a court order is necessary; or

(2) The adult's health or safety has remained the same and there is a possibility the adult may in the future agree to services and to participating in preparing a safety plan.

d. *Criteria to end visits.* Periodic visits shall be terminated when:

(1) The adult agrees to services and services are arranged; or

(2) The adult's health or safety has deteriorated to the point that the department has requested court action pursuant to subrule 176.6(8); or

(3) The adult's health or safety has not changed six months after the initial report of alleged abuse; there appears no possibility the adult will ever agree to services; and the adult is competent to make decisions.

[**ARC 9258B**, IAB 12/1/10, effective 2/1/11]

441—176.7(235B) Appropriate evaluation or assessment.

176.7(1) After receipt of the report alleging dependent adult abuse, the field worker shall make an evaluation or assessment to determine whether the information as reported, other known information, and any information gathered as a result of the worker's contact with collateral sources would tend to corroborate the alleged abuse.

176.7(2) When the information gathered in the evaluation or assessment tends to corroborate, or the worker is uncertain as to whether it repudiates the allegations of the report, the worker shall immediately continue the evaluation or assessment by making a reasonable effort to ensure the safety of the adult. The worker and the worker's supervisor shall determine whether an immediate threat to the physical safety of the adult is believed to exist.

a. If an immediate threat to the physical safety of the adult is believed to exist, the field worker shall make every reasonable effort to examine the adult, as authorized by 176.6(3), within one hour after receipt of the report and shall take any lawful action necessary or advisable for the protection of the adult.

b. When physical safety of the adult is not endangered, the worker shall make every reasonable effort to examine the adult within 24 hours after receipt of the report.

176.7(3) In the event the information gathered in the evaluation or assessment fails to corroborate the allegation of adult abuse, the worker, with approval of the supervisor, may terminate the evaluation or assessment and submit the report required by subrule 176.6(5).

441—176.8(235B) Immunity from liability for reporters. A person participating in good faith in making a report or cooperating or assisting the department in evaluating or assessing a case of dependent adult abuse has immunity from liability, civil or criminal, which might otherwise be incurred or imposed based upon the act of making the report or giving the assistance. The person has the same immunity with respect to participation in good faith in a judicial proceeding resulting from the report or assistance or relating to the subject matter of the report or assistance.

441—176.9(235B) Registry records. Central registry records shall be kept in the name of the dependent adult and cross-referenced in the name of the caretaker.

441—176.10(235B) Adult abuse information disseminated.

176.10(1) *Requests for information.* Written requests for adult abuse information by the subject of a report as defined in subrule 176.10(3), paragraph *"a,"* may be submitted to the county office of the department on Form 470-0612, Request for Dependent Adult Abuse Registry Information.

Oral requests for dependent adult abuse information may be made to the county office or the central registry when the person making the request believes that the information is needed immediately and the person is authorized to access the information, pursuant to the requirements of Iowa Code section 235B.7, subsection 2. If a request is made orally by telephone, a written request shall be filed within 72 hours of the oral request using Form 470-0612, Request for Dependent Adult Abuse Registry Information. When an oral request to the county office to obtain dependent adult abuse information is granted by the central registry, the county shall document the approval to the central registry through use of Form 470-0612.

All other requests for information shall be made to the central registry by mail or fax pursuant to the requirements of Iowa Code section 235B.7.

176.10(2) *Verification of identity.* The county office shall verify the identity of the person making the request on Form 470-0612, Request for Dependent Adult Abuse Registry Information. Upon verification of the identity of the person making the request, the county office shall transmit the request to the central registry. The central registry shall verify the identity of persons making requests for information directly

to the central registry by telephone, mail, fax, or in person, on Form 470-0612, Request for Dependent Adult Abuse Registry Information.

176.10(3) *Approval of requests.* The department shall grant access to dependent adult abuse information as authorized by Iowa Code section 235B.6. Upon approval of any request for dependent adult abuse information authorized by this rule, the department may withhold the name of the person who made the report of dependent adult abuse when the department finds that the disclosure of the person's identity would be detrimental to the person's interest.

176.10(4) *Requests concerning applicants for employment and employees of health care programs.* A health care program making a request for dependent adult abuse information for the purpose of determining employability, as authorized by Iowa Code section 235B.6, subsection 2, paragraph *"e,"* subparagraphs (6) and (7), and section 135C.33, subsection 6, shall request the information directly from the central registry or obtain the information from the Internet electronic information system maintained by the health facilities division of the department of inspections and appeals.

Requests made directly to the central registry shall be made on Form 470-0612, Request for Dependent Adult Abuse Registry Information.

Health care programs requesting dependent adult abuse background checks on employee applicants and employees by use of the Internet electronic information system shall complete Form 470-3767, Non-Redissemination Agreement. The form shall be signed by the administrator of the health care program and be sent to the central registry before receipt of the information from the department. The administrator shall agree not to redisseminate dependent adult abuse information obtained through the Internet electronic information system, except as authorized in Iowa Code sections 235B.6 and 235B.8.

176.10(5) *Dissemination of undetermined reports.* Rescinded IAB 8/6/03, effective 7/10/03.

176.10(6) *Access to unfounded dependent adult abuse information.* Access to unfounded dependent adult abuse information is authorized only to:

a. Persons identified as subjects of a report, including the dependent adult named in a report as a victim, a guardian of a dependent adult named in a report as a victim, a person named in a report as having abused a dependent adult, or an attorney representing any of the above;

b. An employee or agency of the department of human services responsible for the evaluation or assessment of a dependent adult abuse report;

c. Registry or department personnel, when necessary to the performance of their official duties, or a person or agency under contract with the department to carry out official duties and functions of the registry;

d. The mandatory reporter who reported dependent adult abuse in an individual case;

e. The long-term care resident advocate, if the victim resides in a long-term care facility or the alleged perpetrator is an employee of a long-term care facility; and

f. A multidisciplinary team, if the department approves the composition of the team and determines that access to the team is necessary to assist in the evaluation, diagnosis, assessment, and disposition of a dependent adult abuse case.

176.10(7) *Requests concerning employees of department facilities.* When a request is made by the hiring authority of a department operated facility which provides direct client care and the request is made for the purpose of determining continued employability of a person employed, with or without compensation, by the facility, the information shall be requested directly from the central registry. The information requested shall be disseminated to the personnel office of the department. The personnel office shall redisseminate the information to the hiring authority for the person involved only upon a finding that the information has a direct bearing on employability of the person involved.

When the personnel office determines that the information has no direct bearing on employability, the hiring authority shall be notified that no job-related dependent adult abuse information is available. If the central registry and local office files contain no information, the hiring authority shall be so informed.

176.10(8) *Dependent adult abuse information disseminated and redisseminated.* Notwithstanding subrule 176.10(1), written requests and oral requests are not required for dependent adult abuse

information that is disseminated to an employee of the department of human services, a district court, or the attorney representing the department as authorized by Iowa Code section 235B.6.

176.10(9) *Required notification.* The department shall notify orally the subject of a report of the results of the evaluation or assessment. The department shall subsequently transmit a written notice to the subject which will include information regarding the results, the confidentiality provisions of Iowa Code sections 235B.6 and 235B.12, and the procedures for correction or expungement and appeal of dependent adult abuse information as provided in Iowa Code section 235B.10.

176.10(10) *Mandatory reporter notification.* The department shall attempt to notify orally the mandatory reporter who made the report in a dependent adult abuse case of the results of the evaluation or assessment and of the confidentiality provisions of Iowa Code sections 235B.6 and 235B.12. The department shall subsequently transmit a written notice on Form 470-2444, Adult Protective Notification, to the mandatory reporter who made the report. The form shall include information regarding the results of the evaluation or assessment and confidentiality provisions. A copy of the written notice shall be transmitted to the registry and shall be maintained by the registry as provided in Iowa Code section 235B.8.

176.10(11) *Subjects informed of abuse history.* The department may inform a subject of a dependent adult abuse report of a person's abuse history if the department determines at any time that disclosure is necessary for the protection of the dependent adult. A subject may be informed that a person is listed on the child or dependent adult abuse registry as having a founded abuse report or is listed on the sex offender registry.

441—176.11(235B) Person conducting research. The person in charge of the central registry shall be responsible for determining whether a person requesting dependent adult abuse information is conducting bona fide research. To make this determination, the central registry may require these persons to submit credentials and the research design. If the registry determines that identified information is essential to the research design, the registry shall also determine the method by which written permission is to be secured from the dependent adult or guardians of the dependent adult who could be identified by the information to be researched. Any costs incurred in the dissemination of the information shall be assumed by the researcher. The department will keep a public record of persons conducting research.

441—176.12(235B) Examination of information. Examination of information contained in the central registry can be made at the site of the central registry between the hours of 8 a.m. and 12 p.m. or 1 p.m. and 4 p.m., Monday through Friday, except state authorized holidays.

The person, or that person's attorney, requesting to examine the information in the registry which refers to that person, shall be allowed to inspect the information after providing appropriate identification.

441—176.13(235B) Dependent adult abuse information registry. The department shall create a central abuse registry for dependent adult abuse information. The registry shall collect, maintain, and disseminate dependent adult abuse information as follows:

176.13(1) *Founded reports.* A report of dependent adult abuse determined to be founded shall be retained and sealed by the registry in accordance with Iowa Code section 235B.9.

176.13(2) *Unfounded reports.* A report of dependent adult abuse determined to be unfounded shall be expunged five years from the date it is determined to be unfounded, in accordance with Iowa Code section 235B.9, subsection 2, as amended by 2009 Iowa Acts, Senate File 484.

176.13(3) *Rejected intakes.* Reports that are found not to meet the criteria to be accepted for evaluation or assessment of abuse shall be kept in the local office for three years from the date the report of abuse was determined to be rejected.

176.13(4) *Assessments.* Reports classified as assessments shall not be included in the central registry but shall be maintained in the local office. The central registry shall be notified of the disposition of the assessment report.

a. *Self-denial of critical care.* Reports involving abuse as a result of the acts or omissions of the dependent adult will be assessments. These reports shall be retained in the dependent adult's case file in the local office for five years and then destroyed.

b. *Confirmed, not registered.* Reports of dependent adult abuse where physical abuse or denial of critical care committed by a caretaker is confirmed but is determined to be minor, isolated, and unlikely to reoccur shall be assessments. These reports shall be maintained in the local office for five years and then destroyed unless a subsequent report of dependent adult abuse on the same caretaker is founded. If a subsequent report on the same caretaker is founded within the five-year period, the confirmed, not registered report shall be maintained in the local office for ten years from the date of the subsequent report and then sealed.

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441—176.14(235B) Central registry. Rescinded IAB 10/30/91, effective 1/1/92.

441—176.15(235B) Multidisciplinary teams.

176.15(1) *Purpose of multidisciplinary teams.* The service area shall establish multidisciplinary teams for the purpose of assisting the department in assessment, diagnosis, and disposition of reported dependent adult abuse cases. The disposition of a case may include the provision for treatment recommendations and services.

176.15(2) *Execution of team agreement.* When the team is established, the service area manager or designee and all team members shall execute an agreement on Form 470-2328, Dependent Adult Abuse Multidisciplinary Team Agreement. This agreement specifies:

a. That the team shall be consulted solely for the purpose of assisting the department in the assessment, diagnosis and treatment of dependent adult abuse cases.

b. That any team member may cause a dependent adult abuse case to be reviewed if approved by the department through use of the process of requesting adult abuse information specified in rule 176.10(235B).

c. That no team members shall redisseminate adult abuse information obtained solely through the multidisciplinary team. This shall not preclude redissemination of information as authorized by Iowa Code section 235B.6 when an individual team member has received information as a result of another authorized access provision of the Code.

d. That the department may consider the recommendation of the team in a specific dependent adult abuse case but shall not, in any way, be bound by the recommendations.

e. That any written report or document produced by the team pertaining to an individual case shall be made a part of the file for the case and shall be subject to all confidentiality provisions of Iowa Code sections 235B.6 and 235B.8 and of 441—Chapter 176.

f. That any written records maintained by the team which identify an individual dependent adult abuse case shall be destroyed when the agreement lapses.

g. That consultation team members shall serve without compensation.

h. That any party to the contract may withdraw with or without cause upon the giving of 30 days' notice.

i. The date on which the agreement will expire.

176.15(3) *Filing of agreement.* Whenever a team is created, a copy of the executed contract shall be filed with the central registry in addition to any other requirement placed upon execution of agreements by the department.

441—176.16(235B) Medical and mental health examinations. In any year in which the legislature appropriates funds, the department shall administer a payment program for mental health or medical health examinations for subjects of dependent adult abuse reports.

176.16(1) *Conditions for payment.* The following conditions must be met before payment can be made:

a. Local resources to pay these costs must be exhausted.

b. The examination must be scheduled during the evaluation or assessment process.

c. Department staff must be involved in the decision to request the examination.

176.16(2) *Payment limits.* Payment for mental health examinations shall not exceed $250. Payment for a complete medical examination shall not exceed $160.

176.16(3) *Billing procedures.* Claims for payment shall be submitted to the division of behavioral, developmental, and protective services on Form GAX, General Accounting Expenditure, accompanied by a letter from department staff certifying that the necessary conditions for payment have been met.

441—176.17(235B) Request for correction or expungement. The department of human services is responsible for correction or expungement of reports prepared by department staff. The department of inspections and appeals is responsible for correction or expungement of reports prepared by that department's staff and that determination shall be binding on the registry.

176.17(1) Within six months of the date of the notice of evaluation results, a person may file with the registry a written statement to the effect that the dependent adult abuse information referring to the person is partially or entirely erroneous. The person may also request a correction of that information or of the findings of the report. The registry will record all requests and immediately forward the requests to the division of health facilities, department of inspections and appeals, when the reports were prepared by the department of inspections and appeals. The registry will notify the person requesting a correction that the report has been sent to the department of inspections and appeals.

176.17(2) Unless the designated department corrects the information or findings as requested, the designated department shall provide the person with an opportunity for a hearing as provided by 441—Chapter 7 to correct the information or the findings. The department may defer the hearing until the conclusion of a pending district court case relating to the information or findings.

These rules are intended to implement Iowa Code chapter 235B.

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[Prior to 12/14/88, see Health Department[470] Ch 51]
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481—51.1(135B) Definitions. As used in this chapter, unless the context otherwise requires, the following definitions apply:

"Critical access hospital" means any hospital located in a rural area and certified by the Iowa department of public health as being a necessary provider of health care services to residents of the area. A "critical access hospital" makes available 24-hour emergency care, is a designated provider in a rural health network, and meets the criteria specified pursuant to 481—51.53(135B). If swing-bed approval has been granted, all 25 beds may be used interchangeably for acute or skilled nursing facility level of care services.

"Department" means the Iowa department of inspections and appeals.

"Governing board" means the board of trustees, the owner or the person or persons designated by the owner as the governing authority who shall have supreme authority in the hospital and be responsible for the management, control, and appointment of the medical staff.

"Governmental unit" means the state, or any county, municipality, or other political subdivision, or any department, division, board or other agency of any of the foregoing.

"Hospital" or *"general hospital"* means an institution, place, building, or agency represented and held out to the general public as ready, willing and able to furnish care, accommodations, facilities and equipment for the diagnosis or treatment, over a period exceeding 24 hours, of two or more nonrelated individuals suffering from illness, injury, infirmity or deformity, or other physical or mental condition for which medical, surgical and obstetrical care services are provided. The term "hospital" does not include the following:

1. Any institution for well children, day nursery and child care center, foster boarding homes or houses, and homes for disabled children. However, such institutions that have a dual function, including nursing and medical care, and care of the sick are required to be licensed.
2. Homes, houses or institutions for aged persons which limit their functions to room and board and provide no medical or nursing care and house no bedridden person.
3. Dispensary or first-aid stations maintained for the care of employees, students, customers, and members of any commercial or industrial plant, educational institution, or convent.

"Long-term acute care hospital" means any hospital that has an average inpatient length of stay greater than 25 days, and that provides extended medical and rehabilitative care for patients who are clinically complex and who may suffer from multiple acute or chronic conditions. Services provided by a long-term acute care hospital include but are not limited to comprehensive rehabilitation, respiratory therapy, head trauma treatment, and pain management. A long-term acute care hospital shall meet the requirements for a general hospital including emergency services, except that obstetrical facilities are not required, and, if the long-term acute care hospital is located within a separately licensed hospital and does not provide its own emergency services, the long-term acute care hospital shall contract for emergency services with the host general hospital.

"Medical staff" means an organized body that is composed of individuals appointed by the hospital governing board, that operates under bylaws approved by the governing board and that is responsible for the quality of medical care provided to patients by the hospital. All members of the medical staff, one of whom shall be a licensed physician, shall be licensed to practice in the state of Iowa.

"Person" means any individual, firm, partnership, corporation, company, association, or joint stock association and includes any trustee, receiver, assignee, or other similar representative.

"Premises" means any or all designated portions of a building or structure, enclosures or places in the building, or real estate when the distinct and clearly identifiable parts provide separate care and services. The definition of "premises" shall not be construed to permit the existence of a separately licensed specialty hospital within the physical structure of a general hospital. A specialty hospital shall be

defined pursuant to 42 CFR Section 411.351 and any amendments thereto, or pursuant to any regulations promulgated by the Secretary of Health and Human Services.

"Registered nurse" means a person who has graduated from an accredited school of nursing and who is registered in the state of Iowa.

"Specialized hospital" means any hospital devoted primarily to the specialized care and treatment of persons with chronic or long-term illness, injury, or infirmity. The diagnosis, treatment or care shall be administered by or performed under the direction of persons especially qualified in the diagnosis and treatment of the particular illness, injury, or infirmity. A specialized hospital shall meet the requirements for a general hospital. "Specialized hospital" as defined in this rule does not include a specialty hospital defined pursuant to 42 CFR Section 411.351.

481—51.2(135B) Classification, compliance and license.

51.2(1) Classification. For the purpose of administering the hospital licensing law, all institutions subject to licensure shall be classified as a critical access hospital, general hospital, long-term acute care hospital, or specialized hospital. The license issued by the department shall clearly identify the classification of the hospital.

51.2(2) Compliance requirements for each classification. A hospital shall comply with all of the general regulations for hospitals and shall comply with regulations pertaining to specialized services, if specialized services are provided in the hospital.

51.2(3) Separate license required. A separate license shall be required for each hospital even though more than one is operated under the same management. A separate license is not required for separate buildings of a hospital located on separate parcels of land, which are not adjoining but provide elements of the hospital's full range of services for the diagnosis, care, and treatment of human illness, including convalescence and rehabilitation, and which are organized under a single owner or governing board with a single designated administrator and medical staff.

51.2(4) Posting of license. The license shall be conspicuously posted on the premises.

51.2(5) The department shall recognize, in lieu of its own licensure inspection, the comparable inspections and inspection findings of The Joint Commission (JC), the American Osteopathic Association (AOA), or Det Norske Veritas (DNV), if the department is provided with copies of all requested materials relating to the inspection process. In cases of the initial licensure, the department may require its own inspection when needed in addition to comparable accreditations to allow the hospital to begin operations. The department may also initiate its own inspection when it is determined that the inspection findings of the JC, AOA, or DNV are insufficient to address concerns identified as possible licensure issues.

51.2(6) Hospitals not accredited by the JC, AOA, or DNV shall be inspected by the department utilizing the current Medicare conditions of participation found in Title XVIII of the federal Social Security Act and 42 CFR Part 482, Subparts A, B, C, D, and E, or 42 CFR Part 485, Subpart F, as of October 1, 2006. Licensed-only hospitals shall be inspected utilizing the requirements of this chapter. The department may promulgate additional standards. The department may recognize, in lieu of its own licensure inspection, the comparable inspection and inspection findings of a Medicare conditions of participation survey.

This rule is intended to implement Iowa Code chapter 135B.

[**ARC 9253B**, IAB 12/1/10, effective 1/5/11]

481—51.3(135B) Quality improvement program. There shall be an ongoing hospitalwide quality improvement program. This program is to be designed to improve, as needed, the quality of patient care by:

1. Assessing clinical patient care;
2. Assessing nonclinical and patient-related services within the hospital;
3. Developing remedial action as needed;
4. Ongoing monitoring and evaluating of the progress of remedial action taken.

51.3(1) The governing body shall ensure there is an effective hospitalwide patient-oriented quality improvement program.

51.3(2) The quality improvement program shall involve active participation of physician members of the hospital's medical staff and other health care professionals, as appropriate. Evidence of this participation will include ongoing case review and assessment of other patient care problems which have been identified through the quality improvement process.

51.3(3) There shall be a written plan for the quality improvement program that:

a. Describes the program's objectives, organization, scope, and mechanisms for overseeing the effectiveness of monitoring, evaluation, and problem-solving activities;

b. Ensures participation from all departments, services (including services provided both directly and under contract), and disciplines;

c. Provides for assessment of participation through a quality improvement committee meeting on an established periodic basis;

d. Provides for coordination of quality improvement activities;

e. Ensures communication, reporting and documentation of all quality improvement activities on a regular basis to the governing board, the medical staff, and the hospital administrator;

f. Provides for an annual evaluation by the governing board of the effectiveness of the quality improvement program; and

g. Addresses accessibility and confidentiality of materials relating to, generated by or part of the quality improvement process.

This rule is intended to implement Iowa Code chapter 135B.

481—51.4(135B) Long-term acute care hospital located within a general hospital.

51.4(1) If a long-term acute care hospital occupies the same building, premises or physical location of a general hospital, all treatment facilities and administrative offices for each hospital shall be clearly marked and separated from each other, and located within the licensed premises of each licensee.

a. Treatment facilities shall be sufficient to meet the medical needs of the patients.

b. Administrative offices shall include, but not be limited to, record rooms and personnel offices.

c. There shall be clearly identifiable and distinguishable signs for each hospital.

51.4(2) If a long-term acute care hospital occupies the same building, premises or physical location of a general hospital, each hospital shall have its own entrance. The separate entrance shall have appropriate signs and shall be clearly identifiable as belonging to a particular hospital. Nothing shall prohibit a long-term acute care hospital that is occupying the same building, premises or physical location as a general hospital from utilizing the entrance, hallway, stairs, elevators or escalators of the general hospital to provide access to the long-term acute care hospital's separate entrance.

51.4(3) A long-term acute care hospital located within a general hospital shall have sufficient staff to meet the patients' needs. No nursing services staff of either the long-term acute care hospital or the host general hospital shall be simultaneously assigned patient duties in both licensed hospitals.

51.4(4) Each long-term acute care hospital located within a general hospital and the host general hospital shall have a separate and distinct governing board, which shall be in control of the respective hospital. No more than one board member shall serve in a common capacity on the governing board of each licensed hospital. For the purposes of this rule, control exists if an individual or an organization has the power, directly or indirectly, to significantly influence or direct the actions or policies of an organization or institution.

51.4(5) A long-term acute care hospital located within a general hospital may contract with the host general hospital for the provision of services, including but not limited to pharmaceutical, radiological, laboratory, food and dietetic, surgical, anesthesia, emergency, housekeeping, laundry and environmental, or other services necessary to maintain a clean and safe physical environment. The contract shall be executed by the governing boards of the long-term acute care hospital and the host general hospital. All contracts shall clearly delineate the responsibilities of and services provided by the long-term acute care hospital and the host general hospital.

51.4(6) Any life safety code violation identified by the state fire marshal during an inspection of a licensee may be a life safety code violation for both the long-term acute care hospital and the general hospital.

481—51.5(135B) Medical staff.

51.5(1) A roster of medical staff members shall be kept.

51.5(2) All hospitals shall have one or more licensed physicians designated for emergency call service at all times.

51.5(3) A hospital shall not deny clinical privileges to physicians and surgeons, podiatrists, osteopaths or osteopathic surgeons, dentists, certified health service providers in psychology, physician assistants or advanced registered nurse practitioners licensed under Iowa Code chapter 148, 148C, 149, 150, 150A, 152, or 153 or section 154B.7 solely by reason of the license held by the practitioner or solely by reasons of the school or institution in which the practitioner received medical schooling or postgraduate training if the medical schooling or postgraduate training was accredited by an organization recognized by the council on postsecondary accreditation or an accrediting group recognized by the United States Department of Education.

51.5(4) A hospital shall establish and implement written criteria for the granting of clinical privileges. The written criteria shall include, but not be limited to, consideration of the:

a. Ability of the applicant to provide patient care services independently or appropriately in the hospital;

b. License held by the applicant to practice;

c. Training, experience, and competence of applicant;

d. Relationship between the applicant's request for privileges and the hospital's current scope of patient care services;

e. Applicant's ability to provide comprehensive, appropriate and cost-effective services.

481—51.6(135B) Patient rights and responsibilities. The hospital governing board shall adopt a statement of principles relating to patient rights and responsibilities. In developing a statement of principles, the hospital may use reference statements of patient rights and responsibilities developed by the American Hospital Association, The Joint Commission (JC), the American Osteopathic Association (AOA), Det Norske Veritas (DNV), and other appropriate sources.

51.6(1) The statement of principles shall be made available to patients of the hospital.

51.6(2) The statement of principles regarding patient rights shall, at a minimum, address:

a. Access to treatment regardless of race, creed, sex, national origin, diagnosis, or source of payment for care;

b. Preservation of individual dignity and protection of personal privacy in receipt of care;

c. Confidentiality of medical and other appropriate information;

d. Assurance of reasonable safety within the hospital;

e. Knowledge of the identity of the physician or other practitioner primarily responsible for the patient's care as well as identity and professional status of others providing services to the patient while in the hospital;

f. Nature of patient's right to information regarding the patient's medical condition unless medically contraindicated, to consult with a specialist at the patient's request and expense, and to refuse treatment to the extent authorized by law;

g. Access to and explanation of patient billings; and

h. Process for patient pursuit of grievances.

51.6(3) The statement of principles regarding patient responsibilities shall, at a minimum, address:

a. Need of patient to provide accurate and complete information regarding the patient's health status;

b. Need of patient to follow recommended treatment plans;

c. Requirement that patient abide by hospital rules and regulations affecting patient care and conduct and be considerate of the rights of other patients and hospital personnel; and

d. Obligation to fulfill the patient's financial obligations as soon as possible following discharge.

This rule is intended to implement Iowa Code chapter 135B.

[**ARC 9253B**, IAB 12/1/10, effective 1/5/11]

481—51.7(135B) Abuse.

51.7(1) *Definitions.*

a. Mental abuse includes, but is not limited to, humiliation, harassment, and threats of punishment or deprivation.

b. Physical abuse includes, but is not limited to, corporal punishment and the use of restraints as punishment.

c. Sexual abuse includes, but is not limited to, the exposing of pubes to a patient, and the exposure of a patient's genitals, pubes, breasts or buttocks, fondling or touching the inner thigh, groin, buttocks, anus, or breast of a patient or the clothing covering these areas for sexual satisfaction, sexually suggestive comments or remarks made to a patient, a genital-to-genital or oral-to-genital contact or the commission of a sexual offense under Iowa Code chapter 709 or Iowa Code section 726.2.

d. Domestic abuse, as defined in Iowa Code section 236.2, means the commission of assault under either of the following circumstances:

(1) The assault is between family or household members who resided together at the time of the assault; or

(2) The assault is between separated spouses or persons divorced from each other and not residing together at the time of the assault.

e. Family or household members, as defined in Iowa Code section 236.2, are spouses, persons cohabiting, parents, or other persons related by consanguinity or affinity, except children under the age of 18.

51.7(2) *Abuse prohibited.* Each patient shall receive kind and considerate care at all times and shall be free from mental, physical, and sexual abuse.

a. Restraints shall be applied only when they are necessary to prevent injury to the patient or to others and shall be used only when alternative measures are not sufficient to accomplish their purposes.

b. There must be a written order signed by the attending physician approving the use of restraints either at the time they are applied or as soon thereafter as possible.

c. Careful consideration shall be given to the methods by which the restraints can be speedily removed in case of fire or other emergency.

51.7(3) *Domestic abuse.* Each hospital shall establish and implement protocols with respect to victims of domestic abuse.

a. The policies and procedures shall at a minimum provide for:

(1) An interview with the victim in a place that ensures privacy;

(2) Confidentiality of the person's treatment and information;

(3) Sharing of information regarding the domestic abuse hotline and programs; and

(4) Education of appropriate emergency department staff to assist in the identification of victims of domestic abuse.

b. The treatment records of victims of domestic abuse shall include:

(1) An assessment of the extent of abuse to the victim specifically describing the location and extent of the injury and reported pain;

(2) Evidence that the victim was informed of the telephone numbers for the domestic abuse hotline and domestic abuse programs, and the victim's response;

(3) A record of the treatment and intervention by health care provider personnel;

(4) A record of the need for follow-up care and specification of the follow-up care to be given (e.g., X-rays, surgery, consultation, similar care); and

(5) The victim's statement of how the injury occurred.

51.7(4) *Child abuse and dependent adult abuse.* Each hospital shall ensure that written policies and procedures cover all requirements for the mandatory reporting of abuse pursuant to the Iowa Code.

Each hospital shall provide that the treatment records of victims of child abuse or dependent adult abuse include a statement that the department of human services protective services was contacted.

481—51.8(135B) Organ and tissue—requests and procurement.

51.8(1) Each hospital licensed in accordance with Iowa Code chapter 135B shall have in place written policies and protocols for organ and tissue donation. Hospital policies and protocols for organ and tissue donation shall require that the patient, or appropriate person able to consent on behalf of the patient, be made aware of the option to donate as well as the option to refuse donation and the ability, if any, to revoke consent once given.

a. Hospitals shall be familiar with the uniform anatomical gift law, Iowa Code chapter 142C, and shall develop policies and protocols for consent to organ and tissue donation by either the patient or an appropriate person to consent on the patient's behalf consistent with that law's provisions.

b. Hospital policies and protocols for organ and tissue donation shall set forth the responsibilities of the attending physician or physicians, nursing staff, and other appropriate hospital staff persons in the organ and tissue donation process. At a minimum, the policies shall set forth who in particular is authorized to make an organ or tissue donor request and that all such requests shall be made only in accordance with clearly delineated written protocol approved by the hospital's medical staff and governing board.

c. Hospital policies and protocols for organ and tissue donation shall provide that the attending physician inform appropriate family members or others of impending death or that death has occurred prior to an organ or tissue donor request.

d. Hospital policies and protocols for organ and tissue donation shall set forth those situations in which donation shall not be made including, but not necessarily limited to, the following:

(1) Where the patient is not medically suitable, as determined by the organ or tissue procurement organization;

(2) Where the hospital lacks the appropriate facilities or equipment for maintaining the patient or the organs for the time and in the manner necessary to facilitate appropriate procurement of the organ(s);

(3) Where the medical examiner has refused to release the body, except a donor request may be made where the medical examiner indicates that the body will be available at a time where the patient remains medically suitable for organ or tissue donation;

(4) Where the hospital has appropriate documentation that the patient or the appropriate person to consent on behalf of the patient does not want to consider the donation option;

(5) Rescinded IAB 8/6/03, effective 9/10/03.

e. Hospital policies and protocols for organ and tissue donation shall require documentation in the patient's medical record of the fact that a donor request was made and either accepted or refused, stating to whom the request was made and who accepted or refused; or that a donor request was not made, stating the reason why no request was made; or that a consent previously given was subsequently revoked.

f. Method and manner of consent, where consent to organ or tissue donation has been given, shall be noted in the patient's medical record. Where revocation of consent, if applicable, occurs, the manner and method of revocation shall also be noted in the patient's medical record.

g. Where the patient has validly executed a donation prior to death, attempt will be made to notify appropriate family members, if reasonably available, of the donation before the procurement process begins.

h. Hospital policies and protocols for organ and tissue donation shall provide for ongoing communication with the patient's family or other appropriate representatives regarding the donation process, the present status of that process and unexpected delays in the process, and family rights and responsibilities following organ or tissue donation.

51.8(2) Determination of death.

a. No organ or tissue shall be removed from a donor until death has been determined according to the requirements of Iowa law and generally acceptable standards of medical practice.

b. Death is defined by Iowa Code section 702.8 as a condition determined by the following standards:

A person will be considered dead if in the announced opinion of a physician licensed pursuant to Iowa Code chapter 148, 150, or 150A, a physician assistant licensed pursuant to Iowa Code chapter 148C, or a registered nurse or a licensed practical nurse licensed pursuant to Iowa Code chapter 152, based on ordinary standards of medical practice, that person has experienced an irreversible cessation of spontaneous respiratory and circulatory functions. In the event that artificial means of support preclude a determination that these functions have ceased, a person will be considered dead if in the announced opinion of two physicians, based on ordinary standards of medical practice, that person has experienced an irreversible cessation of spontaneous brain functions. Death will have occurred at the time when the relevant functions ceased.

c. The surgeon performing the organ removal shall not participate in the determination of brain death.

d. The patient's medical record shall include documentation of the date and time of death and identification of the practitioner or practitioners who determined death, as provided in 51.8(2)*"b."*

51.8(3) Determination of medical suitability.

a. At or near the time of the patient's death or when death has occurred, no organ and tissue donor request shall be made until the patient has been determined by the designated organ or tissue procurement organization to be medically suitable for organ or tissue donation.

b. Each hospital shall consult with a recognized organ and tissue procurement program or programs in establishing medical requirements for organ and tissue donation and in evaluating a particular patient's suitability for donation. Where required by federal law, hospitals shall work only with organ or tissue procurement organizations designated by the Department of Health and Human Services (DHHS). Organ and tissue procurement programs maintain guidelines for determining medical suitability and generally will provide a hospital with a copy of those guidelines which may be incorporated into the hospital's own policies and protocol for organ and tissue donation.

51.8(4) Organ and tissue procurement.

a. Hospital policies and protocol for organ and tissue donation shall set forth the process to be used for contacting an organ procurement organization (OPO).

b. Hospitals with an agreement with the designated OPO shall take into account the terms and conditions of the agreement in developing their policies and protocols. Hospitals shall contact only the OPO designated by the federal Department of Health and Human Services.

c. Generally an OPO will assume the costs of procuring medically suitable organs and tissues, including costs borne by the donating hospital in maintaining the patient until organ retrieval can occur as well as in the retrieval process itself. A hospital shall be familiar with its financial obligations, if any, in the procurement process and with cost accounting/reporting responsibilities it bears, if any, under Medicare and Medicaid. In situations, if any, where the patient or the patient's family may be liable for certain costs associated with organ donation or procurement, the patient or person able to consent for the patient shall be fully informed of the potential financial obligations at the time of request and before consent is either given or refused.

d. When an organ or tissue is retrieved for transplantation purposes, the hospital shall ensure that the medical records of the donor and, if applicable, the recipient fulfill the requirements for any surgical inpatient medical record. Medical record documentation shall include the method of maintenance of the patient while awaiting organ or tissue retrieval and operative report documentation (including an autopsy if an autopsy has been performed) regarding the removal of the organ or tissue.

e. The procurement process shall not occur until necessary consent by the patient or appropriate person to consent on behalf of the patient is received and documented. Also, in cases requiring the involvement of the medical examiner, release of the body must be authorized by the medical examiner and documented.

f. Where a donor specifies to whom the organ or tissue donation is to be made, the hospital shall first contact the named donee to determine whether the donee accepts the donation. Where the donee refuses the donation or is unable for other reasons to accept, then the hospital shall document in the

medical record the fact that the donation was not accepted. The hospital shall then notify the appropriate consenting party that the donation was not accepted and determine whether the consenting party desires to make further donation. A hospital shall make good faith effort to cooperate in the donation/procurement process where a specific donee has been named but shall not be required to participate in the donation process where procurement for a specific donee would result in undue burden or unreasonable cost to the hospital; in such situations, the hospital shall notify the appropriate consenting party and determine whether the consenting party desires to make further donation.

g. Where consent has been given for organ or tissue donation, revocation of prior consent, if applicable, shall not be effective once surgical procedures have begun on either the donor or the recipient.

51.8(5) Informed consent. Hospital policies and protocols for organ and tissue donation shall be consistent with informed consent provisions provided by the organ or tissue procurement organization.

51.8(6) Confidentiality. Hospital policies and protocols for organ and tissue donation shall provide that donor and recipient patient-identifying information shall be kept confidential except and only to the extent necessary to assist and complete the procurement and transplant process.

51.8(7) Training of hospital personnel. Hospital policies and protocols for organ and tissue donation shall include provisions for initial and ongoing training of hospital medical, nursing, and other appropriate staff persons regarding the various aspects of the organ and tissue donation and procurement process. The type and extent of training will vary from hospital to hospital, based on factors such as likelihood of medically suitable donors, capabilities for maintaining organ donors/patients, referral sources for potential organ and tissue donor candidates, and overall participation in organ and tissue procurement and transplants.

This rule is intended to implement Iowa Code section 135B.7.

481—51.9(135B) Nursing services.

51.9(1) The hospital shall have an organized nursing service which shall provide complete and efficient nursing care to each patient. The authority, responsibility and function of each nurse shall be clearly defined.

51.9(2) Registered nurse(s) shall utilize the nursing process in the provision of nursing care to each patient. The nursing process includes:

a. Nursing assessment about the health status of the patient, analysis of the data, and formation of a nursing diagnosis;

b. Planning of nursing care which includes determining goals and priorities for actions which are based on the nursing diagnosis;

c. Nursing interventions implementing the plan of care;

d. Evaluation of patient status in relation to established goals and the plan of care.

51.9(3) Licensed practical nurse(s) shall participate in the nursing process as described in subrule 51.9(2) consistent with accepted practice by assisting the registered nurse or physician.

51.9(4) All nurses employed in a hospital who practice nursing as a registered nurse or licensed practical nurse shall be licensed in Iowa.

51.9(5) There shall be a director of nursing service with administrative and executive competency who shall be a registered nurse licensed in the state of Iowa.

51.9(6) Supervisors and head nurses shall have had preparation courses and experience in accordance with hospital policy commensurate with the responsibility of the specific assignment.

51.9(7) All nonprofessional workers performing patient-care service shall be under the supervision of a registered nurse. Their duties shall be defined in writing by the hospital and they shall be instructed in all duties assigned to them.

51.9(8) The nursing service shall have adequate numbers of licensed registered nurses, licensed practical nurses, and other personnel to provide nursing care essential for the proper treatment, well-being, and recovery of the patient.

51.9(9) Written policies and procedures shall be established for the administrative and technical guidance of the personnel in the hospital. Each employee shall be familiar with these policies and procedures.

51.9(10) Each hospital shall have a minimum of one registered nurse on duty at all times.

481—51.10(135B) Water supply. Rescinded IAB 12/22/93, effective 1/26/94.

481—51.11(135B) Sewage disposal. Rescinded IAB 12/22/93, effective 1/26/94.

481—51.12(135B) Records and reports.

51.12(1) *Medical records.* Accurate and complete medical records shall be written for all patients and signed by the attending physician. These records shall be filed and stored in an accessible manner in the hospital and in accordance with the statute of limitations as specified in Iowa Code chapter 614.

51.12(2) *Hospital records.*

a. *Admission records.* A register of all admissions to the hospital shall be maintained.

b. *Death records.* A record of all deaths in the hospital shall be kept, including all information required on a standard death certificate as specified in Iowa Code chapter 144.

c. *Birth records.* A record of all births in the hospital shall be kept, including all information required on a standard birth certificate as specified in Iowa Code chapter 144.

d. *Controlled substance records.* Controlled substance records shall be maintained in accordance with state and federal laws, rules and regulations.

51.12(3) *Annual reports.* Annual reports shall be filed with the Iowa department of public health within three months after termination of each fiscal year in accordance with Iowa Code section 135.75.

481—51.13(135B) Sterilizing equipment. Rescinded IAB 12/22/93, effective 1/26/94; see 481—51.50(135B).

481—51.14(135B) Pharmaceutical service.

51.14(1) *General requirements.* Hospital pharmaceutical services shall be licensed in accordance with Iowa board of pharmacy examiners rules in 657—Chapter 7.

51.14(2) *Medication administration.* All drugs and biologicals must be administered by, or under the supervision of, nursing or other trained personnel in accordance with hospital policies and procedures. The person assigned the responsibility of medication administration must complete the entire procedure by personally preparing the dose from a multiple-dose container or using a prepackaged unit dose, personally administering it to the patient, and observing the act of the medication being taken.

51.14(3) *Medication orders.* All verbal orders must be authenticated in writing and signed by the prescribing practitioner within a period not to exceed 30 days following a patient's discharge.

When telephone, oral or electronic mechanisms are used to transmit medication orders, they must be accepted only by personnel that are authorized to do so by hospital policies and procedures in a manner consistent with federal and state law.

51.14(4) *Standing orders.* Standing orders for drugs may be used for specified patients when authorized by the prescribing practitioner. These standing orders shall be in accordance with policies and procedures established by the appropriate committee within each hospital. At a minimum, the standing orders shall:

a. Specify the circumstances under which the drug is to be administered;

b. Specify the types of medical conditions of the patients for whom the standing orders are intended;

c. Be reviewed and revised by the prescribing practitioner on a regular basis as specified by hospital policies and procedures;

d. Be specific as to the drug, dosage, route, and frequency of administration; and

e. Be dated, signed by the prescribing practitioner within a period not to exceed 30 days following a patient's discharge, and included in the patient's medical record.

51.14(5) *Self-administration of medications.* Patients shall only be permitted to self-administer medications when specifically ordered by the prescribing practitioner and the prescribing practitioner has determined this practice is safe for the specific patient. The hospital shall develop policies and procedures regarding storage and documentation of the administration of drugs.

481—51.15(135B) Screens. Rescinded IAB 12/22/93, effective 1/26/94; see 481—51.50(135B).

481—51.16(135B) Radiological services.

51.16(1) The hospital must maintain, or have available, radiological services to meet the needs of the patients.

51.16(2) All radiological services including diagnostic, fluoroscopy, mammography, therapeutic, and nuclear medicine furnished by the hospital or its agent shall be furnished in compliance with 641 IAC Chapters 38 to 42.

481—51.17(135B) Laundry. Rescinded IAB 12/22/93, effective 1/26/94; see 481—51.50(135B).

481—51.18(135B) Laboratory service.

51.18(1) The hospital must maintain, or have available, adequate laboratory and pathology services and facilities to meet the needs of its patients. The medical staff shall determine which laboratory tests are necessary to be performed on site to meet the needs of the patients.

51.18(2) Emergency laboratory services must be available 24 hours a day.

51.18(3) The hospital must ensure that all laboratory services provided to its patients are performed in a laboratory certified in accordance with the Code of Federal Regulations in 42 CFR Part 493, October 1, 2004.

51.18(4) All laboratory services shall be under the supervision of a physician, preferably a clinical pathologist.

481—51.19 Reserved.

481—51.20(135B) Food and nutrition services.

51.20(1) *Food and nutrition service definition.* "Food service" means providing safe, satisfying, and nutritionally adequate food for patients through the provision of appropriate staff, space, equipment, and supplies. "Nutrition service" means providing assessment and education to ensure that the nutritional needs of the patients are met.

51.20(2) *General requirements.*

a. All food shall be handled, prepared, served, and stored in compliance with the requirements of the 2005 Food and Drug Administration Food Code with Supplement adopted under provisions of Iowa Code section 137F.2.

b. The food service shall provide food of the quality and quantity to meet the patient's needs in accordance with the qualified health practitioner's orders and, to the extent medically possible, to meet the current Recommended Dietary Allowances, adopted by the Food and Nutrition Board of the National Research Council, National Academy of Sciences, and the following:

(1) Not less than three meals shall be served daily unless contraindicated.

(2) Not more than 14 hours shall elapse between the evening meal and breakfast of the following day.

(3) Nourishment between meals shall be available to all patients unless contraindicated by the qualified health care practitioner.

(4) Patient food preferences shall be respected as much as possible, and substitutes shall be offered through use of appropriate food groups.

(5) When food is provided by a contract food service, all applicable requirements set forth herein shall be met. The hospital shall maintain adequate space, equipment, and staple food supplies to provide patient food service in emergencies.

c. Policies and procedures shall be developed and maintained in consultation with representatives of the medical staff, nursing staff, food and nutrition service staff, pharmacy staff, and administration to govern the provision of food and nutrition services. Policies and procedures shall be approved by the medical staff, administration, and governing body.

d. A current diet manual approved by the dietitian and the medical staff shall be used as the basis for diet orders and for planning therapeutic diets. The diet manual shall be reviewed, revised and updated

at least every five years. Copies of the diet manual shall be readily available to all medical, nursing, and food service personnel.

e. Therapeutic diets shall be provided as prescribed by the qualified health care practitioner and shall be planned, prepared, and served with supervision or consultation from the licensed dietitian. Persons responsible for therapeutic diets shall have sufficient knowledge of food to make appropriate substitutions when necessary.

f. The patient's diet card shall state likes, dislikes, food allergies, and other pertinent information.

g. Menus.

(1) Menus for regular and therapeutic diets shall be written, approved, dated and available in the food service area at least one week in advance.

(2) If meals served vary from the planned menu, the change shall be noted in writing as part of the available menu. A copy of the menu as served shall be kept on file for at least 30 days.

(3) Menus should be planned with consideration for cultural and religious background and food habits of patients.

(4) Standardized recipes with nutritional analysis adjusted to number of portions shall be maintained and used in food preparation.

h. Food shall be prepared by methods that conserve nutritive value, flavor, and appearance. Food shall be served attractively at appropriate and safe temperatures and in a form to meet individual needs.

i. Nutritional care.

(1) Nutrition screening shall be conducted by qualified hospital staff to determine the patient's need for a comprehensive nutrition assessment by the licensed dietitian.

(2) Nutritional care shall be integrated in the patient care plan, as appropriate, based upon the patient's diagnosis and length of stay.

(3) The licensed dietitian shall record in the patient's medical record any observations and information pertinent to medical nutrition therapy.

(4) Pertinent dietary records shall be included in the patient's transfer discharge record to ensure continuity of nutritional care.

(5) Upon discharge, nutrition counseling and education shall be provided to the patient and family as ordered by the qualified health care practitioner, requested by the patient or deemed appropriate by the licensed dietitian.

j. In-service training, in accordance with hospital policies, shall be provided for all food and nutrition service personnel. A record of subject areas covered, date and duration of each session, and attendance lists shall be maintained. In-service records shall be kept for a minimum of one year.

k. On the nursing units, a separate patient food storage area shall be maintained that ensures proper temperature control.

51.20(3) *Food and nutrition service staff.*

a. A licensed dietitian shall be employed on a full-time, part-time or consulting basis. Part-time or consultant services shall be provided on the premises at appropriate times on a regularly scheduled basis. These services shall be of sufficient duration and frequency to provide continuing liaison with medical and nursing staffs, advice to the administrator, patient counseling, guidance to the supervisor and staff of the food and nutrition service, approval of all menus, and participation in the development or revision of departmental policies and procedures and in planning and conducting in-service education programs.

b. If a licensed dietitian is not employed full-time, then one must be employed on a part-time or consultation basis with an additional full-time person who has completed a 250-hour dietary manager course and who shall be employed to be responsible for the operation of the food service.

c. Sufficient food service personnel shall be employed, oriented, trained, and their working hours scheduled to provide for the nutritional needs of the patients and to maintain the food service areas. If food service employees are assigned duties in other service areas, those duties shall not interfere with the sanitation, safety, or time required for food service work assignments.

51.20(4) *Food service equipment and supplies.* Equipment necessary for preparation and maintenance of menus, records, and references shall be provided. At least one week's supply of staple

foods and a reasonable supply of perishable foods shall be maintained on the premises. Supplies shall be appropriate to meet the requirements of the menu.
[**ARC 9252B**, IAB 12/1/10, effective 1/5/11]

481—51.21 Reserved.

481—51.22(135B) Equipment for patient care. Hospital equipment shall be selected, maintained and utilized in accordance with the needs of the patients.

51.22(1) *Furnishings, supplies and equipment.* Rescinded IAB 12/1/99, effective 1/5/00.

51.22(2) *Hot water bags.* Rescinded IAB 12/1/99, effective 1/5/00.

51.22(3) *Restraints.* Rescinded IAB 3/30/94, effective 5/4/94. See rule 51.7(135B).

51.22(4) *Signals.* Rescinded IAB 12/1/99, effective 1/5/00.

51.22(5) *Screens.* Rescinded IAB 12/1/99, effective 1/5/00.

51.22(6) *Storage space.* Rescinded IAB 12/1/99, effective 1/5/00.

481—51.23 Reserved.

481—51.24(135B) Infection control. There shall be proper policies and procedures for the prevention and control of communicable diseases. The hospital shall provide for compliance with the rules for the control of communicable disease as provided by the state department of public health in 641—Chapter 1, 1987 and 1988 Centers for Disease Control (CDC) guidelines on universal precautions and 1985 CDC guidelines for hand washing.

51.24(1) *Segregation.* There shall be proper arrangement of areas, rooms and patients' beds to provide for the prevention of cross-infections and the control of communicable diseases.

a. There shall be proper procedures for the cleansing of rooms and surgeries, immediately following the care of a communicable case.

b. Segregation of communicable cases shall include policies for the medical, nursing and lay staffs, providing for proper isolation technique in order to prevent cross-infection.

51.24(2) *Visitors.* The governing authority of the hospital shall establish proper policies for the control of visitors to all services in the hospital in accordance with hospital practice. In the maternity area, each hospital should develop its own criteria, control measures, and protocols to ensure against introduction of infection in this critical area. These criteria should be reviewed and approved by the committee of the hospital.

51.24(3) *Health examinations.* Health examinations for all personnel shall be required at the commencement of employment and thereafter at least every four years. The examination shall include, at a minimum, the health and tuberculosis status of the employee. Consideration shall be given to requiring health examinations at shorter intervals for those employees working in high-risk areas.

51.24(4) *Notification.* Prior to removal of a deceased resident/patient from a facility, the funeral director or person responsible for transporting the body shall be notified by the facility staff of any special precautions that were followed by the facility having to do with the mode of transmission of a known or suspected communicable disease.

This rule is intended to implement Iowa Code section 135B.7.

481—51.25 Reserved.

481—51.26(135B) Surgical services. All hospitals providing surgical services shall be properly organized and equipped to provide for the safe and aseptic treatment of surgical patients.

51.26(1) Written policies and procedures shall be implemented governing surgical services that are consistent with the needs of the patient and the resources of the hospital. Policies and procedures shall be developed in consultation with and the approval of the hospital's medical staff. At a minimum, the policies and procedures shall provide for:

a. Surgical services under the direction of a qualified doctor of medicine or osteopathy.

b. Delineation of the privileges and qualifications of individuals authorized to provide surgical services as set forth in the hospital's medical staff bylaws and in accordance with subrule 51.5(4). The surgical service must maintain a roster of these individuals specifying the surgical privileges of each. Surgical privileges shall be reviewed and updated at least once every two years.

c. Immediate availability of at least one registered nurse for the operating room suites to respond to emergencies.

d. The qualifications and job descriptions of nursing personnel, surgical technicians, and other support personnel and continuing education required.

e. Appropriate staffing for surgical services including physician and anesthesia coverage and other support personnel.

f. Availability of ancillary services for surgical patients including, but not limited to: blood banking, laboratory, radiology, and anesthesia.

g. Infection control and disease prevention, including aseptic surveillance and practice, identification of infected and noninfected cases, sterilization and disinfection procedures, and ongoing monitoring of infections and infection rates.

h. Housekeeping requirements.

i. Safety practices.

j. Ongoing quality assessment, performance improvement, and process improvement.

k. Provisions for the pathological examination of tissue specimens either directly or through contractual arrangements.

l. Appropriate preoperative teaching and discharge planning.

Reference sources to guide hospitals in the development of policies and procedures are: "Statement of Principles," March 1994 Edition, American College of Surgeons; and "Standards and Recommended Practices," 1995 Edition, Association of Operating Room Nurses.

51.26(2) Policies and procedures may be adjusted as appropriate to reflect the provision of surgical services in inpatient, outpatient or one-day surgical settings.

51.26(3) There must be an appropriate history and physical workup documented and a properly executed consent form in the chart of each patient prior to surgery, except in the event of an emergency.

51.26(4) An operative report must be written or dictated promptly following surgery and signed by the individual conducting the surgery.

51.26(5) Equipment available in the operating room, recovery room, outpatient surgical areas, and for postsurgical care, must be consistent with the needs of the patient.

51.26(6) The surgical facilities shall be constructed in accordance with 481—51.50(135B).

481—51.27 Reserved.

481—51.28(135B) Anesthesia services.

51.28(1) There shall be written policies and procedures governing anesthesia services which are consistent with the needs and resources of the hospital.

a. Policies and procedures shall be developed in consultation with and with the approval of the hospital's medical staff.

b. At a minimum, the policies and procedures shall provide:

(1) Anesthesia services shall be provided under the direction of a qualified doctor of medicine or osteopathy.

(2) Delineation of the qualifications of individuals authorized to administer anesthesia as set out in the hospital's medical staff bylaws or medical staff rules and regulations.

(3) For preanesthesia evaluation, appraisal of a patient's current condition, preparation of an intraoperative anesthesia record, and discharge criteria for patients.

(4) For equipment functioning and safety, including ensuring that a qualified medical doctor, osteopathic physician and surgeon or anesthetist checks, prior to the administration of anesthesia, the readiness, availability, cleanliness, and working condition of all equipment to be used in the administration of anesthetic agents.

(5) For minimizing electrical hazards in all anesthetizing areas.

(6) Quality assurance which shall at least include infection control procedures; integration of anesthesia services into various areas of the hospital; and ongoing monitoring, review, and evaluation of anesthesia services, processes, and procedures.

51.28(2) Policies and procedures may be adjusted as appropriate to reflect provision of anesthesia services in inpatient, outpatient, or one-day surgery settings.

This rule is intended to implement Iowa Code section 135B.7.

481—51.29 Reserved.

481—51.30(135B) Emergency services. All hospitals shall provide for emergency service which offers reasonable care within the medical capabilities of the facility in determining whether an emergency exists, renders care appropriate to the facility and at a minimum renders lifesaving first aid and makes appropriate referral to a facility that is capable of providing needed services.

51.30(1) The hospital has written policies and procedures specifying the scope and conduct of patient care to be provided in the emergency service.

a. The policies specify the mechanism for providing physician coverage at all times as defined by the medical staff bylaws.

b. The policies provide for a planned, formal training program required of all personnel providing patient care in the emergency service. This program shall cover emergency care for patients of all ages.

c. The policies require that a medical record be kept on every patient given treatment in the emergency service and establish the medical record documentation. The documentation should include at a minimum appropriate information regarding the medical screening provided, except where the person refuses, then notation of patient refusal; physician documentation of the presence or absence of an emergency medical condition or active labor; physician documentation of transfer or discharge, stating the basis for transfer or discharge; and where transfer occurs, identity of the facility of transfer, acceptance of the patient by the facility of transfer, and means of transfer of the patient.

d. The policies and procedures are reviewed and approved annually by the governing board.

51.30(2) Hospital policies and procedures shall be developed in accordance with the hospital's medical, technological, personnel and equipment capabilities.

481—51.31 Reserved.

481—51.32(135B) Obstetric and neonatal services.

51.32(1) All general or specialized hospitals providing for the obstetrical care of maternity patients shall be properly organized and equipped to provide accommodations for mothers and newborn infants. The supervision of the maternity area shall be under the direction of a qualified registered nurse, and there shall be accommodations for the isolation of infected cases.

51.32(2) Written policies and procedures shall be implemented governing obstetric and neonatal services that are consistent with the needs of the patient and resources of the hospital. Policies and procedures shall be developed in consultation with and with the approval of the hospital's medical staff. At a minimum, the policies and procedures shall provide for:

a. Obstetric and neonatal services under the direction of a qualified doctor of medicine or osteopathy.

b. Delineation of the privileges and qualifications of individuals authorized to provide obstetrical/gynecological service as set out in the hospital's medical staff bylaws.

c. The qualifications of nursing personnel and continuing education required.

d. Adequate staffing for obstetrical and newborn services.

e. Location and arrangement of obstetric and newborn services.

f. Infection control and disease prevention.

g. Ongoing quality assessment.

Reference sources to guide hospitals in the development of policies and procedures are: 641—Chapter 150, Iowa Regionalized System of Perinatal Health Care, Iowa Administrative Code, and Guidelines for Perinatal Care, Fourth Edition, American Academy of Pediatrics, American College of Obstetrics and Gynecology.

481—51.33 Reserved.

481—51.34(135B) Pediatric services.

51.34(1) All general or specialized hospitals providing pediatric care shall be properly organized and equipped to provide appropriate accommodations for children. The supervision of the pediatric area shall be under the direction of a qualified registered nurse.

51.34(2) Written policies and procedures shall be implemented governing pediatric services that are consistent with the needs of the child and resources of the hospital. Policies and procedures shall be developed in consultation with and the approval of the hospital's medical staff. At a minimum, the policies and procedures shall provide for:

a. Pediatric services under the medical direction of a qualified doctor of medicine or osteopathy.

b. Delineation of the privileges and qualifications of individuals authorized to provide pediatric services as set out in the hospital's medical staff bylaws.

c. The qualifications of nursing personnel and continuing education required, including care in the event of emergency situations.

d. Adequate staffing and equipment for pediatric services including ancillary services. Staff participating in the care of pediatric patients shall have an interest in pediatrics and shall have specialized education appropriate to their profession for the care of pediatric patients.

e. Ancillary services for pediatric patients shall be available and include, but not be limited to, pharmaceutical care, laboratory services, respiratory therapy, physical therapy and speech therapy.

f. Ongoing quality assessment.

g. Written protocol for transfer of pediatric patients in the event the hospital does not have capability to provide care for these patients.

Reference sources to guide hospitals in the development of policies and procedures are American Academy of Pediatrics' 1994 Policy Reference Guide and policy statements which are published on a monthly basis in "Pediatrics" and "Pediatric Dosage Handbook," Third Edition, American Pharmaceutical Association.

51.34(3) There shall be proper facilities and procedures for the isolation of pediatric patients with communicable diseases.

481—51.35 Reserved.

481—51.36(135B) Psychiatric services.

51.36(1) Any institution operating as a psychiatric hospital or operating a designated psychiatric unit shall:

a. Be a hospital or unit primarily engaged in providing, by or under the supervision of a doctor of medicine or osteopathy, psychiatric services for the diagnosis and treatment of persons with psychiatric illnesses/disorders;

b. Meet the general and specialized rules of this chapter pertaining to general hospitals. If medical and surgical diagnostic and treatment services are not available within the institution, the institution shall have an agreement with an outside source of these services to ensure they are immediately available;

c. Have policies and procedures for informing patients of their rights and responsibilities and for ensuring the availability of a patient advocate; and

d. Have sufficient numbers of qualified professionals and support staff to evaluate patients, formulate written individualized comprehensive treatment plans, provide active treatment measures, and engage in discharge planning.

51.36(2) Personnel.

a. Director of inpatient psychiatric services. The director of inpatient psychiatric services shall be a doctor of medicine or osteopathy qualified to meet the training and experience requirements for examination by the American Board of Psychiatry and Neurology or the American Osteopathic Board of Neurology and Psychiatry. The number and qualifications of doctors of medicine or doctors of osteopathy on staff must be adequate to provide essential psychiatric and medical services.

b. Director of psychiatric nursing services. The director of psychiatric nursing services shall:

(1) Be a registered nurse who has a master's degree in psychiatric or mental health nursing; or

(2) Be qualified by education and two years' experience in the care of persons with mental disorders.

c. Psychological services. Psychological services shall be provided or available which are in compliance with Iowa Code chapter 154B.

d. Social services. Social services shall provide, or have available by contract, at least one staff member who has:

(1) A master's degree from an accredited school of social work; or

(2) A bachelor's degree in social work with two years' experience in the care of persons with mental disorders.

e. Therapeutic services. Therapeutic activities shall be provided by qualified therapists. The activities shall be appropriate to the needs and interests of the patients.

51.36(3) Individual written plan of care. An individual written plan of care shall be developed by an interdisciplinary team of a physician and other personnel who are employed by, or who provide service under contract to patients in the facility. The plan of care shall:

a. Be based on a diagnostic and psychiatric evaluation that includes examination of the medical, psychological, social, behavioral, and developmental aspects of the patient. The initial diagnostic and psychiatric evaluation shall be completed within 60 hours of admission;

b. Be developed by an interdisciplinary team in consultation with the patient, the patient's legal guardian, and others who are currently providing services or who will provide care upon discharge;

c. State treatment objectives through measurable and obtainable outcomes;

d. Prescribe an integrated program of therapies, activities, and experiences designed to meet those objectives;

e. Include an appropriate postdischarge plan with coordination of services to provide continuity of care following discharge; and

f. Be reviewed as needed or at least every 30 days by the interdisciplinary team for the continued appropriateness of the plan and for a determination of needed changes.

481—51.37 Reserved.

481—51.38(135B) Long-term care service.

51.38(1) *Long-term care service definition.* Long-term care service means any building or distinct part of a building utilized by the hospital for the provision of a service (except as provided by 51.38(2) below) that falls within the definition of a health care facility as specified in Iowa Code chapter 135C and Iowa Code section 135C.1(12), nursing facility, as it would be applied were it not operating as part of a hospital licensed under Iowa Code chapter 135B.

51.38(2) *Long-term care service general requirements.* The general requirements for the hospital's long-term care service shall be the same as required by Iowa Code chapter 135C and the rules promulgated under its authority for the category of health care facility involved. Exceptions to those rules requiring distinct parts to be established may be waived where it is found to be in the best interest of the long-term care resident and of no detriment to the patients in the hospital.

Requests for variances to other rules for which equivalent health, safety and welfare provisions are provided may be made in accordance with the appropriate health care facility rules. In any case where a distinct part has been established for long-term residents or where the department has given approval for the intermingling of such residents with acute care patients, the same provisions and rules promulgated under Iowa Code chapter 135C shall be applicable. These rules include, but are not limited

to, the same restrictions, obligations, programs of care, personal and rehabilitative services and all of the conveniences and considerations which the residents would normally have received in a licensed health care facility.

51.38(3) *Long-term care service staff.* The staffing requirements for the hospital's long-term care service shall be the same as required by Iowa Code chapter 135C and the rules promulgated under its authority for the category of health care facility involved. Where a hospital operates a freestanding nursing care facility, it shall be under the administrative authority of a licensed nursing home administrator who will be responsible to the hospital's administrator. Where a hospital operates a distinct part long-term care unit under the auspices of the hospital license, a licensed nursing home administrator is not required.

51.38(4) *Long-term care service equipment and supplies.* The equipment and supplies required for the hospital's long-term care service shall be the same as required by Iowa Code chapter 135C and the rules promulgated under its authority for the category of health care facility involved.

51.38(5) *Long-term care service space.* The space requirements for the various areas and resident rooms of the hospital's long-term care service shall be the same as required by Iowa Code chapter 135C and the rules promulgated under its authority for the category of health care facility involved.

481—51.39(135B) Penalty and enforcement. See Iowa Code sections 135B.14 to 135B.16.

481—51.40(135B) Validity of rules. If any provision of these rules or the application thereof to any person or circumstances shall be held invalid, such validity shall not affect the provisions or application of these rules which can be given effect without the invalid provision or application, and to this end the provisions of these rules are declared to be severable.

481—51.41 to **51.49** Reserved.

481—51.50(135B) Minimum standards for construction.

51.50(1) *Minimum standards.* Hospitals and off-site premises licensed under this chapter shall be built in accordance with the following construction standards.

a. Construction shall be in accordance with the standards set forth in Part 2 and other applicable provisions of the Guidelines for Design and Construction of Health Care Facilities, 2010 edition, produced by the Facility Guidelines Institute.

Existing hospitals and off-site premises built in compliance with prior editions of the hospital construction guidelines will be deemed in compliance with subsequent regulations, with the exception of any new renovations, additions, functional alterations, or changes in utilization to existing facilities, which shall meet the standards specified in this subrule.

b. In jurisdictions without a local building code enforcement program, the construction shall be in conformance with the state building code, as authorized by Iowa Code section 103A.7, in effect at the time of plan submittal for review and approval. In jurisdictions with a local building code enforcement program, local building code enforcement must include both the adoption and enforcement of a local building code through plan reviews and inspections.

A hospital or off-site premises that is required to meet the provisions of the state building code shall be deemed to be in compliance with the fire safety requirements of the state building code if the hospital or off-site premises is in compliance with the provisions of rule 661—205.5(100). In any case in which an applicable requirement of the Life Safety Code, 2000 edition, is inconsistent with an applicable requirement of the state building code, the hospital shall be deemed to be in compliance with the state building code requirement if the Life Safety Code requirement is met.

Rule 661—301.5(103A) shall not be applicable to hospitals and other structures required under this chapter to meet the provisions of the state building code.

c. The design and construction of a hospital or off-site premises shall be in conformance with NFPA 101: Life Safety Code 2000 as published by the National Fire Protection Association.

51.50(2) *Submission of construction documents.*

a. Submissions of architectural technical documents, engineering documents, and plans and specifications to the building code commissioner are the responsibility of the owner of the building or facility, although the actual submission may be completed by an authorized agent of the owner or the responsible design professional.

b. "Responsible design professional" means a registered architect or licensed professional engineer who signs the documents submitted.

c. Plans, specifications and other supporting information shall be sufficiently clear and complete to show in detail that the proposed work will comply with the requirements of the applicable provisions of the state building code.

d. In section 107.2.5 of the International Building Code, 2009 edition, the word "permit" shall be replaced by the words "plan review."

e. Submittals to the commissioner shall be certified or stamped and signed as required by Iowa Code chapters 542B and 544A unless the applicant has certified on the submittal to the applicability of a specific exception under Iowa Code section 544A.18 and the submittal does not constitute the practice of professional engineering as defined by Iowa Code section 542B.2.

f. The responsible design professional shall certify that the building plans meet the requirements specified in subrule 51.50(1), unless a variance has been granted pursuant to subrule 51.50(3).

51.50(3) *Variances.* The director of the department may grant variances to building and construction guidelines as contained in the 2010 edition of the Guidelines for Design and Construction of Health Care Facilities. The hospital or off-site premises must submit a variance request in writing to the director. The request must demonstrate how patient safety and the quality of care offered will not be compromised by the variance. The facility must demonstrate its ability to completely fulfill all other requirements of the service. The director shall make a written determination of the request. In determining whether a variance request shall be granted, the director shall give consideration to the following conditions and to any other conditions the director deems relevant:

a. The design and planning for the specific property shall offer improved or compensating features which provide equivalent desirability and utility;

b. Alternate or special construction methods, techniques, and mechanical equipment shall offer equivalent durability; utility; safety; structural strength and rigidity; sanitation; odor control; protection from corrosion, decay and insect attack; and quality of workmanship;

c. The health, safety or welfare of any patient shall not be endangered;

d. The variance shall be limited to the specific project under consideration and shall not be construed as establishing a precedent for similar acceptance in other cases;

e. Occupancy and function of the building shall be considered; and

f. The type of licensing shall be considered.

[**ARC 9251B**, IAB 12/1/10, effective 1/5/11]

481—51.51(135B) Minimum standards for construction after July 8, 1998, and prior to May 22, 2002. Rescinded IAB 12/1/10, effective 1/5/11.

481—51.52(135B) Minimum standards for construction after May 22, 2002. Rescinded IAB 12/1/10, effective 1/5/11.

481—51.53(135B) Critical access hospitals. Critical access hospitals shall meet the following criteria:

51.53(1) The hospital shall be no less than 35 miles from another hospital or no less than 15 miles over secondary roads or shall be designated by the department of public health as a necessary provider of health care prior to January 1, 2006.

51.53(2) The hospital shall be a public or nonprofit hospital and shall be located in a county in a rural area. Rural counties do not include Black Hawk, Johnson, Linn, Polk, Pottawattamie, Scott and Woodbury Counties. All other counties are considered to be in rural areas for purposes of this subrule.

51.53(3) The hospital shall provide 24-hour emergency care services as described in 481 IAC 51.30(135B).

51.53(4) The hospital shall maintain no more than 25 acute care inpatient beds. However, if the hospital provides inpatient psychiatric services in a distinct part unit or inpatient rehabilitation services in a distinct part unit, no more than 10 beds shall be maintained in the distinct part unit. The beds in the distinct part unit are excluded from the 25 inpatient-bed count limit specified in 42 CFR 485.620(a).

51.53(5) The hospital shall meet the Medicare conditions of participation as a critical access hospital as described in 42 CFR Part 485, Subpart F, as of October 1, 2004.

51.53(6) The hospital shall continue to comply with all general hospital license requirements as defined in 481 IAC 51.

51.53(7) The department shall recognize, in lieu of its own inspection, the comparable inspections and inspections findings of The Joint Commission (JC), the American Osteopathic Association (AOA), or Det Norske Veritas (DNV) if the department is provided with copies of all requested materials relating to the inspections and the inspection process.

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◊ Two or more ARCs

[1] Hospital Protocol for Donor Requests as it appeared in IAC 641—Chapter 180 prior to 4/4/90.

CHAPTER 23
EMISSION STANDARDS FOR CONTAMINANTS

[Prior to 7/1/83, DEQ Ch 4]
[Prior to 12/3/86, Water, Air and Waste Management[900]]

567—23.1(455B) Emission standards.

23.1(1) *In general.* The federal standards of performance for new stationary sources (new source performance standards) shall be applicable as specified in subrule 23.1(2). The federal standards for hazardous air pollutants (national emission standards for hazardous air pollutants) shall be applicable as specified in subrule 23.1(3). The federal standards for hazardous air pollutants for source categories (national emission standards for hazardous air pollutants for source categories) shall be applicable as specified in subrule 23.1(4). The federal emission guidelines (emission guidelines) shall be applicable as specified in subrule 23.1(5). Compliance with emission standards specified elsewhere in this chapter shall be in accordance with 567—Chapter 21.

23.1(2) *New source performance standards.* The federal standards of performance for new stationary sources, as defined in 40 Code of Federal Regulations Part 60 as amended or corrected through October 8, 2009, are adopted by reference, except § 60.530 through § 60.539b (Part 60, Subpart AAA), and shall apply to the following affected facilities. The corresponding 40 CFR Part 60 subpart designation is in parentheses. Reference test methods (Appendix A), performance specifications (Appendix B), determination of emission rate change (Appendix C), quality assurance procedures (Appendix F) and the general provisions (Subpart A) of 40 CFR Part 60 also apply to the affected facilities.

a. *Fossil fuel-fired steam generators.* A fossil fuel-fired steam generating unit of more than 250 million Btu heat input for which construction, reconstruction, or modification is commenced after August 17, 1971. Any facility covered under paragraph *"z"* is not covered under this paragraph. (Subpart D)

b. *Incinerators.* An incinerator of more than 50 tons per day charging rate. (Subpart E)

c. *Portland cement plants.* Any of the following in a Portland cement plant: kiln; clinker cooler; raw mill system; finish mill system; raw mill dryer; raw material storage; clinker storage; finished product storage; conveyor transfer points; bagging and bulk loading and unloading systems. (Subpart F)

d. *Nitric acid plants.* A nitric acid production unit. (Subpart G)

e. *Sulfuric acid plants.* A sulfuric acid production unit. (Subpart H)

f. *Asphalt concrete plants.* An asphalt concrete plant. (Subpart I)

g. *Petroleum refineries.* Any of the following at a petroleum refinery: fluid catalytic cracking unit catalyst regenerator; fluid catalytic cracking unit incinerator-waste heat boilers; fuel gas combustion devices; and claus sulfur recovery plants greater than 20 long tons per day. (Subpart J)

h. *Secondary lead smelters.* Any of the following in a secondary lead smelter: pot furnaces of more than 250 kilograms (550 pounds) charging capacity; blast (cupola) furnaces; and reverberatory furnaces. (Subpart L)

i. *Secondary brass and bronze ingot production plants.* Any of the following at a secondary brass and bronze ingot production plant; reverberatory and electric furnaces of 1000/kilograms (2205 pounds) or greater production capacity and blast (cupola) furnaces of 250 kilograms per hour (550 pounds per hour) or greater production capacity. (Subpart M)

j. *Iron and steel plants.* A basic oxygen process furnace. (Subpart N)

k. *Sewage treatment plants.* An incinerator which burns the sludge produced by municipal sewage treatment plants. (Subpart O of 40 CFR 60 and Subpart E of 40 CFR 503.)

l. *Steel plants.* Either of the following at a steel plant: electric arc furnaces and dust-handling equipment, the construction, modification, or reconstruction of which commenced after October 21, 1974, and on or before August 17, 1983. (Subpart AA)

m. *Primary copper smelters.* Any of the following at a primary copper smelter: dryer, roaster, smelting furnace and copper converter. (Subpart P)

n. *Primary zinc smelters.* Either of the following at a primary zinc smelter: a roaster or a sintering machine. (Subpart Q)

o. Primary lead smelter. Any of the following at a primary lead smelter: sintering machine, sintering machine discharge end, blast furnace, dross reverberatory furnace, converter and electric smelting furnace. (Subpart R)

p. Primary aluminum reduction plants. Either of the following at a primary aluminum reduction plant: potroom groups and anode bake plants. (Subpart S)

q. Wet process phosphoric acid plants in the phosphate fertilizer industry. A wet process phosphoric acid plant, which includes any combination of the following: reactors, filters, evaporators and hotwells. (Subpart T)

r. Superphosphoric acid plants in the phosphate fertilizer industry. A superphosphoric acid plant which includes any combination of the following: evaporators, hotwells, acid sumps, and cooling tanks. (Subpart U)

s. Diammonium phosphate plants in the phosphate fertilizer industry. A granular diammonium phosphate plant which includes any combination of the following: reactors, granulators, dryers, coolers, screens and mills. (Subpart V)

t. Triple super phosphate plants in the phosphate fertilizer industry. A triple super phosphate plant which includes any combination of the following: mixers, curing belts (dens), reactors, granulators, dryers, cookers, screens, mills and facilities which store run-of-pile triple superphosphate. (Subpart W)

u. Granular triple superphosphate storage facilities in the phosphate fertilizer industry. A granular triple superphosphate storage facility which includes any combination of the following: storage or curing piles, conveyors, elevators, screens and mills. (Subpart X)

v. Coal preparation plants. Any of the following at a coal preparation plant which processes more than 200 tons per day: thermal dryers; pneumatic coal cleaning equipment (air tables); coal processing and conveying equipment (including breakers and crushers); coal storage systems; and coal transfer and loading systems. (Subpart Y)

w. Ferroalloy production. Any of the following: electric submerged arc furnaces which produce silicon metal, ferrosilicon, calcium silicon, silicomanganese zirconium, ferrochrome silicon, silvery iron, high-carbon ferrochrome, charge chrome, standard ferromanganese, silicomanganese, ferromanganese silicon, or calcium carbide; and dust-handling equipment. (Subpart Z)

x. Kraft pulp mills. Any of the following in a kraft pulp mill: digester system; brown stock washer system; multiple effect evaporator system; black liquor oxidation system; recovery furnace; smelt dissolving tank; lime kiln; and condensate stripper system. In pulp mills where kraft pulping is combined with neutral sulfite semichemical pulping, the provisions of the standard of performance are applicable when any portion of the material charged to an affected facility is produced by the kraft pulping operation. (Subpart BB)

y. Lime manufacturing plants. A rotary lime kiln or a lime hydrator used in the manufacture of lime at other than a kraft pulp mill. (Subpart HH)

z. Electric utility steam generating units. An electric utility steam generating unit that is capable of combusting more than 250 million Btus per hour (73 megawatts) heat input of fossil fuel for which construction or modification or reconstruction is commenced after September 18, 1978, or an electric utility combined cycle gas turbine that is capable of combusting more than 250 million Btus per hour (73 megawatts) heat input. "Electric utility steam generating unit" means any steam electric generating unit that is constructed for the purpose of supplying more than one-third of its potential electric output capacity and more than 25 MW net-electrical output to any utility power distribution system for sale. Also, any steam supplied to a steam distribution system for the purpose of providing steam to a steam electric generator that would produce electrical energy for sale is considered in determining the electrical energy output capacity of the affected facility. (Subpart Da)

aa. Stationary gas turbines. Any simple cycle gas turbine, regenerative cycle gas turbine or any gas turbine portion of a combined cycle steam/electric generating system that is not self-propelled. It may, however, be mounted on a vehicle for portability. (Subpart GG)

bb. Petroleum storage vessels. Unless exempted, any storage vessel for petroleum liquids for which the construction, reconstruction, or modification commenced after June 11, 1973, and prior to May 19, 1978, having a storage capacity greater than 151,412 liters (40,000 gallons). (Subpart K)

cc. Petroleum storage vessels. Unless exempted, any storage vessel for petroleum liquids for which the construction, reconstruction, or modification commenced after May 18, 1978, and prior to July 23, 1984, having a storage capacity greater than 151,416 liters (40,000 gallons). (Subpart Ka)

dd. Glass manufacturing plants. Any glass melting furnace. (Subpart CC)

ee. Automobile and light-duty truck surface coating operations at assembly plants. Any of the following in an automobile or light-duty truck assembly plant: prime coat operations, guide coat operations, and topcoat operations. (Subpart MM)

ff. Ammonium sulfate manufacture. Any of the following in the ammonium sulfate industry: ammonium sulfate dryers in the caprolactam by-product, synthetic, and coke oven by-product sectors of the industry. (Subpart PP)

gg. Surface coating of metal furniture. Any metal furniture surface coating operation in which organic coatings are applied. (Subpart EE)

hh. Lead-acid battery manufacturing plants. Any lead-acid battery manufacturing plant which uses any of the following: grid casting, paste mixing, three-process operation, lead oxide manufacturing, lead reclamation, other lead-emitting operations. (Subpart KK)

ii. Phosphate rock plants. Any phosphate rock plant which has a maximum plant production capacity greater than four tons per hour including the following: dryers, calciners, grinders, and ground rock handling and storage facilities, except those facilities producing or preparing phosphate rock solely for consumption in elemental phosphorus production. (Subpart NN)

jj. Graphic arts industry. Publication rotogravure printing. Any publication rotogravure printing press except proof presses. (Subpart QQ)

kk. Industrial surface coating — large appliances. Any surface coating operation in a large appliance surface coating line. (Subpart SS)

ll. Metal coil surface coating. Any of the following at a metal coil surface coating operation: prime coat operation, finish coat operation, and each prime and finish coat operation combined when the finish coat is applied wet-on-wet over the prime coat and both coatings are cured simultaneously. (Subpart TT)

mm. Asphalt processing and asphalt roofing manufacturing. Any saturator, mineral handling and storage facility at asphalt roofing plants; and any asphalt storage tank and any blowing still at asphalt processing plants, petroleum refineries, and asphalt roofing plants. (Subpart UU)

nn. Equipment leaks of volatile organic compounds (VOC) in the synthetic organic chemicals manufacturing industry. Standards for affected facilities in the synthetic organic chemicals manufacturing industry (SOCMI) that commenced construction, reconstruction, or modification after January 5, 1981, and on or before November 7, 2006, are set forth in Subpart VV. Standards for affected SOCMI facilities that commenced construction, reconstruction or modification after November 7, 2006, are set forth in Subpart VVa. The standards apply to pumps, compressors, pressure relief devices, sampling systems, open-ended valves or lines (OEL), valves, and flanges or other connectors which handle VOC. (Subpart VV and Subpart VVa)

oo. Beverage can surface coating. Any beverage can surface coating lines for two-piece steel or aluminum containers in which soft drinks or beer are sold. (Subpart WW)

pp. Bulk gasoline terminals. The total of all loading racks at bulk gasoline terminals which deliver liquid product into gasoline tank trucks. (Subpart XX)

qq. Pressure sensitive tape and label surface coating operations. Any coating line used in the tape manufacture of pressure sensitive tape and label materials. (Subpart RR)

rr. Metallic mineral processing plants. Any ore processing and handling equipment. (Subpart LL)

ss. Synthetic fiber production facilities. Any solvent-spun synthetic fiber process that produces more than 500 megagrams of fiber per year. (Subpart HHH)

tt. Equipment leaks of VOC in petroleum refineries. A compressor and all equipment (defined in 40 CFR, Part 60.591) within a process unit for which the construction, reconstruction, or modification commenced after January 4, 1983. (Subpart GGG)

uu. Flexible vinyl and urethane coating and printing. Each rotogravure printing line used to print or coat flexible vinyl or urethane products. (Subpart FFF)

vv. Petroleum dry cleaners. Petroleum dry-cleaning plant with a total manufacturer's rated dryer capacity equal to or greater than 38 kilograms (84 pounds): petroleum solvent dry-cleaning dryers, washers, filters, stills, and settling tanks. (Subpart JJJ)

ww. Electric arc furnaces and argon-oxygen decarburization vessels constructed after August 17, 1983. Steel plants that produce carbon, alloy, or specialty steels: electric arc furnaces, argon-oxygen decarburization vessels, and dust-handling systems. (Subpart AAa)

xx. Wool fiberglass insulation manufacturing plants. Rotary spin wool fiberglass manufacturing line. (Subpart PPP)

yy. Iron and steel plants. Secondary emissions from basic oxygen process steelmaking facilities for which construction, reconstruction, or modification commenced after January 20, 1983. (Subpart Na)

zz. Equipment leaks of VOC from on-shore natural gas processing plants. A compressor and all equipment defined in 40 CFR, Part 60.631, unless exempted, for which construction, reconstruction, or modification commenced after January 20, 1984. (Subpart KKK)

aaa. On-shore natural gas processing: SO2 emissions. Unless exempted, each sweetening unit and each sweetening unit followed by a sulfur recovery unit for which construction, reconstruction, or modification commenced after January 20, 1984. (Subpart LLL)

bbb. Nonmetallic mineral processing plants. Unless exempted, each crusher, grinding mill, screening operation, bucket elevator, belt conveyor, bagging operation, storage bin, enclosed truck or rail car loading station in fixed or portable nonmetallic mineral processing plants for which construction, reconstruction, or modification commenced after August 31, 1983. (Subpart OOO)

ccc. Industrial-commercial-institutional steam generating units. Unless exempted, each steam generating unit for which construction, reconstruction, or modification commenced after June 19, 1984, and which has a heat input capacity of more than 100 million Btu/hour. (Subpart Db)

ddd. Volatile organic liquid storage vessels. Unless exempted, volatile organic liquid storage vessels for which construction, reconstruction, or modification commenced after July 23, 1984. (Subpart Kb)

eee. Rubber tire manufacturing plants. Unless exempted, each undertread cementing operation, each sidewall cementing operation, each tread end cementing operation, each bead cementing operation, each green tire spraying operation, each Michelin-A operation, each Michelin-B operation, and each Michelin-C automatic operation that commences construction or modification after January 20, 1983. (Subpart BBB)

fff. Industrial surface coating: surface coating of plastic parts for business machines. Each spray booth in which plastic parts for use in the manufacture of business machines receive prime coats, color coats, texture coats, or touch-up coats for which construction, modification, or reconstruction begins after January 8, 1986. (Subpart TTT)

ggg. VOC emissions from petroleum refinery wastewater systems. Each individual drain system, each oil-water separator, and each aggregate facility for which construction, modification or reconstruction is commenced after May 4, 1987. (Subpart QQQ)

hhh. Magnetic tape coating facilities. Unless exempted, each coating operation and each piece of coating mix preparation equipment for which construction, modification, or reconstruction is commenced after January 22, 1986. (Subpart SSS)

iii. Polymeric coating of supporting substrates. Unless exempted, each coating operation and any on-site coating mix preparation equipment used to prepare coatings for the polymeric coating of supporting substrates for which construction, modification, or reconstruction begins after April 30, 1987. (Subpart VVV)

jjj. VOC emissions from synthetic organic chemical manufacturing industry air oxidation unit processes. Unless exempted, any air oxidation reactor, air oxidation reactor and recovery system or combination of two or more reactors and the common recovery system used in the production of any of the chemicals listed in 40 CFR §60.617 for which construction, modification or reconstruction commenced after October 21, 1983. (Subpart III)

kkk. VOC emissions from synthetic organic chemical manufacturing industry distillation operations. Unless exempted, any distillation unit, distillation unit and recovery system or combination

of two or more distillation units and the common recovery system used in the production of any of the chemicals listed in 40 CFR §60.667 for which construction, modification or reconstruction commenced after December 30, 1983. (Subpart NNN)

lll. Small industrial-commercial-institutional steam generating units. Each steam generating unit for which construction, modification, or reconstruction is commenced after June 9, 1989, and that has a maximum design heat input capacity of 100 million Btu per hour or less, but greater than or equal to 10 million Btu per hour. (Subpart Dc)

mmm. VOC emissions from the polymer manufacturing industry. Each of the following process sections in the manufacture of polypropylene and polyethylene—raw materials preparation, polymerization reaction, material recovery, product finishing, and product storage; each material recovery section of polystyrene manufacturing using a continuous process; each polymerization reaction section of poly(ethylene terephthalate) manufacturing using a continuous process; each material recovery section of poly(ethylene terephthalate) manufacturing using a continuous process that uses dimethyl terephthalate; each raw material section of poly(ethylene terephthalate) manufacturing using a continuous process that uses terephthalic acid; and each group of fugitive emissions equipment within any process unit in the manufacturing of polypropylene, polyethylene, or polystyrene (including expandable polystyrene). The applicability date for construction, modification or reconstruction for polystyrene and poly(ethylene terephthalate) affected facilities and some polypropylene and polyethylene affected facilities is September 30, 1987. For the other polypropylene and polyethylene affected facilities the applicability date for these regulations is January 10, 1989. (Subpart DDD)

nnn. Municipal waste combustors. Unless exempted, a municipal waste combustor with a capacity greater than 225 megagrams per day of municipal solid waste for which construction is commenced after December 20, 1989, and on or before September 20, 1994, and modification or reconstruction is commenced after December 20, 1989, and on or before June 19, 1996. (Subpart Ea)

ooo. Grain elevators. A grain terminal elevator or any grain storage elevator except as provided under 40 CFR 60.304(b), August 31, 1993. A grain terminal elevator means any grain elevator which has a permanent storage capacity of more than 2.5 million U.S. bushels except those located at animal food manufacturers, pet food manufacturers, cereal manufacturers, breweries, and livestock feedlots. A grain storage elevator means any grain elevator located at any wheat flour mill, wet corn mill, dry corn mill (human consumption), rice mill, or soybean oil extraction plant which has a permanent grain storage capacity of 1 million bushels. Any construction, modification, or reconstruction after August 3, 1978, is subject to this paragraph. (Subpart DD)

ppp. Mineral processing plants. Each calciner and dryer at a mineral processing plant unless excluded for which construction, modification, or reconstruction is commenced after April 23, 1986. (Subpart UUU)

qqq. VOC emissions from synthetic organic chemical manufacturing industry reactor processes. Unless exempted, each affected facility that is part of a process unit that produces any of the chemicals listed in 40 CFR §60.707 as a product, coproduct, by-product, or intermediate for which construction, modification, or reconstruction commenced after June 29, 1990. Affected facility is each reactor process not discharging its vent stream into a recovery system, each combination of a reactor process and the recovery system into which its vent stream is discharged, or each combination of two or more reactor processes and the common recovery system into which their vent streams are discharged. (Subpart RRR)

rrr. Municipal solid waste landfills, as defined by 40 CFR 60.751. Each municipal solid waste landfill that commenced construction, reconstruction or modification or began accepting waste on or after May 30, 1991, must comply. (Subpart WWW)

sss. Municipal waste combustors. Unless exempted, a municipal waste combustor with a combustion capacity greater than 250 tons per day of municipal solid waste for which construction, modification or reconstruction is commenced after September 20, 1994, or for which modification or reconstruction is commenced after June 19, 1996. (Subpart Eb)

ttt. Hospital/medical/infectious waste incinerators. Unless exempted, a hospital/medical/infectious waste incinerator for which construction is commenced after June 20, 1996, or for which modification is commenced after March 16, 1998. (Subpart Ec)*

*As of November 24, 2010, the adoption by reference of Part 60 Subpart Ec is rescinded.

uuu. New small municipal waste combustion units. Unless exempted, this standard applies to a small municipal waste combustion unit that commenced construction after August 30, 1999, or small municipal waste combustion units that commenced reconstruction or modification after June 6, 2001. (Part 60, Subpart AAAA)

vvv. Commercial and industrial solid waste incineration. Unless exempted, this standard applies to units for which construction is commenced after November 30, 1999, or for which modification or reconstruction is commenced on or after June 1, 2001. (Part 60, Subpart CCCC)

www. Other solid waste incineration (OSWI) units. Unless exempted, this standard applies to other solid waste incineration (OSWI) units for which construction is commenced after December 9, 2004, or for which modification or reconstruction is commenced on or after June 16, 2006. (Part 60, Subpart EEEE)

xxx. Reserved.

yyy. Stationary compression ignition internal combustion engines. Unless otherwise exempted, these standards apply to each stationary compression ignition internal combustion engine whose construction, modification or reconstruction commenced after July 11, 2005. (Part 60, Subpart IIII)

zzz. Stationary spark ignition internal combustion engines. These standards apply to each stationary spark ignition internal combustion engine whose construction, modification or reconstruction commenced after June 12, 2006. (Part 60, Subpart JJJJ)

aaaa. Stationary combustion turbines. Unless otherwise exempted, these standards apply to stationary combustion turbines with a heat input at peak load equal to or greater than 10 MMBtu per hour, based on the higher heating value of the fuel, that commence construction, modification, or reconstruction after February 18, 2005. (Part 60, Subpart KKKK)

23.1(3) *Emission standards for hazardous air pollutants.* The federal standards for emissions of hazardous air pollutants, 40 Code of Federal Regulations Part 61 as amended or corrected through May 16, 2007, and 40 CFR Part 503 as adopted on August 4, 1999, are adopted by reference, except 40 CFR §61.20 to §61.26, §61.90 to §61.97, §61.100 to §61.108, §61.120 to §61.127, §61.190 to §61.193, §61.200 to §61.205, §61.220 to §61.225, and §61.250 to §61.256, and shall apply to the following affected pollutants and facilities and activities listed below. The corresponding 40 CFR Part 61 subpart designation is in parentheses. Reference test methods (Appendix B), compliance status information requirements (Appendix A), quality assurance procedures (Appendix C) and the general provisions (Subpart A) of Part 61 also apply to the affected activities or facilities.

a. Asbestos. Any of the following involves asbestos emissions: asbestos mills, surfacing of roadways, manufacturing operations, fabricating, insulating, waste disposal, spraying applications and demolition and renovation operations. (Subpart M)

b. Beryllium. Any of the following stationary sources: beryllium extraction plants, ceramic plants, foundries, incinerators, and propellant plants which process beryllium ore, beryllium oxide, beryllium alloys, or beryllium-containing waste; and machine shops which process beryllium, beryllium oxides, or any alloy when such alloy contains more than 5 percent beryllium by weight. (Subpart C)

c. Beryllium rocket motor firing. Rocket motor test sites. (Subpart D)

d. Mercury. Any of the following involving mercury emissions: mercury ore processing facilities, mercury cell chlor-alkali plants, sludge incineration plants, sludge drying plants, and a combination of sludge incineration plants and sludge drying plants. (Subpart E)

e. Vinyl chloride. Ethylene dichloride purification and the oxychlorination reactor in ethylene dichloride plants. Vinyl chloride formation and purification in vinyl chloride plants. Any of the following involving polyvinyl chloride plants: reactor; stripper; mixing, weighing, and holding containers; monomer recovery system; sources following the stripper(s). Any of the following involving ethylene dichloride, vinyl chloride, and polyvinyl chloride plants: relief valve discharge; fugitive emission sources. (Subpart F)

f. Equipment leaks of benzene (fugitive emission sources). Any pumps, compressors, pressure relief devices, sampling connection systems, open-ended valves or lines, valves, flanges and other connectors, product accumulator vessels, and control devices or systems which handle benzene. (Subpart J)

g. Equipment leaks of volatile hazardous air pollutants (fugitive emission sources). Any pumps, compressors, pressure relief devices, sampling connection systems, open-ended valves or lines, valves, flanges and other connectors, product accumulator vessels, and control devices or systems which handle volatile hazardous air pollutants. (Subpart V)

h. Inorganic arsenic emissions from arsenic trioxide and metallic arsenic production facilities. Each metallic arsenic production plant and each arsenic trioxide plant that processes low-grade arsenic bearing materials by a roasting condensation process. (Subpart P)

i. Inorganic arsenic emissions from glass manufacturing plants. Each glass melting furnace (except pot furnaces) that uses commercial arsenic as a raw material. (Subpart N)

j. Inorganic arsenic emissions from primary copper smelters. Each copper converter at any new or existing primary copper smelter except as noted in 40 CFR §61.172(a). (Subpart O)

k. Benzene emissions from coke by-product recovery plants. Each of the following sources at furnace and foundry coke by-product recovery plants: tar decanters, tar storage tanks, tar-intercepting sumps, flushing-liquor circulation tanks, light-oil sumps, light-oil condensers, light-oil decanters, wash-oil decanters, wash-oil circulation tanks, naphthalene processing, final coolers, final-cooler cooling towers, and the following equipment that is intended to operate in benzene service: pumps, valves, exhausters, pressure relief devices, sampling connection systems, open-ended valves or lines, flanges or other connectors, and control devices or systems required by 40 CFR §61.135.

The provisions of this subpart also apply to benzene storage tanks, BTX storage tanks, light-oil storage tanks, and excess ammonia-liquor storage tanks at furnace coke by-product recovery plants. (Subpart L)

l. Benzene emissions from benzene storage vessels. Unless exempted, each storage vessel that is storing benzene having a specific gravity within the range of specific gravities specified in ASTM D 836-84 for Industrial Grade Benzene, ASTM D 835-85 for Refined Benzene-485, ASTM D 2359-85a for Refined Benzene-535, and ASTM D 4734-87 for Refined Benzene-545. These specifications are incorporated by reference as specified in 40 CFR §61.18. (Subpart Y)

m. Benzene emissions from benzene transfer operations. Unless exempted, the total of all loading racks at which benzene is loaded into tank trucks, rail cars, or marine vessels at each benzene production facility and each bulk terminal. (Subpart BB)

n. Benzene waste operations. Unless exempted, the provisions of this subrule apply to owners and operators of chemical manufacturing plants, coke by-product recovery plants, petroleum refineries, and facilities at which waste management units are used to treat, store, or dispose of waste generated by any of these listed facilities. (Subpart FF)

23.1(4) *Emission standards for hazardous air pollutants for source categories.* The federal standards for emissions of hazardous air pollutants for source categories, 40 Code of Federal Regulations Part 63 as amended or corrected through March 3, 2010, are adopted by reference, except those provisions which cannot be delegated to the states. The corresponding 40 CFR Part 63 subpart designation is in parentheses. An earlier date for adoption by reference may be included with the subpart designation in parentheses. 40 CFR Part 63, Subpart B, incorporates the requirements of Clean Air Act Sections 112(g) and 112(j) and does not adopt standards for a specific affected facility. Test methods (Appendix A), sources defined for early reduction provisions (Appendix B), and determination of the fraction biodegraded (F_{bio}) in the biological treatment unit (Appendix C) of Part 63 also apply to the affected activities or facilities. For the purposes of this subrule, "hazardous air pollutant" has the same meaning found in 567—22.100(455B). For the purposes of this subrule, a "major source" means any stationary source or group of stationary sources located within a contiguous area and under common control that emits or has the potential to emit, considering controls, in the aggregate, 10 tons per year or more of any hazardous air pollutant or 25 tons per year or more of any combination of hazardous air pollutants, unless a lesser quantity is established, or in the case of radionuclides, where

different criteria are employed. For the purposes of this subrule, an "area source" means any stationary source of hazardous air pollutants that is not a "major source" as defined in this subrule. Paragraph 23.1(4)*"a,"* general provisions (Subpart A) of Part 63, shall apply to owners or operators who are subject to subsequent subparts of 40 CFR Part 63 (except when otherwise specified in a particular subpart or in a relevant standard) as adopted by reference below.

a. General provisions. General provisions apply to owners or operators of affected activities or facilities except when otherwise specified in a particular subpart or in a relevant standard. (Subpart A)

b. Requirements for control technology determinations for major sources in accordance with Clean Air Act Sections 112(g) and 112(j). (40 CFR Part 63, Subpart B)

(1) Section 112(g) requirements. For the purposes of this subparagraph, the definitions shall be the same as the definitions found in 40 CFR 63.2 and 40 CFR 63.41 as amended through December 27, 1996. The owner or operator of a new or reconstructed major source of hazardous air pollutants must apply maximum achievable control technology (MACT) for new sources to the new or reconstructed major source. If the major source in question has been specifically regulated or exempted from regulation under a standard issued pursuant to Section 112(d), Section 112(h), or Section 112(j) of the Clean Air Act and incorporated in another subpart of 40 CFR Part 63, excluded in 40 CFR 63.40(e) and (f), or the owner or operator of such major source has received all necessary air quality permits for such construction or reconstruction project before June 29, 1998, then the major source in question is not subject to the requirements of this subparagraph. The owner or operator of an affected source shall apply for a construction permit as required in 567—paragraph 22.1(1)*"b."* The construction permit application shall contain an application for a case-by-case MACT determination for the major source.

(2) Section 112(j) requirements. The owner or operator of a new or existing major source of hazardous air pollutants which includes one or more stationary sources included in a source category or subcategory for which the U.S. Environmental Protection Agency has failed to promulgate an emission standard within 18 months of the deadline established under CAA 112(d) must submit a MACT application (Parts 1 and 2) in accordance with the provisions of 40 CFR 63.52, as amended through April 5, 2002, by the CAA Section 112(j) deadline. In addition, the owner or operator of a new emission unit may submit an application for a Notice of MACT Approval before construction, as defined in 40 CFR 63.41, in accordance with the provisions of 567—paragraph 22.1(3)*"a."*

c. Reserved.

d. Compliance extensions for early reductions of hazardous air pollutants. Compliance extensions for early reductions of hazardous air pollutants are available to certain owners or operators of an existing source who wish to obtain a compliance extension from a standard issued under Section 112(d) of the Act. (Subpart D)

e. Reserved.

f. Emission standards for organic hazardous air pollutants from the synthetic chemical manufacturing industry. These standards apply to chemical manufacturing process units that are part of a major source. These standards include applicability provisions, definitions and other general provisions that are applicable to Subparts F, G, and H of 40 CFR 63. (Subpart F)

g. Emission standards for organic hazardous air pollutants from the synthetic organic chemical manufacturing industry for process vents, storage vessels, transfer operations, and wastewater. These standards apply to all process vents, storage vessels, transfer racks, and wastewater streams within a source subject to Subpart F of 40 CFR 63. (Subpart G)

h. Emission standards for organic hazardous air pollutants for equipment leaks. These standards apply to emissions of designated organic hazardous air pollutants from specified processes that are located at a plant site that is a major source. Affected equipment includes: pumps, compressors, agitators, pressure relief devices, sampling connection systems, open-ended valves or lines, valves, connectors, surge control vessels, bottoms receivers, instrumentation systems and control devices or systems required by this subpart that are intended to operate in organic hazardous air pollutant service 300 hours or more during the calendar year within a source subject to the provisions of a specific subpart in 40 CFR Part 63. In organic hazardous air pollutant or in organic HAP service means that a piece of equipment either contains or contacts a fluid (liquid or gas) that is at least 5 percent by weight

of total organic HAPs as determined according to the provisions of 40 CFR Part 63.161. The provisions of 40 CFR Part 63.161 also specify how to determine that a piece of equipment is not in organic HAP service. (Subpart H)

i. Emission standards for organic hazardous air pollutants for certain processes subject to negotiated regulation for equipment leaks. These standards apply to emissions of designated organic hazardous air pollutants from specified processes (defined in 40 CFR 63.190) that are located at a plant site that is a major source. Subject equipment includes pumps, compressors, agitators, pressure relief devices, sampling connection systems, open-ended valves or lines, valves, connectors, and instrumentation systems at certain source categories. These standards establish the applicability of Subpart H for sources that are not classified as synthetic organic chemical manufacturing industries. (Subpart I)

j. Emission standards for hazardous air pollutants for polyvinyl chloride and copolymers production. This standard applies to a polyvinyl chloride (PVC) or copolymer production facility that is located at, or is part of, a major source of hazardous air pollutant (HAP) emissions. (Part 63, Subpart J)

k. Reserved.

l. Emission standards for coke oven batteries. These standards apply to existing coke oven batteries, including by-product and nonrecovery coke oven batteries and to new coke oven batteries, or as defined in the subpart. (Subpart L)

m. Perchloroethylene air emission standards for dry cleaning facilities (40 CFR Part 63, Subpart M). These standards apply to the owner or operator of each dry cleaning facility that uses perchloroethylene (also known as perc). The specific standards applicable to dry cleaning facilities, including the compliance deadlines, are set out in the federal regulations contained in Subpart M. In general, dry cleaning facilities must meet the following requirements, which are set out in greater detail in Subpart M:

(1) New and existing major source dry cleaning facilities are required to control emissions to the level of the maximum achievable control technology (MACT).

(2) New and existing area source dry cleaning facilities are required to control emissions to the level achieved by generally available control technologies (GACT) or management practices.

(3) New area sources that are located in residential buildings and that commence operation after July 13, 2006, are prohibited from using perc.

(4) New area sources located in residential buildings that commenced operation between December 21, 2005, and July 13, 2006, must eliminate all use of perc by July 27, 2009.

(5) Existing area sources located in residential buildings must eliminate all use of perc by December 21, 2020.

(6) New area sources that are not located in residential buildings are prohibited from operating transfer machines.

(7) Existing area sources that are not located in residential buildings are prohibited from operating transfer machines after July 27, 2008.

(8) All sources must comply with the requirements in Subpart M for emissions control, equipment specifications, leak detection and repair, work practice standards, record keeping and reporting.

n. Emission standards for chromium emissions from hard and decorative chromium electroplating and chromium anodizing tanks. These standards limit the discharge of chromium compound air emissions from existing and new hard chromium electroplating, decorative chromium electroplating, and chromium anodizing tanks at major and area sources. (Subpart N)

o. Emission standards for hazardous air pollutants for ethylene oxide commercial sterilization and fumigation operations. New and existing major source ethylene oxide commercial sterilization and fumigation operations are required to control emissions to the level of the maximum achievable control technology (MACT). New and existing area source ethylene oxide commercial sterilization and fumigation operations are required to control emissions to the level achieved by generally available control technologies (GACT). Certain sources are exempt as described in 40 CFR 63.360. (Subpart O)

p. Emission standards for primary aluminum reduction plants. These standards apply to each new or existing potline, paste production plant, or anode bake furnace associated with a primary aluminum

reduction plant, and for each new pitch storage tank associated with a primary aluminum production plant, except existing furnaces not located on the same site as the primary aluminum reduction plant. (Subpart LL)

q. Emission standards for hazardous air pollutants for industrial process cooling towers. These standards apply to all new and existing industrial process cooling towers that are operated with chromium-based water treatment chemicals on or after September 8, 1994, and are either major sources or are integral parts of facilities that are major sources. (Subpart Q)

r. Emission standards for hazardous air pollutants for sources categories: gasoline distribution: (Stage 1). These standards apply to all existing and new bulk gasoline terminals and pipeline breakout stations that are major sources of hazardous air pollutants or are located at plant sites that are major sources. Bulk gasoline terminals and pipeline breakout stations located within a contiguous area or under common control with a refinery complying with 40 CFR Subpart CC are not subject to 40 CFR Subpart R standards. (Subpart R)

s. Emission standards for hazardous air pollutants for pulp and paper (noncombustion). These standards apply to pulping and bleaching process sources at kraft, soda, sulfite, and stand-alone semichemical pulp mills. Affected sources include pulp mills and integrated mills (mills that manufacture pulp and paper/paperboard) that chemically pulp wood fiber (using kraft, sulfite, soda, or semichemical methods); pulp secondary fiber; pulp nonwood fiber; and mechanically pulp wood fiber. (Subpart S)

t. Emission standards for hazardous air pollutants: halogenated solvent cleaning. These standards require batch vapor solvent cleaning machines and in-line solvent cleaning machines to meet emission standards reflecting the application of maximum achievable control technology (MACT) for major and area sources; area source batch cold cleaning machines are required to achieve generally available control technology (GACT). The subpart regulates the emissions of the following halogenated hazardous air pollutant solvents: methylene chloride, perchloroethylene, trichloroethylene, 1,1,1-trichloroethane, carbon tetrachloride, and chloroform. (Subpart T)

u. Emission standards for hazardous air pollutants: Group I polymers and resins. Applicable to existing and new major sources that emit organic HAP during the manufacture of one or more elastomers including but not limited to producers of butyl rubber, halobutyl rubber, epichlorohydrin elastomers, ethylene propylene rubber, Hypalon™, neoprene, nitrile butadiene rubber, nitrile butadiene latex, polybutadiene rubber/styrene butadiene rubber by solution, polysulfide rubber, styrene butadiene rubber by emulsion, and styrene butadiene latex. MACT is required for major sources. (Subpart U)

v. Reserved.

w. Emission standards for hazardous air pollutants for epoxy resins production and nonnylon polyamides production. These standards apply to all existing, new and reconstructed manufacturers of basic liquid epoxy resins and manufacturers of wet strength resins that are located at a plant site that is a major source. (Subpart W)

x. National emission standards for hazardous air pollutants from secondary lead smelting. These standards apply to all existing and new secondary lead smelters sources which use blast, reverberatory, rotary, or electric smelting furnaces for lead recovery of scrap lead that are located at major or area sources. The provisions apply to smelting furnaces, refining kettles, agglomerating furnaces, dryers, process fugitive sources, and fugitive dust. Excluded from the rule are primary lead smelters, lead refiners, and lead remelters. Hazardous air pollutants regulated under this standard include but are not limited to lead compounds, arsenic compounds, and 1,3-butadiene. (Subpart X)

y. Emission standards for marine tank vessel loading operations. This standard requires existing and new major sources to control emissions using maximum achievable control technology (MACT) to control hazardous air pollutants (HAP). (Subpart Y)

z. Reserved.

aa. Emission standards for hazardous air pollutants for phosphoric acid manufacturing. These standards apply to all new and existing major sources of phosphoric acid manufacturing. Affected processes include, but are not limited to, wet process phosphoric acid process lines, superphosphoric

acid process lines, phosphate rock dryers, phosphate rock calciners, and purified phosphoric acid process lines. (Subpart AA)

ab. Emission standards for hazardous air pollutants for phosphate fertilizers production. These standards apply to all new and existing major sources of phosphate fertilizer production plants. Affected processes include, but are not limited to, diammonium and monoammonium phosphate process lines, granular triple superphosphate process lines, and granular triple superphosphate storage buildings. (Subpart BB)

ac. National emission standards for hazardous air pollutants: petroleum refineries. These standards apply to petroleum refining process units and colocated emission points at new and existing major sources. Affected sources include process vents, equipment leaks, storage vessels, transfer operations, and wastewater streams. The standards also apply to marine tank vessel and gasoline loading racks. Excluded from the standard are catalyst regeneration from catalytic cracking units and catalytic reforming units, and vents from sulfur recovery units. Compliance with the standard includes emission control and prevention. (Subpart CC)

ad. Emission standards for hazardous air pollutants for off-site waste and recovery operations. This rule applies to major sources of HAP emissions which receive certain wastes, used oil, and used solvents from off-site locations for storage, treatment, recovery, or disposal at the facility. Maximum achievable control technology (MACT) is required to reduce HAP emissions from tanks, surface impoundments, containers, oil-water separators, individual drain systems and other material conveyance systems, process vents, and equipment leaks. Regulated entities include but are not limited to businesses that operate any of the following: hazardous waste treatment, storage, and disposal facilities; Resource Conservation and Recovery Act (RCRA) exempt hazardous wastewater treatment facilities other than publicly owned treatment works; used solvent recovery plants; RCRA exempt hazardous waste recycling operations; used oil re-refineries. The regulations also apply to federal agency facilities that operate any of the waste management or recovery operations. (Subpart DD)

ae. Emission standards for magnetic tape manufacturing operations. These standards apply to major sources performing magnetic tape manufacturing operations. (Subpart EE)

af. Reserved.

ag. National emission standards for hazardous air pollutants for source categories: aerospace manufacturing and rework facilities. These standards apply to major sources involved in the manufacture, repair, or rework of aerospace components and assemblies, including but not limited to airplanes, helicopters, missiles, and rockets for civil, commercial, or military purposes. Hazardous air pollutants regulated under this standard include chromium, cadmium, methylene chloride, toluene, xylene, methyl ethyl ketone, ethylene glycol, and glycol ethers. (Subpart GG)

ah. Emission standards for hazardous air pollutants for oil and natural gas production. These standards apply to all new and existing major sources of oil and natural gas production. Affected sources include, but are not limited to, processing of liquid or gaseous hydrocarbons, such as ethane, propane, butane, pentane, natural gas, and condensate extracted from field natural gas. (Subpart HH)

ai. Emission standards for hazardous air pollutants for shipbuilding and ship repair (surface coating) operations. Requires existing and new major sources to control hazardous air pollutant (HAP) emissions using the maximum achievable control technology (MACT). (Subpart II)

aj. Emission standards for hazardous air pollutants for hazardous air pollutant (HAP) emissions from wood furniture manufacturing operations. These standards apply to each facility that is engaged, either in part or in whole, in the manufacture of wood furniture or wood furniture components and that is located at a plant site that is a major source. (Subpart JJ)

ak. Emission standards for hazardous air pollutants for the printing and publishing industry. Existing and new major sources are required to control hazardous air pollutants (HAP) using the maximum achievable control technology (MACT). Affected units are publication rotogravure, product and packaging rotogravure, and wide-web flexographic printing. (Subpart KK)

al. Emission standards for hazardous air pollutants for primary aluminum reduction plants. These standards apply to each new or existing potline, paste production plant, and anode bake furnace

associated with a primary aluminum reduction plant, and for each new pitch storage tank associated with a primary aluminum production plant. (Part 63, Subpart LL)

am. Emission standards for hazardous air pollutants for chemical recovery combustion sources at kraft, soda, sulfite, and stand-alone semichemical pulp mills. (Part 63, Subpart MM)

an. Reserved.

ao. Emission standards for tanks – level 1. These provisions apply when another paragraph under this rule references the use of this paragraph for such air emission control. These air emission standards are placed here for administrative convenience and only apply to those owners and operators of facilities subject to the referencing paragraph. The provisions of paragraph 23.1(4)*"a,"* general provisions (Subpart A), do not apply to this paragraph except as specified in a referencing paragraph. (Part 63, Subpart OO)

ap. Emission standards for containers. These provisions apply when another paragraph under this rule references the use of this paragraph for such air emission control. These air emission standards are placed here for administrative convenience and only apply to those owners and operators of facilities subject to the referencing paragraph. The provisions of paragraph 23.1(4)*"a,"* general provisions (Subpart A), do not apply to this paragraph except as specified in a referencing paragraph. (Part 63, Subpart PP)

aq. Emission standards for surface impoundments. These provisions apply when another paragraph under this rule references the use of this paragraph for such air emission control. These air emission standards are placed here for administrative convenience and only apply to those owners and operators of facilities subject to the referencing paragraph. The provisions of paragraph 23.1(4)*"a,"* general provisions (Subpart A), do not apply to this paragraph except as specified in a referencing paragraph. (Part 63, Subpart QQ)

ar. Emission standards for individual drain systems. These provisions apply when another paragraph under this rule references the use of this paragraph for such air emission control. These air emission standards are placed here for administrative convenience and only apply to those owners and operators of facilities subject to the referencing paragraph. The provisions of paragraph 23.1(4)*"a,"* general provisions (Subpart A), do not apply to this paragraph except as specified in a referencing paragraph. (Part 63, Subpart RR)

as. Emission standards for closed vent systems, control devices, recovery devices and routing to a fuel gas system or a process. These provisions apply when another paragraph under this rule references the use of this paragraph for such air emission control. These air emission standards are placed here for administrative convenience and only apply to those owners and operators of facilities subject to the referencing paragraph. The provisions of paragraph 23.1(4)*"a,"* general provisions, (Subpart A), do not apply to this paragraph except as specified in a referencing paragraph. (Subpart SS)

at. Emission standards for equipment leaks—control level 1. These provisions apply to the control of air emissions from equipment leaks for which another paragraph under this rule references the use of this paragraph for such emission control. These air emission standards for equipment leaks are placed here for administrative convenience and only apply to those owners and operators of facilities subject to the referencing paragraph. The provisions of paragraph 23.1(4)*"a,"* general provisions, (Subpart A), do not apply to this paragraph except as specified in a referencing paragraph. (Subpart TT)

au. Emission standards for equipment leaks—control level 2 standards. These provisions apply to the control of air emissions from equipment leaks for which another paragraph under this rule references the use of this paragraph for such air emission control. These air emission standards for equipment leaks are placed here for administrative convenience and only apply to those owners and operators of facilities subject to the referencing paragraph. The provisions of paragraph 23.1(4)*"a,"* general provisions, (Subpart A), do not apply to this paragraph except as specified in a referencing paragraph. (Subpart UU)

av. Emission standards for oil-water separators and organic-water separators. These provisions apply when another paragraph under this rule references the use of this paragraph for such air emission control. These air emission standards are placed here for administrative convenience and only apply to those owners and operators of facilities subject to the referencing paragraph. The provisions of paragraph

23.1(4)*"a,"* general provisions (Subpart A), do not apply to this paragraph except as specified in a referencing paragraph. (Part 63, Subpart VV)

aw. Emission standards for storage vessels (tanks)—control level 2. These provisions apply to the control of air emissions from storage vessels for which another paragraph under this rule references the use of this paragraph for such air emission control. These air emission standards for storage vessels are placed here for administrative convenience and only apply to those owners and operators of facilities subject to the referencing paragraph. The provisions of paragraph 23.1(4)*"a,"* general provisions, (Subpart A), do not apply to this paragraph except as specified in a referencing paragraph. (Subpart WW)

ax. Emission standards for ethylene manufacturing process units: heat exchange systems and waste operations. This standard applies to hazardous air pollutants (HAPs) from heat exchange systems and waste streams at new and existing ethylene production units. (Part 63, Subpart XX)

ay. Emission standards for hazardous air pollutants: generic maximum achievable control technology (Generic MACT). These standards apply to new and existing major sources of acetal resins (AR) production, acrylic and modacrylic fiber (AMF) production, hydrogen fluoride (HF) production, polycarbonate (PC) production, carbon black production, cyanide chemicals manufacturing, ethylene production, and Spandex production. Affected processes include, but are not limited to, producers of homopolymers and copolymers of alternating oxymethylene units, acrylic fiber, modacrylic fiber synthetics composed of acrylonitrile (AN) units, hydrogen fluoride and polycarbonate. (Subpart YY)

az. to *bb.* Reserved.

bc. Emission standards for hazardous air pollutants for steel pickling—HCL process facilities and hydrochloric acid regeneration plants. Unless exempted, these standards apply to all new and existing major sources of hydrochloric acid process steel pickling facilities and hydrochloric acid regeneration plants. Affected processes include, but are not limited to, equipment and tanks configured for the pickling process, including the immersion, drain and rinse tanks and hydrochloric acid regeneration plants. (Subpart CCC)

bd. Emission standards for hazardous air pollutants for mineral wool production. These standards apply to all new and existing major sources of mineral wool production. Affected processes include, but are not limited to, cupolas and curing ovens. (Subpart DDD)

be. Emission standards for hazardous air pollutants from hazardous waste combustors. These standards apply to all hazardous waste combustors: hazardous waste incinerators, hazardous waste burning cement kilns, hazardous waste burning lightweight aggregate kilns, hazardous waste solid fuel boilers, hazardous waste liquid fuel boilers, and hazardous waste hydrochloric acid production furnaces, except as specified in Subpart EEE. Both area sources and major sources are subject to this subpart as of April 19, 1996, and are subject to the requirement to apply for and obtain a Title V permit. (Part 63, Subpart EEE)

bf. Reserved.

bg. Emission standards for hazardous air pollutants for pharmaceutical manufacturing. These standards apply to producers of finished dosage forms of drugs, for example, tablets, capsules, and solutions, that contain an active ingredient generally, but not necessarily, in association with inactive ingredients. Pharmaceuticals include components whose intended primary use is to furnish pharmacological activity or other direct effect in the diagnosis, cure, mitigation, treatment, or prevention of disease, or to affect the structure or any function of the body of humans or other animals. The regulations do not apply to research and development facilities. (Subpart GGG)

bh. Emission standards for hazardous air pollutants for natural gas transmission and storage. These standards apply to all new and existing major sources of natural gas transmission and storage. Natural gas transmission and storage facilities are those that transport or store natural gas prior to its entering the pipeline to a local distribution company. Affected sources include, but are not limited to, mains, valves, meters, boosters, regulators, storage vessels, dehydrators, compressors and delivery systems. (Subpart HHH)

bi. Emission standards for hazardous air pollutants for flexible polyurethane foam production. These standards apply to producers of slabstock, molded, and rebond flexible polyurethane

foam. The regulations do not apply to processes dedicated exclusively to the fabrication (i.e., gluing or otherwise bonding foam pieces together) of flexible polyurethane foam or to research and development. (Subpart III)

bj. Emission standards for hazardous air pollutants: Group IV polymers and resins. Applicable to existing and new major sources that emit organic HAP during the manufacture of the following polymers and resins: acrylonitrile butadiene styrene resin (ABS), styrene acrylonitrile resin (SAN), methyl methacrylate acrylonitrile butadiene styrene resin (MABS), methyl methacrylate butadiene styrene resin (MBS), polystyrene resin, poly (ethylene terephthalate) resin (PET), and nitrile resin. MACT is required for major sources. (Subpart JJJ)

bk. Reserved.

bl. Emission standards for hazardous air pollutants for Portland cement manufacturing operations. These standards apply to all new and existing major and area sources of Portland cement manufacturing unless exempted. Cement kiln dust (CKD) storage facilities, including CKD piles and landfills, are excluded from this standard. Affected processes include, but are not limited to, all cement kilns and in-line kiln/raw mills, unless they burn hazardous waste. (Subpart LLL)

bm. Emission standards for hazardous air pollutants for pesticide active ingredient production. These standards apply to all new and existing major sources of pesticide active ingredient production that manufacture organic pesticide active ingredients (PAI), including herbicides, insecticides and fungicides. Affected processes include, but are not limited to, processing equipment, connected piping and ducts, associated storage vessels, pumps, compressors, agitators, pressure relief devices, sampling connection systems, open-ended valves or lines, valves and connectors. Exempted sources include research and development facilities, storage vessels already subject to another 40 CFR Part 63 NESHAP, production of ethylene, storm water from segregated sewers, water from fire-fighting and deluge systems (including testing of such systems) and various spills. (Subpart MMM)

bn. Emission standards for hazardous air pollutants for wool fiberglass manufacturing. These standards apply to all new and existing major sources of wool fiberglass manufacturing. Affected processes include, but are not limited to, all glass-melting furnaces, rotary spin (RS) manufacturing lines that produce bonded building insulation, flame attenuation (FA) manufacturing lines producing bonded pipe insulation and new FA manufacturing lines producing bonded heavy-density products. (Subpart NNN)

bo. Emission standards for hazardous air pollutants for amino/phenolic resins production. These standards apply to new or existing facilities that own or operate an amino or phenolic resins production unit. (Part 63, Subpart OOO)

bp. Emission standards for hazardous air pollutants for polyether polyols production. These standards apply to all new and existing major sources of polyether polyols. Polyether polyols are compounds formed through polymerization of ethylene oxide, propylene oxide or other cyclic ethers with compounds having one or more reactive hydrogens to form polyethers. Affected processes include, but are not limited to, storage vessels, process vents, heat exchange systems, equipment leaks and wastewater operations. (Subpart PPP)

bq. Emission standards for hazardous air pollutants for primary copper smelting. This standard applies to a new or existing primary copper smelter that is (or is part of) a major source of hazardous air pollutant (HAP) emissions. (Part 63, Subpart QQQ)

br. Emission standards for hazardous air pollutants for secondary aluminum production. (Part 63, Subpart RRR)

bs. Reserved.

bt. Emission standards for hazardous air pollutants for primary lead smelting. These standards apply to all new and existing major sources of primary lead smelting. Affected processes include, but are not limited to, sintering machines, blast furnaces, dross furnaces and process fugitive sources. (Subpart TTT)

bu. Emission standards for hazardous air pollutants for petroleum refineries: catalytic cracking units, catalytic reforming units, and sulfur recovery units. This standard applies to a new or existing

petroleum refinery that is located at a major source of hazardous air pollutants (HAPs) emissions. (Part 63, Subpart UUU)

bv. Emission standards for hazardous air pollutants publicly owned treatment works (POTW). (Part 63, Subpart VVV)

bw. Reserved.

bx. Emission standards for hazardous air pollutants for ferroalloys production: ferromanganese and silicomanganese. These standards apply to all new and existing major sources of ferroalloys production of ferromanganese and silicomanganese. Affected processes include, but are not limited to, submerged arc furnaces, metal oxygen refining (MOR) processes, crushing and screening operations, and fugitive dust sources. (Subpart XXX)

by. to *bz.* Reserved.

ca. Emission standards for hazardous air pollutants: municipal solid waste landfills. This standard applies to existing and new municipal solid waste (MSW) landfills. (Part 63, Subpart AAAA)

cb. Reserved.

cc. Emission standards for hazardous air pollutants for the manufacturing of nutritional yeast. (Part 63, Subpart CCCC)

cd. Emission standards for hazardous air pollutants for plywood and composite wood products (formerly plywood and particle board manufacturing). These standards apply to new and existing major sources with equipment used to manufacture plywood and composite wood products. This equipment includes dryers, refiners, blenders, formers, presses, board coolers, and other process units associated with the manufacturing process. This also includes coating operations, on-site storage and wastewater treatment. However, only certain process units (defined in the federal rule) are subject to control or work practice requirements. (Part 63, Subpart DDDD)

ce. Emission standards for hazardous air pollutants for organic liquids distribution (non-gasoline). These standards apply to new and existing major source organic liquids distribution (non-gasoline) operations, which are carried out at storage terminals, refineries, crude oil pipeline stations, and various manufacturing facilities. (Part 63, Subpart EEEE)

cf. Emission standards for hazardous air pollutants for miscellaneous organic chemical manufacturing (MON). These standards establish emission limits and work practice standards for new and existing major sources with miscellaneous organic chemical manufacturing process units, wastewater treatment and conveyance systems, transfer operations, and associated ancillary equipment. (Part 63, Subpart FFFF)

cg. Emission standards for hazardous air pollutants for solvent extraction for vegetable oil production. (Part 63, Subpart GGGG)

ch. Emission standards for hazardous air pollutants for wet-formed fiberglass mat production. This standard applies to wet-formed fiberglass mat production plants that are major sources of hazardous air pollutants. These plants may be stand-alone facilities or located with asphalt roofing and processing facilities. (Part 63, Subpart HHHH)

ci. Emission standards for hazardous air pollutants for surface coating of automobiles and light-duty trucks. These standards apply to new, reconstructed, or existing affected sources, as defined in the standard, that are located at a facility which applies topcoat to new automobile or new light-duty truck bodies or body parts for new automobiles or new light-duty trucks and that is a major source, is located at a major source, or is part of a major source of emissions of hazardous air pollutants. Additional applicability criteria and exemptions from these standards may apply. (Part 63, Subpart IIII)

cj. Emission standards for hazardous air pollutants: paper and other web coating. This standard applies to a facility that is engaged in the coating of paper, plastic film, metallic foil, and other web surfaces located at a major source of hazardous air pollutant (HAP) emissions. (Part 63, Subpart JJJJ)

ck. Emission standards for hazardous air pollutants for surface coating of metal cans. These standards apply to a metal can surface coating operation that uses at least 5,700 liters (1,500 gallons (gal)) of coatings per year and is a major source, is located at a major source, or is part of a major source of hazardous air pollutant emissions. Coating operations located at an area source are not subject to

this rule. Additional applicability criteria and exemptions from these standards may apply. (Part 63, Subpart KKKK)

cl. Reserved.

cm. Emission standards for hazardous air pollutants for surface coating of miscellaneous metal parts and products. These standards apply to miscellaneous metal parts and products surface coating facilities that are a major source, are located at a major source, or are part of a major source of hazardous air pollutant emissions. A miscellaneous metal parts and products surface coating facility that is located at an area source is not subject to this standard. Certain sources are exempt as described in the standard. (Part 63, Subpart MMMM)

cn. Emission standards for hazardous air pollutants: surface coating of large appliances. This standard applies to a facility that applies coatings to large appliance parts or products, and is a major source, is located at a major source, or is part of a major source of emissions of hazardous air pollutants (HAPs). The large appliances source category includes facilities that apply coatings to large appliance parts or products. Large appliances include "white goods" such as ovens, refrigerators, freezers, dishwashers, laundry equipment, trash compactors, water heaters, comfort furnaces, electric heat pumps and most HVAC equipment intended for any application. (Part 63, Subpart NNNN)

co. Emission standards for hazardous air pollutants for printing, coating, and dyeing of fabrics and other textiles. These standards apply to new and existing facilities with fabric or other textile coating, printing, slashing, dyeing, or finishing operations, or group of such operations, that are a major source of hazardous air pollutants or are part of a facility that is a major source of hazardous air pollutants. Coating, printing, slashing, dyeing, or finishing operations located at an area source are not subject to this standard. Several exclusions from this source category are listed in the standard. (Part 63, Subpart OOOO)

cp. Emission standards for surface coating of plastic parts and products. These standards apply to new and existing major sources with equipment used to coat plastic parts and products. The surface coating application process includes drying/curing operations, mixing or thinning operations, and cleaning operations. Coating materials include, but are not limited to, paints, stains, sealers, topcoats, basecoats, primers, inks, and adhesives. (Part 63, Subpart PPPP)

cq. Emission standards for hazardous air pollutants for surface coating of wood building products. These standards establish emission limitations, operating limits, and work practice requirements for wood building products surface coating facilities that use at least 1,100 gallons of coatings per year and are a major source, are located at a major source, or are part of a major source of hazardous air pollutant emissions. Wood building products surface coating facilities located at an area source are not subject to this standard. Several exclusions from this source category are listed in the standard. (Part 63, Subpart QQQQ)

cr. Emission standards for hazardous air pollutants: surface coating of metal furniture. This standard applies to a metal furniture surface coating facility that is a major source, is located at a major source, or is part of a major source of HAP emissions. A metal furniture surface coating facility is one that applies coatings to metal furniture or components of metal furniture. Metal furniture means furniture or components that are constructed either entirely or partially from metal. (Part 63, Subpart RRRR)

cs. Emission standards for hazardous air pollutants: surface coating of metal coil. This standard requires that all new and existing "major" air toxics sources in the metal coil coating industry meet specific emission limits. Metal coil coating is the process of applying a coating (usually protective or decorative) to one or both sides of a continuous strip of sheet metal. Industries using coated metal include: transportation, building products, appliances, can manufacturing, and packaging. Other products using coated metal coil include measuring tapes, ventilation systems for walls and roofs, lighting fixtures, office filing cabinets, cookware, and sign stock material. (Part 63, Subpart SSSS)

ct. Emission standards for hazardous air pollutants for leather finishing operations. This standard applies to a new or existing leather finishing operation that is a major source of hazardous air pollutants (HAPs) emissions or that is located at, or is part of, a major source of HAP emissions. In general, a leather finishing operation is a single process or group of processes used to adjust and improve the

physical and aesthetic characteristics of the leather surface through multistage application of a coating comprised of dyes, pigments, film-forming materials, and performance modifiers dissolved or suspended in liquid carriers. (Part 63, Subpart TTTT)

cu. Emission standards for hazardous air pollutants for cellulose products manufacturing. This standard applies to a new or existing cellulose products manufacturing operation that is located at a major source of HAP emissions. Cellulose products manufacturing includes both the miscellaneous viscose processes source category and the cellulose ethers production source category. (Part 63, Subpart UUUU)

cv. Emission standards for hazardous air pollutants for boat manufacturing. (Part 63, Subpart VVVV)

cw. Emission standards for hazardous air pollutants: reinforced plastic composites production. This standard applies to a new or an existing reinforced plastic composites production facility that is located at a major source of HAP emissions. (Part 63, Subpart WWWW)

cx. Emission standards for hazardous air pollutants: rubber tire manufacturing. This standard applies to a rubber tire manufacturing facility that is located at, or is a part of, a major source of hazardous air pollutant (HAP) emissions. Rubber tire manufacturing includes the production of rubber tires and/or the production of components integral to rubber tires, the production of tire cord, and the application of puncture sealant. (Part 63, Subpart XXXX)

cy. Emission standards for hazardous air pollutants for stationary combustion turbines. These standards apply to stationary combustion turbines which are located at a major source of hazardous air pollutant emissions. Several subcategories have been defined within the stationary combustion turbine source category. Each subcategory has distinct requirements as specified in the standards. These standards do not apply to stationary combustion turbines located at an area source of hazardous air pollutant emissions. (Part 63, Subpart YYYY)

cz. Emission standards for stationary reciprocating internal combustion engines. These standards apply to new and existing major sources with stationary reciprocating internal combustion engines (RICE). These standards also apply to new and reconstructed RICE located at area sources. For purposes of these standards, stationary RICE means any reciprocating internal combustion engine which uses reciprocating motion to convert heat energy into mechanical work and which is not mobile. (Part 63, Subpart ZZZZ)

da. Emission standards for hazardous air pollutants for lime manufacturing plants. These standards regulate hazardous air pollutant emissions from new and existing lime manufacturing plants that are major sources, are colocated with major sources, or are part of major sources. Additional applicability criteria and exemptions from these standards may apply. (Part 63, Subpart AAAAA)

db. Emission standards for hazardous air pollutants: semiconductor manufacturing. These standards apply to new and existing major sources with semiconductor manufacturing. (Part 63, Subpart BBBBB)

dc. Emission standards for hazardous air pollutants for coke ovens: pushing, quenching, and battery stacks. This standard applies to a new or existing coke oven battery at a plant that is a major source of HAP emissions. (Part 63, Subpart CCCCC)

dd. Emission standards for industrial, commercial and institutional boilers and process heaters. These standards apply to new and existing major sources with industrial, commercial or institutional boilers and process heaters. (Part 63, Subpart DDDDD)*

*As of April 15, 2009, the adoption by reference of Part 63, Subpart DDDDD, is rescinded. On July 30, 2007, the United States Court of Appeals for the District of Columbia Circuit issued its mandate vacating 40 CFR Part 63, Subpart DDDDD, in its entirety, and requiring EPA to repromulgate final standards for industrial, commercial or institutional boilers and process heaters at new and existing major sources.

de. Emission standards for hazardous air pollutants for iron and steel foundaries. These standards apply to each new or existing iron and steel foundary that is a major source of hazardous air pollutant emissions. A new affected source is an iron and steel foundary for which construction or reconstruction

began after December 23, 2002. An existing affected source is an iron and steel foundary for which construction or reconstruction began on or before December 23, 2002. (Part 63, Subpart EEEEE)

df. Emission standards for hazardous air pollutants for integrated iron and steel manufacturing. These standards apply to affected sources at an integrated iron and steel manufacturing facility that is, or is part of, a major source of hazardous air pollutant emissions. The affected sources are each new or existing sinter plant, blast furnace, and basic oxygen process furnace (BOPF) shop at an integrated iron and steel manufacturing facility that is, or is part of, a major source of hazardous air pollutant emissions. (Part 63, Subpart FFFFF)

dg. Emission standards for hazardous air pollutants: site remediation. These standards apply to new and existing major sources with certain types of site remediation activity on the source's property or on a contiguous property. These standards control hazardous air pollutant (HAP) emissions at major sources where remediation technologies and practices are used at the site to clean up contaminated environmental media (e.g., soil, groundwater, or surface water) or certain stored or disposed materials that pose a reasonable potential threat to contaminate environmental media.

Some site remediations already regulated by rules established under the Comprehensive Environmental Response and Compensation Liability Act (CERCLA) or the Resource Conservation and Recovery Act (RCRA) are not subject to these standards, as specified in Subpart GGGGG. There are also exemptions for short-term remediation and for certain leaking underground storage tanks, as specified in Subpart GGGGG. (Part 63, Subpart GGGGG)

dh. Emission standards for hazardous air pollutants for miscellaneous coating manufacturing. These standards establish emission limits and work practice requirements for new and existing miscellaneous coating manufacturing operations, including, but not limited to, process vessels, storage tanks, wastewater, transfer operations, equipment leaks, and heat exchange systems. (Part 63, Subpart HHHHH)

di. Emission standards for mercury emissions from mercury cell chlor-alkali plants. These standards apply to the chlorine production source category. This source category contains the mercury cell chlor-alkali plant subcategory and includes all plants engaged in the manufacture of chlorine and caustic in mercury cells. These standards define two affected sources: mercury cell chlor-alkali production facilities and mercury recovery facilities. (Part 63, Subpart IIIII)

dj. Emission standards for hazardous air pollutants for brick and structural clay products manufacturing. These standards apply to new and existing brick and structural clay products manufacturing facilities that are, are located at, or are part of a major source of hazardous air pollutant emissions. (Part 63, Subpart JJJJJ)*

*As of April 15, 2009, the adoption by reference of Part 63, Subpart JJJJJ, is rescinded. On June 18, 2007, the United States Court of Appeals for the District of Columbia Circuit issued its mandate vacating 40 CFR Part 63, Subpart JJJJJ, in its entirety, and requiring EPA to repromulgate final standards for brick and structural clay products manufacturing at new and existing major sources.

dk. Emission standards for hazardous air pollutants for clay ceramics manufacturing. These standards apply to clay ceramics manufacturing facilities that are, are located at, or are part of a major source of hazardous air pollutant emissions. The clay ceramics manufacturing source category includes those facilities that manufacture pressed floor tile, pressed wall tile, and other pressed tile; or sanitaryware, such as toilets and sinks. (Part 63, Subpart KKKKK)

dl. Emission standards for hazardous air pollutants: asphalt processing and asphalt roofing manufacturing. This standard applies to an existing or new asphalt processing or asphalt roofing manufacturing facility that is a major source of hazardous air pollutants (HAPs) emissions, or is located at, or is part of a major source of HAP emissions. (Part 63, Subpart LLLLL)

dm. Emission standards for hazardous air pollutants: flexible polyurethane foam fabrication operations. This standard applies to a new or existing source at a flexible polyurethane foam fabrication facility. The standard defines two affected sources (units or collections of units to which a given standard or limit applies) corresponding to the two subcategories, loop slitter adhesive use or flame lamination. (Part 63, Subpart MMMMM)

dn. Emission standards for hazardous air pollutants: hydrochloric acid production. This standard applies to a new or existing HCl production facility that produces a liquid HCl product at a concentration of 30 weight percent or greater during its normal operations and is located at, or is part of, a major source of HAP. This does not include HCl production facilities that only occasionally produce liquid HCl product at a concentration of 30 weight percent or greater. (Part 63, Subpart NNNNN)

do. Reserved.

dp. Emission standards for hazardous air pollutants: engine test cells/stands. This standard applies to an engine test cell/stand that is located at a major source of HAP emissions. An engine test cell/stand is any apparatus used for testing uninstalled stationary or uninstalled mobile engines. (Part 63, Subpart PPPPP)

dq. Emission standards for hazardous air pollutants for friction materials manufacturing facilities. This standard applies to a new or existing friction materials manufacturing facility that is (or is part of) a major source of hazardous air pollutants (HAPs) emissions. Friction materials manufacturing facilities produce friction materials for use in brake and clutch assemblies. (Part 63, Subpart QQQQQ)

dr. Emission standards for hazardous air pollutants: taconite iron ore processing. These standards apply to new and existing taconite iron ore processing plants that are, or are part of, a major source of HAP emissions. (Part 63, Subpart RRRRR)

ds. Emission standards for hazardous air pollutants for refractory products manufacturing. This standard applies to a new or existing refractory products manufacturing facility that is, is located at, or is part of, a major source of hazardous air pollutant (HAP) emissions. (Part 63, Subpart SSSSS)

dt. Emission standards for hazardous air pollutants: primary magnesium refining. These standards apply to primary magnesium refining plants that are, or are part of, a major source of HAP emissions. (Part 63, Subpart TTTTT)

du. and *dv.* Reserved.

dw. Emission standards for hazardous air pollutants for hospital ethylene oxide sterilizer area sources. This standard applies to a hospital that is an area source for hazardous air pollutant emissions and that owns or operates a new or existing ethylene oxide sterilization facility. (Part 63, Subpart WWWWW)

dx. Reserved.

dy. Emission standards for hazardous air pollutants for electric arc furnace steelmaking area sources. This standard applies to new or existing electric arc furnace (EAF) steelmaking facilities that are area sources for hazardous air pollutant emissions. (Part 63, Subpart YYYYY)

dz. Emission standards for hazardous air pollutants for iron and steel foundry area sources. This standard applies to new or existing iron and steel foundries that are area sources for hazardous air pollutant emissions. (Part 63, Subpart ZZZZZ)

ea. Reserved.

eb. Emission standards for hazardous air pollutants for gasoline distribution area sources: bulk terminals, bulk plants and pipeline facilities. This standard applies to new and existing bulk gasoline terminals, pipeline breakout stations, pipeline pumping stations and bulk gasoline plants that are area sources for hazardous air pollutant emissions. (Part 63, Subpart BBBBBB)

ec. Emmission standards for hazardous air pollutants for area sources: gasoline dispensing facilities. This standard applies to new and existing gasoline dispensing facilities (GDF) that are area sources for hazardous air pollutant emissions. The affected equipment includes each gasoline cargo tank during delivery of product to GDF and also includes each storage tank. The equipment used for refueling of motor vehicles is not covered under these standards. (Part 63, Subpart CCCCCC)

ed. to *eg.* Reserved.

eh. Emission standards for hazardous air pollutants for area sources: paint stripping and miscellaneous surface coating operations. This standard applies to new or existing area sources of hazardous air pollutant emissions that engage in any of the following activities: (1) paint stripping operations that use methylene chloride (MeCl)-containing paint stripping formulations; (2) spray application of coatings to motor vehicles or mobile equipment; or (3) spray application of coatings to

plastic or metal substrate with coatings that contain compounds of chromium (Cr), lead (Pb), manganese (Mn), nickel (Ni) or cadmium (Cd). (Part 63, Subpart HHHHHH)

ei. to *ek.* Reserved.

el. Emission standards for hazardous air pollutants for acrylic and modacrylic fibers production area sources. This standard applies to acrylic and modacrylic fibers production plants that are area sources for hazardous air pollutant emissions. (Part 63, Subpart LLLLLL)

em. Emission standards for hazardous air pollutants for carbon black production area sources. This standard applies to carbon black production plants that are area sources for hazardous air pollutants. (Part 63, Subpart MMMMMM)

en. Emission standards for hazardous air pollutants for chemical manufacturing of chromium compounds area sources. This standard applies to plants that produce chromium compounds and are area sources for hazardous air pollutants. (Part 63, Subpart NNNNNN)

eo. Emission standards for hazardous air pollutants for flexible polyurethane foam production and fabrication area sources. This standard applies to plants that produce flexible polyurethane foam or rebond foam, and plants that fabricate polyurethane foam, that are area sources for hazardous air pollutants. This standard applies to both new and existing area sources. An affected source is existing if construction or reconstruction commenced on or before April 4, 2007. An affected source is new if construction or reconstruction commenced after April 4, 2007. (Part 63, Subpart OOOOOO)

ep. Emission standards for hazardous air pollutants for lead acid battery manufacturing area sources. This standard applies to lead acid battery manufacturing plants that are area sources for hazardous air pollutants. Affected sources include all grid casting facilities, paste mixing facilities, three-process operation facilities, lead oxide manufacturing facilities, lead reclamation facilities, and any other lead-emitting operation that is associated with a lead acid battery manufacturing plant. This standard applies to both new and existing area sources. An affected source is existing if construction or reconstruction commenced on or before April 4, 2007. An affected source is new if construction or reconstruction commenced after April 4, 2007. (Part 63, Subpart PPPPPP)

eq. Emission standards for hazardous air pollutants for wood preserving area sources. This standard applies to wood preserving operations that are area sources for hazardous air pollutants. This standard applies to both new and existing area sources. An affected source is existing if construction or reconstruction commenced on or before April 4, 2007. An affected source is new if construction or reconstruction commenced after April 4, 2007. (Part 63, Subpart QQQQQQ)

er. Emission standards for hazardous air pollutants for clay ceramics manufacturing area sources. This standard applies to any new or existing clay ceramics manufacturing facility with an atomized glaze spray booth or kiln that fires glazed ceramic ware, that processes more than 50 tons per year of wet clay, and that is an area source for hazardous air pollutant emissions. (Part 63, Subpart RRRRRR)

es. Emission standards for hazardous air pollutants for glass manufacturing area sources. This standard applies to any new or existing glass manufacturing facility that is an area source for hazardous air pollutant emissions and meets the following criteria: (1) manufactures flat glass, glass containers or pressed and blown glass by melting a mixture of raw materials to produce molten glass and form the molten glass into sheets, containers or other shapes; and (2) uses one or more continuous furnaces to produce glass at a rate of at least 50 tons per year and that contains compounds of one or more "glass manufacturing metal HAP," as defined in 40 CFR 63.11459, as raw materials in a glass manufacturing batch formulation. (Part 63, Subpart SSSSSS)

et. Emissions standards for hazardous air pollutants for secondary nonferrous metals processing area sources. This standard applies to any new or existing secondary nonferrous metals processing facility that is an area source for hazardous air pollutant emissions. This standard applies to all crushing and screening operations at a secondary zinc processing facility and to all furnace melting operations located at any secondary nonferrous metals processing facility. (Part 63, Subpart TTTTTT)

eu. Reserved.

ev. Emission standards for hazardous air pollutants for area sources: chemical manufacturing. This standard applies to chemical manufacturing at new and existing facilities that are area sources for hazardous air pollutant emissions. (Part 63, Subpart VVVVVV)

ew. Emission standards for hazardous air pollutants for area sources: plating and polishing. This standard applies to plating and polishing activities at new and existing facilities that are area sources for hazardous air pollutant emissions. (Part 63, Subpart WWWWWW)

ex. Emission standards for hazardous air pollutants for area sources: metal fabrication and finishing. This standard applies to new and existing facilities in which the primary activity or activities at the facility are metal fabrication and finishing and that are area sources for hazardous air pollutant emissions. (Part 63, Subpart XXXXXX)

fa. and *fb.* Reserved.

fc. Emission standards for hazardous air pollutants for area sources: paint and allied products manufacturing. This standard applies to paint and allied products manufacturing at new and existing facilities that are area sources for hazardous air pollutant emissions. (Part 63, Subpart CCCCCCC)

fd. Emission standards for hazardous air pollutants for area sources: prepared feeds manufacturing. This standard applies to prepared feeds manufacturing that produces animal feed products (not including feed for cats or dogs) and uses chromium or manganese compounds at new and existing facilities that are area sources for hazardous air pollutant emissions. (Part 63, Subpart DDDDDDD)

23.1(5) *Emission guidelines.* The emission guidelines and compliance times for existing sources, as defined in 40 Code of Federal Regulations Part 60 as amended through June 9, 2006, shall apply to the following affected facilities. The corresponding 40 CFR Part 60 subpart designation is in parentheses. The control of the designated pollutants will be in accordance with federal standards established in Sections 111 and 129 of the Act and 40 CFR Part 60, Subpart B (Adoption and Submittal of State Plans for Designated Facilities), and the applicable subpart(s) for the existing source. Reference test methods (Appendix A), performance specifications (Appendix B), determination of emission rate change (Appendix C), quality assurance procedures (Appendix F) and the general provisions (Subpart A) of 40 CFR Part 60 also apply to the affected facilities.

a. Emission guidelines for municipal solid waste landfills (Subpart Cc). Emission guidelines and compliance times for the control of certain designated pollutants from designated municipal solid waste landfills shall be in accordance with federal standards established in Subparts Cc (Emission Guidelines and Compliance Times for Municipal Solid Waste Landfills) and WWW (Standards of Performance for Municipal Solid Waste Landfills) of 40 CFR Part 60.

(1) Definitions. For the purpose of 23.1(5)*"a,"* the definitions have the same meaning given to them in the Act and 40 CFR Part 60, Subparts A (General Provisions), B, and WWW, if not defined in this subparagraph.

"Municipal solid waste landfill" or *"MSW landfill"* means an entire disposal facility in a contiguous geographical space where household waste is placed in or on land. An MSW landfill may also receive other types of RCRA Subtitle D wastes such as commercial solid waste, nonhazardous sludge, and industrial solid waste. Portions of an MSW landfill may be separated by access roads. An MSW landfill may be publicly or privately owned. An MSW landfill may be a new MSW landfill, an existing MSW landfill or a lateral expansion.

(2) Designated facilities.

1. The designated facility to which the emission guidelines apply is each existing MSW landfill for which construction, reconstruction or modification was commenced before May 30, 1991.

2. Physical or operational changes made to an existing MSW landfill solely to comply with an emission guideline are not considered a modification or reconstruction and would not subject an existing MSW landfill to the requirements of 40 CFR Part 60, Subpart WWW (40 CFR 60.750).

3. For MSW landfills subject to rule 567—22.101(455B) only because of applicability to subparagraph 23.1(5)*"a"*(2), the following apply for obtaining and maintaining a Title V operating permit under 567—22.104(455B):

The owner or operator of an MSW landfill with a design capacity less than 2.5 million megagrams or 2.5 million cubic meters is not required to obtain an operating permit for the landfill.

The owner or operator of an MSW landfill with a design capacity greater than or equal to 2.5 million megagrams and 2.5 million cubic meters on or before June 22, 1998, becomes subject to the requirements of 567—subrule 22.105(1) on September 20, 1998. This requires the landfill to submit a Title V permit application to the Air Quality Bureau, Department of Natural Resources, no later than September 20, 1999.

The owner or operator of a closed MSW landfill does not have to maintain an operating permit for the landfill if either of the following conditions are met: the landfill was never subject to the requirement for a control system under subparagraph 23.1(5)*"a"*(3); or the owner or operator meets the conditions for control system removal specified in 40 CFR § 60.752(b)(2)(v).

(3) Emission guidelines for municipal solid waste landfill emissions.

1. MSW landfill emissions at each MSW landfill meeting the conditions below shall be controlled. A design capacity report must be submitted to the director by November 18, 1997.

The landfill has accepted waste at any time since November 8, 1987, or has additional design capacity available for future waste deposition.

The landfill has a design capacity greater than or equal to 2.5 million megagrams or 2.5 million cubic meters. The landfill may calculate design capacity in either megagrams or cubic meters for comparison with the exemption values. Any density conversions shall be documented and submitted with the report. All calculations used to determine the maximum design capacity must be included in the design capacity report.

The landfill has a nonmethane organic compound (NMOC) emission rate of 50 megagrams per year or more. If the MSW landfill's design capacity exceeds the established thresholds in 23.1(5)*"a"*(3)"1," the NMOC emission rate calculations must be provided with the design capacity report.

2. The planning and installation of a collection and control system shall meet the conditions provided in 40 CFR 60.752(b)(2) at each MSW landfill meeting the conditions in 23.1(5)*"a"*(3)"1."

3. MSW landfill emissions collected through the use of control devices must meet the following requirements, except as provided in 40 CFR 60.24 after approval by the Director and U.S. Environmental Protection Agency.

An open flare designed and operated in accordance with the parameters established in 40 CFR 60.18; a control system designed and operated to reduce NMOC by 98 weight percent; or an enclosed combustor designed and operated to reduce the outlet NMOC concentration to 20 parts per million as hexane by volume, dry basis at 3 percent oxygen, or less.

(4) Test methods and procedures. The following must be used:

1. The calculation of the landfill NMOC emission rate listed in 40 CFR 60.754, as applicable, to determine whether the landfill meets the condition in 23.1(5)*"a"*(3)"3";

2. The operational standards in 40 CFR 60.753;

3. The compliance provisions in 40 CFR 60.755; and

4. The monitoring provisions in 40 CFR 60.756.

(5) Reporting and record-keeping requirements. The record-keeping and reporting provisions listed in 40 CFR 60.757 and 60.758, as applicable, except as provided under 40 CFR 60.24 after approval by the Director and U.S. Environmental Protection Agency, shall be used.

(6) Compliance times.

1. Except as provided for under 23.1(5)*"a"*(6)"2," planning, awarding of contracts, and installation of MSW landfill air emission collection and control equipment capable of meeting the emission guidelines established under 23.1(5)*"a"*(3) shall be accomplished within 30 months after the date the initial NMOC emission rate report shows NMOC emissions greater than or equal to 50 megagrams per year.

2. For each existing MSW landfill meeting the conditions in 23.1(5)*"a"*(3)"1" whose NMOC emission rate is less than 50 megagrams per year on August 20, 1997, installation of collection and control systems capable of meeting emission guidelines in 23.1(5)*"a"*(3) shall be accomplished within

30 months of the date when the condition in 23.1(5)*"a"*(3)"1" is met (i.e., the date of the first annual nonmethane organic compounds emission rate which equals or exceeds 50 megagrams per year).

b. Emission guidelines for hospital/medical/infectious waste incinerators (Subpart Ce). This paragraph contains emission guidelines and compliance times for the control of certain designated pollutants from hospital/medical/infectious waste incinerator(s) (HMIWI) in accordance with Subparts Ce and Ec (Standards of Performance for Hospital/Medical/Infectious Waste Incinerators) of 40 CFR Part 60.*

*As of November 24, 2010, the emission guidelines for hospital/medical/infectious waste incinerators (Subpart Ce) are rescinded.

c. Emission guidelines and compliance schedules for commercial and industrial solid waste incineration units that commenced construction on or before November 30, 1999. Emission guidelines and compliance schedules for the control of designated pollutants from affected commercial and industrial solid waste incinerators that commenced construction on or before November 30, 1999, shall be in accordance with federal plan requirements established in Subpart III of 40 CFR Part 62.

d. Emission guidelines for mercury for coal-fired electric utility steam generating units. Rescinded IAB 10/7/09, effective 11/11/09.

23.1(6) *Calculation of emission limitations based upon stack height.* This rule sets limits for the maximum stack height credit to be used in ambient air quality modeling for the purpose of setting an emission limitation and calculating the air quality impact of a source. The rule does not limit the actual physical stack height for any source.

For the purpose of this subrule, definitions of "stack," "a stack in existence," "dispersion technique," "nearby" and "excessive concentration" as set forth in 40 CFR §§ 51.100(ff) through (hh), (jj) and (kk) as amended through June 14, 1996, are adopted by reference.

a. "Good engineering practice (GEP) stack height" means the greater of:

(1) Sixty-five meters, measured from the ground level elevation at the base of the stack; or

(2) For stacks in existence on January 12, 1979, and for which the owner and operator had obtained all applicable permits or approvals required under 567—Chapter 22 and 40 CFR § 52.21 as amended through June 13, 2007,

$$H_g = 2.5H$$

provided the owner or operator produces evidence that this equation was actually relied on in establishing an emission limitation;

For all other stacks,

$$H_g = H + 1.5L$$

where:

H_g= good engineering practice stack height, measured from the ground level elevation at the base of the stack,

H = height of nearby structure(s) measured from the ground level elevation at the base of the stack,

L = lesser dimension, height or projected width, of nearby structure(s), provided that the department may require the use of a field study or fluid model to verify GEP stack height for the source; or

(3) The height demonstrated by a fluid model or a field study approved by the department, which ensures that the emissions from a stack do not result in excessive concentrations of any air pollutant as a result of atmospheric downwash, wakes, or eddy effects created by the source itself, nearby structures or nearby terrain features. Public notification of the availability of such study and opportunity for public hearing are required prior to approval by the department.

b. The degree of emission limitation required for control of any air contaminant under this chapter shall not be affected in any manner by:

(1) The consideration of that portion of a stack which exceeds GEP stack height; or

(2) Varying the rate of emission of a pollutant according to atmospheric conditions or ambient concentrations of that pollutant; or

(3) Increasing final exhaust gas plume rise by manipulating source process parameters, exhaust gas parameters, stack parameters, or combined exhaust gases from several existing stacks into one stack; or other selective handling of exhaust gas streams so as to increase gas plume rise.

This rule is intended to implement Iowa Code section 455B.133.

[**ARC 7565B**, IAB 2/11/09, effective 3/18/09; **ARC 7623B**, IAB 3/11/09, effective 4/15/09; **ARC 8216B**, IAB 10/7/09, effective 11/11/09; **ARC 8215B**, IAB 10/7/09, effective 11/11/09; **ARC 9154B**, IAB 10/20/10, effective 11/24/10 (See Delay note at end of chapter)]

567—23.2(455B) Open burning.

23.2(1) *Prohibition.* No person shall allow, cause or permit open burning of combustible materials, except as provided in 23.2(2) and 23.2(3).

23.2(2) *Variances from rules.* Any person wishing to conduct open burning of materials not exempted in 23.2(3) may make application for a variance as specified in 567—subrule 21.2(1). In addition to requiring the information specified under 567—subrule 21.2(1), the director may require any person applying for a variance from the open burning rules to submit adequate documentation to allow the director to assess whether granting the variance will hinder attainment or maintenance of a National Ambient Air Quality Standard (NAAQS).

23.2(3) *Exemptions.* The open burning exemptions specified in this subrule shall not be construed as exemptions from any other applicable environmental regulations. In particular, the exemptions contained in this subrule do not absolve any person from compliance with the rules for solid waste disposal, including ash disposal, and solid waste permitting contained in 567—Chapters 100 through 130 or the rules for storm water runoff and storm water permitting contained in 567—Chapters 60 and 64. The following shall be permitted unless prohibited by local ordinances or regulations.

a. *Disaster rubbish.* The open burning of rubbish, including landscape waste, for the duration of the community disaster period in cases where an officially declared emergency condition exists. Burning of any structures or demolished structures shall be conducted in accordance with 40 CFR Section 61.145 as amended through January 16, 1991, which is the "Standard for Demolition and Renovation" of the asbestos National Emission Standard for Hazardous Air Pollutants.

b. *Trees and tree trimmings.* The open burning of trees and tree trimmings not originated on the premises provided that the burning site is operated by a local governmental entity, the burning site is fenced and access is controlled, burning is conducted on a regularly scheduled basis and is supervised at all times, burning is conducted only when weather conditions are favorable with respect to surrounding property, and the burning site is limited to areas at least one-quarter mile from any inhabited building unless a written waiver in the form of an affidavit is submitted by the owner of the building to the department and to the local governmental entity prior to the first instance of open burning at the site which occurs after November 13, 1996. The written waiver shall become effective only upon recording in the office of the recorder of deeds of the county in which the inhabited building is located. However, when the open burning of trees and tree trimmings causes air pollution as defined in Iowa Code section 455B.131(3), the department may take appropriate action to secure relocation of the burning operation. Rubber tires shall not be used to ignite trees and tree trimmings.

This exemption shall not apply within the area classified as the PM10 (inhalable) particulate Group II area of Mason City. This Group II area is described as follows: the area in Cerro Gordo County, Iowa, in Lincoln Township including Sections 13, 24 and 25; in Lime Creek Township including Sections 18, 19, 20, 21, 27, 28, 29, 30, 31, 32, 33, 34 and 35; in Mason Township the W ½ of Section 1, Sections 2, 3, 4, 5, 8, 9, the N ½ of Section 11, the NW ¼ of Section 12, the N ½ of Section 16, the N ½ of Section 17 and the portions of Sections 10 and 15 north and west of the line from U.S. Highway 18 south on Kentucky Avenue to 9th Street SE; thence west on 9th Street SE to the Minneapolis and St. Louis railroad tracks; thence south on Minneapolis and St. Louis railroad tracks to 19th Street SE; thence west on 19th Street SE to the section line between Sections 15 and 16.

c. *Flare stacks.* The open burning or flaring of waste gases, providing such open burning or flaring is conducted in compliance with 23.3(2)*"d"* and 23.3(3)*"e."*

d. *Landscape waste.* The disposal by open burning of landscape waste originating on the premises. However, the burning of landscape waste produced in clearing, grubbing and construction operations

shall be limited to areas located at least one-fourth mile from any building inhabited by other than the landowner or tenant conducting the open burning. Rubber tires shall not be used to ignite landscape waste.

e. Recreational fires. Open fires for cooking, heating, recreation and ceremonies, provided they comply with 23.3(2)*"d."* Burning rubber tires is prohibited from this activity.

f. Residential waste. Backyard burning of residential waste at dwellings of four-family units or less. The adoption of more restrictive ordinances or regulations of a governing body of the political subdivision, relating to control of backyard burning, shall not be precluded by these rules.

g. Training fires. For purposes of subrule 23.2(3), a "training fire" is a fire set for the purposes of conducting bona fide training of public or industrial employees in firefighting methods. For purposes of this paragraph, "bona fide training" means training that is conducted according to the National Fire Protection Association 1403 Standard of Live Fire Training Evolutions (2002 Edition) or a comparable training fire standard. A training fire may be conducted, provided that all of the following conditions are met:

(1) A training fire on a building is conducted with the building structurally intact.

(2) The training fire does not include the controlled burn of a demolished building.

(3) If the training fire is to be conducted on a building, written notification is provided to the department on DNR Form 542-8010, Notification of an Iowa Training Fire-Demolition or a Controlled Burn of a Demolished Building, and is postmarked or delivered to the director at least ten working days before such action commences.

(4) Notification shall be made in accordance with 40 CFR Section 61.145, "Standard for Demolition and Renovation" of the asbestos National Emission Standard for Hazardous Air Pollutants (NESHAP), as amended through January 16, 1991.

(5) All asbestos-containing materials shall be removed prior to the training fire.

(6) Asphalt roofing may be burned in the training fire only if notification to the director contains testing results indicating that none of the layers of asphalt roofing contain asbestos. During each calendar year, each fire department may conduct no more than two training fires on buildings where asphalt roofing has not been removed, provided that for each of those training fires the asphalt roofing material present has been tested to ensure that it does not contain asbestos. Each fire department's limit on the burning of asphalt roofing shall include both training fires and the controlled burning of a demolished building, as specified in 23.2(3)*"j."*

(7) Rubber tires shall not be burned during a training fire.

h. Paper or plastic pesticide containers and seed corn bags. The disposal by open burning of paper or plastic pesticide containers (except those formerly containing organic forms of beryllium, selenium, mercury, lead, cadmium or arsenic) and seed corn bags resulting from farming activities occurring on the premises. Such open burning shall be limited to areas located at least one-fourth mile from any building inhabited by other than the landowner or tenant conducting the open burning, livestock area, wildlife area, or water source. The amount of paper or plastic pesticide containers and seed corn bags that can be disposed of by open burning shall not exceed one day's accumulation or 50 pounds, whichever is less. However, when the burning of paper or plastic pesticide containers or seed corn bags causes a nuisance, the director may take action to secure relocation of the burning operation. Since the concentration levels of pesticide combustion products near the fire may be hazardous, the person conducting the open burning should take precautions to avoid inhalation of the pesticide combustion products.

i. Agricultural structures. The open burning of agricultural structures, provided that the open burning occurs on the premises and, for agricultural structures located within a city or town, at least one-fourth mile from any building inhabited by a person other than the landowner, a tenant, or an employee of the landowner or tenant conducting the open burning unless a written waiver in the form of an affidavit is submitted by the owner of the building to the department prior to the open burning; all chemicals and asphalt roofing are removed; burning is conducted only when weather conditions are favorable with respect to surrounding property; and permission from the local fire chief is secured in advance of the burning. Rubber tires shall not be used to ignite agricultural structures. The asbestos National Emission Standard for Hazardous Air Pollutants (NESHAP), as amended through January

16, 1991, requires the burning of agricultural structures to be conducted in accordance with 40 CFR Section 61.145, "Standard for Demolition and Renovation."

For the purposes of this subrule, "agricultural structures" means barns, machine sheds, storage cribs, animal confinement buildings, and homes located on the premises and used in conjunction with crop production, livestock or poultry raising and feeding operations. "Agricultural structures," for asbestos NESHAP purposes, includes all of the above, with the exception of a single residential structure on the premises having four or fewer dwelling units, which has been used only for residential purposes.

j. *Controlled burning of a demolished building.* A city, as "city" is defined in Iowa Code section 362.2(4), with approval of its council, as "council" is defined in Iowa Code section 362.2(8), may conduct a controlled burn of a demolished building. A city is the only party that may conduct such a burn and is responsible for ensuring that all of the following conditions are met:

(1) *Prohibition.* The controlled burning of a demolished building is prohibited within the city limits of Cedar Rapids, Marion, Hiawatha, Council Bluffs, Carter Lake, Des Moines, West Des Moines, Clive, Windsor Heights, Urbandale, Pleasant Hill, Buffalo, Davenport, Mason City or any other area where area-specific state implementation plans require the control of particulate matter.

(2) *Notification requirements.* For each building proposed to be burned, the city fire department or a city official, on behalf of the city, shall submit to the department a completed notification postmarked at least 10 working days prior to commencing demolition and at least 30 days before the proposed controlled burn commences. Documentation of city council approval shall be submitted with the notification. Information required to be provided shall include: the exact location of the burn site; the approximate distance to the nearest neighboring residence or business; the method used by the city to notify nearby residents of the proposed burn; an explanation of why alternative methods of demolition debris management are not being used; and information required by 40 CFR Section 61.145, "Standard for Demolition and Renovation" of the asbestos National Emission Standard for Hazardous Air Pollutants (NESHAP), as amended through January 16, 1991. Notification shall be provided on DNR Form 542-8010, Notification of an Iowa Training Fire-Demolition or a Controlled Burn of a Demolished Building. For burns conducted outside the city limits, the city shall send to the chairperson of the applicable county board a copy of the completed DNR notification form 542-8010 and documentation of city council approval. Notification to the county board shall be postmarked, faxed or sent by electronic mail at least 30 days before the proposed controlled burn commences.

(3) *Asbestos removal requirements.* All asbestos-containing materials shall be removed before the building to be burned is demolished. The department may require proof that any applicable inspection, notification, removal and demolition occurred, or will occur, in accordance with 40 CFR Section 61.145, "Standard for Demolition and Renovation" of the asbestos National Emission Standard for Hazardous Air Pollutants (NESHAP), as amended through January 16, 1991.

(4) *Requirements for asphalt roofing.* During each calendar year, each city shall conduct no more than two controlled burns of a demolished building in which asphalt roofing has not been removed, provided that for each controlled burn of a demolished building the asphalt roofing material present has been tested to ensure that it does not contain asbestos. Each city's limit on the burning of asphalt roofing shall include both the controlled burning of a demolished building and training fires, as specified in paragraph 23.2(3)*"g."*

(5) *Building size limit.* For each proposed controlled burn located within the city limits, more than one demolished building may be included in the burn, provided that the sum total of all building material to be burned at a designated site does not exceed 1700 square feet in size. For a controlled burn site located outside the city limits, the sum total of all building material to be burned, per day, may not exceed 1700 square feet in size. For purposes of this subparagraph, "square feet" includes both finished and unfinished basements and excludes unfinished attics, carports, attached garages, and porches that are not protected from weather.

(6) *Time of day requirements.* The controlled burning of a demolished building may be conducted only between the hours of 6 a.m. and 6 p.m. and only when weather conditions are favorable with respect to surrounding property. The city shall adequately schedule and sufficiently control the burn to ensure that burning is completed by 6 p.m.

(7) *Prohibited materials.* Rubber tires, chemicals, furniture, carpeting, household appliances, vinyl products (such as flooring or siding), trade waste, garbage, rubbish, landscape waste, residential waste, and other nonstructural materials shall not be burned.

(8) *Limits on the number and location of burns.* For burns conducted within the city limits, each city may undertake no more than one controlled burn of demolished building material in every 0.6-mile-radius circle during each calendar year. For burn sites established outside the city limits, each city shall undertake no more than one controlled burn of demolished building material per day. A burn site outside the city limits must be located at least 0.6 of a mile from any building inhabited by a person, as "person" is defined in Iowa Code section 362.2(17).

(9) *Requirements for burn access and supervision.* The city shall control access to all demolished building burn sites. Representatives of the city who are city employees or who are hired by the city shall supervise the burning of demolished building material at all times.

(10) *Record-keeping requirements.* The city shall retain at least one copy of all notifications and supplementary information required to be sent to the department under subparagraph (2). Additionally, the city shall maintain a map of the exact location of each burn site, and supporting documentation showing the date of each demolished building burn and the square feet of building material burned on each date. All maps, notifications and associated records shall be maintained by the city clerk, as "clerk" is defined in Iowa Code section 362.2(7), for a period of at least three years and shall be made available for inspection by the department upon request.

(11) *Variance from this paragraph.* In accordance with 567—subrules 21.2(1) and 23.2(2), a city may apply for a variance from the specific conditions for controlled burning of a demolished building and may request that the director conduct a review of the ambient air impacts of the request. The director shall approve or deny the request in accordance with 567—subrule 21.2(4).

(12) *Compliance with other applicable environmental regulations.* Compliance with the exemption requirements in this paragraph shall not absolve a city of the responsibility to comply with any other applicable environmental regulations. In particular, a city conducting a controlled burn of a demolished building shall comply with all applicable solid waste disposal, including ash disposal, and solid waste permitting rules contained in 567—Chapters 100 through 130, as well as all applicable storm water discharge and storm water permitting rules contained in 567—Chapters 60 and 64.

23.2(4) *Unavailability of exemptions in certain areas.* Notwithstanding 23.2(2) and 23.2(3)*"b," "d," "f,"* and *"i,"* no person shall allow, cause or permit the open burning of trees or tree trimmings, residential or landscape waste or agricultural structures in the cities of: Cedar Rapids, Marion, Hiawatha, Council Bluffs, Carter Lake, Des Moines, West Des Moines, Clive, Windsor Heights, Urbandale, and Pleasant Hill.

This rule is intended to implement Iowa Code section 455B.133.

567—23.3(455B) Specific contaminants.

23.3(1) *General.* The emission standards contained in this rule shall apply to each source operation unless a specific emission standard for the process involved is prescribed elsewhere in this chapter, in which case the specific standard shall apply.

23.3(2) *Particulate matter.* No person shall cause or allow the emission of particulate matter from any source in excess of the emission standards specified in this chapter, except as provided in 567—Chapter 24.

a. *General emission rate.*

(1) For sources constructed, modified or reconstructed on or after July 21, 1999, the emission of particulate matter from any process shall not exceed an emission standard of 0.1 grain per dry standard cubic foot (dscf) of exhaust gas, except as provided in 567—21.2(455B), 23.1(455B), 23.4(455B), and 567—Chapter 24.

(2) For sources constructed, modified or reconstructed prior to July 21, 1999, the emission of particulate matter from any process shall not exceed the amount determined from Table I, or amount specified in a permit if based on an emission standard of 0.1 grain per standard cubic foot of exhaust gas, or established from standards provided in 23.1(455B) and 23.4(455B).

TABLE I
ALLOWABLE RATE OF EMISSION BASED ON PROCESS WEIGHT RATE*

Process Weight Rate		Emission Rate	Process Weight Rate		Emission Rate
Lb/Hr	Tons/Hr	Lb/Hr	Lb/Hr	Tons/Hr	Lb/Hr
100	0.05	0.55	16,000	8.00	16.5
200	0.10	0.88	18,000	9.00	17.9
400	0.20	1.40	20,000	10.00	19.2
600	0.30	1.83	30,000	15.00	25.2
800	0.40	2.22	40,000	20.00	30.5
1,000	0.50	2.58	50,000	25.00	35.4
1,500	0.75	3.38	60,000	30.00	40.0
2,000	1.00	4.10	70,000	35.00	41.3
2,500	1.25	4.76	80,000	40.00	42.5
3,000	1.50	5.38	90,000	45.00	43.6
3,500	1.75	5.96	100,000	50.00	44.6
4,000	2.00	6.52	120,000	60.00	46.3
5,000	2.50	7.58	140,000	70.00	47.8
6,000	3.00	8.56	160,000	80.00	49.0
7,000	3.50	9.49	200,000	100.00	51.2
8,000	4.00	10.4	1,000,000	500.00	69.0
9,000	4.50	11.2	2,000,000	1,000.00	77.6
10,000	5.00	12.0	6,000,000	3,000.00	92.7
12,000	6.00	13.6			

*Interpolation of the data in this table for process weight rates up to 60,000 lb/hr shall be accomplished by the use of the equation

$$E=4.10\ P^{0.67},$$

and interpolation and extrapolation of the data for process weight rates in excess of 60,000 lb/hr shall be accomplished by use of the equation

$$E=55.0\ P^{0.11}—40,$$

where E = rate of emission in lb/hr, and

P = process weight in tons/hr

b. Combustion for indirect heating. Emissions of particulate matter from the combustion of fuel for indirect heating or for power generation shall be limited by the ASME Standard APS-1, Second Edition, November, 1968, "Recommended Guide for the Control of Dust Emission—Combustion for Indirect Heat Exchangers." For the purpose of this paragraph, the allowable emissions shall be calculated from equation (15) in that standard, with $Comax^2$=50 micrograms per cubic meter. Allowable emissions from a single stack may be estimated from Figure 1. The maximum ground level dust concentrations designated are above the background level. For plants with 4,000 million Btu/hour input or more, the "a" factor shall be 1.0. In plants with less than 4,000 million Btu/hour input, appropriate "a" factors, less than 1.0, shall be applied. Pertinent correction factors, as specified in the standard, shall be applied for installations with multiple stacks. However, for fuel-burning units in operation on January 13, 1976, the maximum allowable emissions calculated under APS-1 for the facility's equipment configuration on January 13, 1976, shall not be increased even if the changes in the equipment or stack configuration would otherwise allow a recalculation and a higher maximum allowable emission under APS-1.

(1) Outside any standard metropolitan statistical area, the maximum allowable emissions from each stack, irrespective of stack height, shall be 0.8 pounds of particulates per million Btu input.

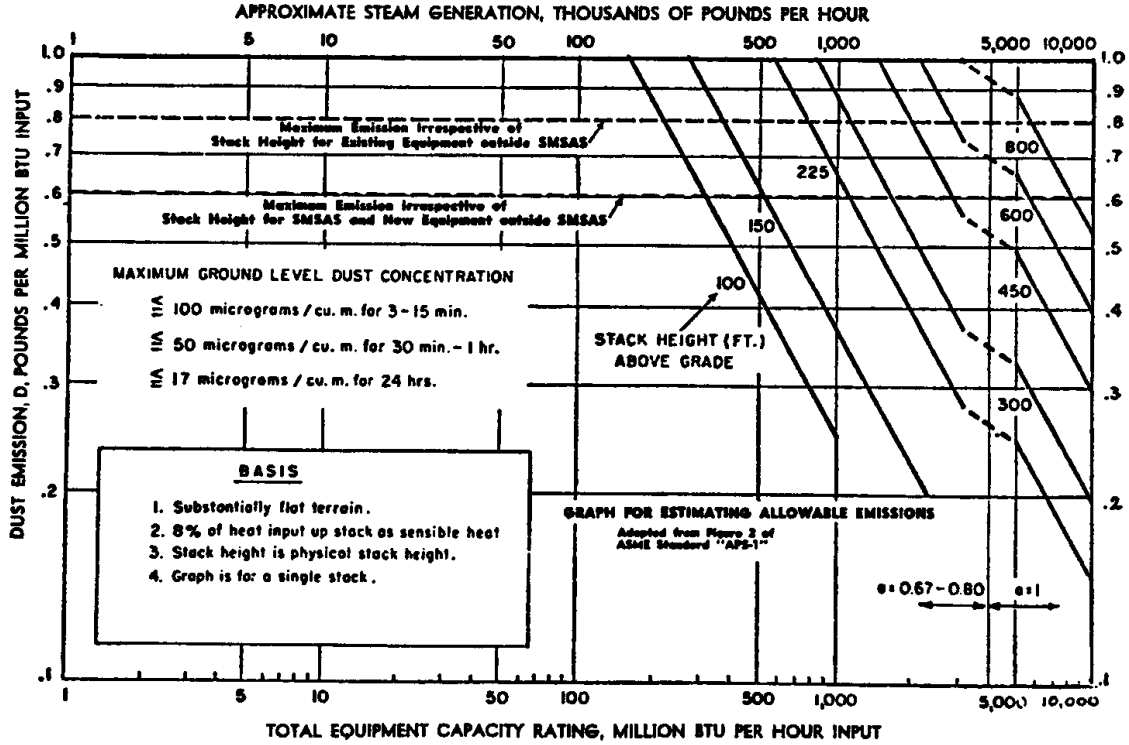
(2) Inside any standard metropolitan statistical area, the maximum allowable emission from each stack, irrespective of stack height, shall be 0.6 pounds of particulates per million Btu input.

(3) For a new fossil fuel-fired steam generating unit of more than 250 million Btu per hour heat input, 23.1(2)*"a"* shall apply. For a new unit of between 150 million and 250 million (inclusive) Btu per hour heat input, the maximum allowable emissions from such new unit shall be 0.2 pounds of particulates per million Btu of heat input. For a new unit of less than 150 million Btu per hour heat input, the maximum allowable emissions from such new unit shall be 0.6 pounds of particulates per million Btu of heat input.

(4) Measurements of emissions from a particulate source will be made in accordance with the provisions of 567—Chapter 25.

FIGURE 1

COMBUSTION FOR INDIRECT HEAT EXCHANGERS



(5) For fuel-burning sources in operation prior to July 29, 1977, which are not subject to 23.1(2) and which significantly impact a primary or secondary particulate standard nonattainment area, the emission limitations specified in this subparagraph apply. A significant impact shall be equal to or exceeding 5 micrograms of particulate matter per cubic meter of air (24-hour average) or 1 microgram of particulate matter per cubic meter of air (annual average) determined by an EPA approved single source dispersion model using allowable emission rates and five-year worst case meteorological conditions. In the case where two or more boilers discharge into a common stack, the applicable stack emission limitation shall be based upon the heat input of the largest operating boiler. The plantwide allowable emission limitation shall be the weighted average of the allowable emission limitations for each stack or the applicable APS-1 plantwide standard as determined under paragraph 23.3(2)*"b,"* whichever is more stringent.

The maximum allowable emission rate for a single stack with a total heat input capacity less than 250 million Btu per hour shall be 0.60 pound of particulate matter per million Btu heat input; the maximum allowable emission rate for a single stack with a total heat input capacity greater than or equal to 250 million Btu per hour and less than 500 million Btu per hour shall be 0.40 pound of particulate matter per million Btu heat input; the maximum allowable emission rate for a single stack with a total heat input capacity greater than or equal to 500 million Btu per hour shall be 0.30 pound of particulate matter per

million Btu heat input; except that the maximum allowable emission rate for the stack serving Unit #1 of Iowa Public Service at Port Neal shall be 0.50 pound of particulate matter per million Btu heat input.

All sources regulated under this subparagraph shall demonstrate compliance by October 1, 1981; however, a source is considered to be in compliance with this subparagraph if by October 1, 1981, it is on a compliance schedule to be completed as expeditiously as possible, but no later than December 31, 1982.

c. Fugitive dust.

(1) Attainment and unclassified areas. A person shall take reasonable precautions to prevent particulate matter from becoming airborne in quantities sufficient to cause a nuisance as defined in Iowa Code section 657.1 when the person allows, causes or permits any materials to be handled, transported or stored or a building, its appurtenances or a construction haul road to be used, constructed, altered, repaired or demolished, with the exception of farming operations or dust generated by ordinary travel on unpaved roads. Ordinary travel includes routine traffic and road maintenance activities such as scarifying, compacting, transporting road maintenance surfacing material, and scraping of the unpaved public road surface. All persons, with the above exceptions, shall take reasonable precautions to prevent the discharge of visible emissions of fugitive dusts beyond the lot line of the property on which the emissions originate. The public highway authority shall be responsible for taking corrective action in those cases where said authority has received complaints of or has actual knowledge of dust conditions which require abatement pursuant to this subrule. Reasonable precautions may include, but not be limited to, the following procedures.

1. Use, where practical, of water or chemicals for control of dusts in the demolition of existing buildings or structures, construction operations, the grading of roads or the clearing of land.

2. Application of suitable materials, such as but not limited to asphalt, oil, water or chemicals on unpaved roads, material stockpiles, race tracks and other surfaces which can give rise to airborne dusts.

3. Installation and use of containment or control equipment, to enclose or otherwise limit the emissions resulting from the handling and transfer of dusty materials, such as but not limited to grain, fertilizer or limestone.

4. Covering, at all times when in motion, open-bodied vehicles transporting materials likely to give rise to airborne dusts.

5. Prompt removal of earth or other material from paved streets or to which earth or other material has been transported by trucking or earth-moving equipment, erosion by water or other means.

6. Reducing the speed of vehicles traveling over on-property surfaces as necessary to minimize the generation of airborne dusts.

(2) Nonattainment areas. Subparagraph (1) notwithstanding, no person shall allow, cause or permit any visible emission of fugitive dust in a nonattainment area for particulate matter to go beyond the lot line of the property on which a traditional source is located without taking reasonable precautions to prevent emission. Traditional source means a source category for which a particulate emission standard has been established in 23.1(2), 23.3(2)*"a,"* 23.3(2)*"b"* or 23.4(455B) and includes a quarry operation, haul road or parking lot associated with a traditional source. This paragraph does not modify the emission standard stated in 23.1(2), 23.3(2)*"a,"* 23.3(2)*"b"* or 23.4(455B), but rather establishes a separate requirement for fugitive dust from such sources. For guidance on the types of controls which may constitute reasonable precautions, see "Identification of Techniques for the Control of Industrial Fugitive Dust Emissions," [available from the department] adopted by the commission on May 19, 1981.

(3) Reclassified areas. Reasonable precautions implemented pursuant to the nonattainment area provisions of subparagraph (2) shall remain in effect if the nonattainment area is redesignated to either attainment or unclassified after March 6, 1980.

d. Visible emissions. No person shall allow, cause or permit the emission of visible air contaminants into the atmosphere from any equipment, internal combustion engine, premise fire, open fire or stack, equal to or in excess of 40 percent opacity or that level specified in a construction permit, except as provided below and in 567—Chapter 24.

(1) *Residential heating equipment.* Residential heating equipment serving dwellings of four family units or less is exempt.

(2) *Gasoline-powered vehicles.* No person shall allow, cause or permit the emission of visible air contaminants from gasoline-powered motor vehicles for longer than five consecutive seconds.

(3) *Diesel-powered vehicles.* No person shall allow, cause or permit the emission of visible air contaminants from diesel-powered motor vehicles in excess of 40 percent opacity, for longer than five consecutive seconds.

(4) *Diesel-powered locomotives.* No person shall allow, cause or permit the emission of visible air contaminants from diesel-powered locomotives in excess of 40 percent opacity, except for a maximum period of 40 consecutive seconds during acceleration under load, or for a period of four consecutive minutes when a locomotive is loaded after a period of idling.

(5) *Startup and testing.* Initial start and warmup of a cold engine, the testing of an engine for trouble, diagnosis or repair, or engine research and development activities, is exempt.

(6) *Uncombined water.* The provisions of this paragraph shall apply to any emission which would be in violation of these provisions except for the presence of uncombined water, such as condensed water vapor.

23.3(3) *Sulfur compounds.* The provisions of this subrule shall apply to any installation from which sulfur compounds are emitted into the atmosphere.

a. Sulfur dioxide from use of solid fuels.

(1) No person shall allow, cause, or permit the emission of sulfur dioxide into the atmosphere from an existing solid fuel-burning unit, (i.e., a unit which was in operation or for which components had been purchased, or which was under construction prior to September 23, 1970), in an amount greater than 6 pounds, replicated maximum three-hour average, per million Btu of heat input if such unit is located within the following counties: Black Hawk, Clinton, Des Moines, Dubuque, Jackson, Lee, Linn, Lousia, Muscatine and Scott.

(2) No person shall allow, cause, or permit the emission of sulfur dioxide into the atmosphere from an existing solid fuel-burning unit, (i.e., a unit which was in operation or for which components had been purchased, or which was under construction prior to September 23, 1970), in an amount greater than 5 pounds, replicated maximum three-hour average, per million Btu of heat input if such unit is located within the remaining 89 counties of the state not listed in subparagraph 23.3(3)*"a"*(1).

(3) No person shall allow, cause, or permit the emission of sulfur dioxide into the atmosphere from any new solid fuel-burning unit (i.e., a unit which was not in operation or for which components had not been purchased, or which was not under construction prior to September 23, 1970) which has a capacity of 250 million Btu or less per hour heat input, in an amount greater than 6 pounds, replicated maximum three-hour average, per million Btu of heat input.

(4) Subparagraphs (1) through (3) notwithstanding, a fossil fuel-fired steam generator to which 23.1(2)*"a,"*23.1(2)*"z"* or 23.1(2)*"ccc"* applies shall comply with 23.1(2)*"a,"*23.1(2)*"z"* or 23.1(2)*"ccc,"* respectively.

b. Sulfur dioxide from use of liquid fuels.

(1) No person shall allow, cause, or permit the combustion of number 1 or number 2 fuel oil exceeding a sulfur content of 0.5 percent by weight.

(2) No person shall allow, cause, or permit the emission of sulfur dioxide into the atmosphere in an amount greater than 2.5 pounds of sulfur dioxide, replicated maximum three-hour average, per million Btu of heat input from a liquid fuel-burning unit.

(3) Notwithstanding this paragraph, a fossil fuel-fired steam generator to which 23.1(2)*"a,"*23.1(2)*"z"* or 23.1(2)*"ccc"* applies shall comply with 23.1(2)*"a,"*23.1(2)*"z"* or 23.1(2)*"ccc."*

c. Sulfur dioxide from sulfuric acid manufacture. After January 1, 1975, no person shall allow, cause or permit the emission of sulfur dioxide from an existing sulfuric acid manufacturing plant in excess of 30 pounds of sulfur dioxide, maximum three-hour average, per ton of product calculated as 100 percent sulfuric acid.

d. Acid mist from sulfuric acid manufacture. After January 1, 1974, no person shall allow, cause or permit the emission of acid mist calculated as sulfuric acid from an existing sulfuric acid manufacturing plant in excess of 0.5 pounds, maximum three-hour average, per ton of product calculated as 100 percent sulfuric acid.

e. Other processes capable of emitting sulfur dioxide. After January 1, 1974, no person shall allow, cause or permit the emission of sulfur dioxide from any process, other than sulfuric acid manufacture, in excess of 500 parts per million, based on volume. This paragraph shall not apply to devices which have been installed for air pollution abatement purposes where it is demonstrated by the owner of the source that the ambient air quality standards are not being exceeded.

This rule is intended to implement Iowa Code section 455B.133.

567—23.4(455B) Specific processes.

23.4(1) *General.* The provisions of this rule shall not apply to those facilities for which performance standards are specified in 23.1(2). The emission standards specified in this rule shall apply and those specified in 23.3(2)*"a"* and 23.3(2)*"b"* shall not apply to each process of the types listed in the following subrules, except as provided below.

EXCEPTION: Whenever the director determines that a process complying with the emission standard prescribed in this section is causing or will cause air pollution in a specific area of the state, the specific emission standard may be suspended and compliance with the provisions of 23.3(455B) may be required in such instance.

23.4(2) *Asphalt batching plants.* No person shall cause, allow or permit the operation of an asphalt batching plant in a manner such that the particulate matter discharged to the atmosphere exceeds 0.15 grain per standard cubic foot of exhaust gas.

23.4(3) *Cement kilns.* Cement kilns shall be equipped with air pollution control devices to reduce the particulate matter in the gas discharged to the atmosphere to no more than 0.3 percent of the particulate matter entering the air pollution control device. Regardless of the degree of efficiency of the air pollution control device, particulate matter discharged from such kilns shall not exceed 0.1 grain per standard cubic foot of exhaust gas.

23.4(4) *Cupolas for metallurgical melting.* The emissions of particulate matter from all new foundry cupolas, and from all existing foundry cupolas with a process weight rate in excess of 20,000 pounds per hour, shall not exceed the amount specified in paragraph 23.3(2)*"a,"* except as provided in 567—Chapter 24.

The emissions of particulate matter from all existing foundry cupolas with a process weight rate less than or equal to 20,000 pounds per hour shall not exceed the amount determined from Table II of these rules, except as provided in 567—Chapter 24.

TABLE II
ALLOWABLE EMISSIONS FROM
EXISTING SMALL FOUNDRY CUPOLAS

Process weight rate (lb/hr)	Allowable emission (lb/hr)
1,000	3.05
2,000	4.70
3,000	6.35
4,000	8.00
5,000	9.58
6,000	11.30
7,000	12.90
8,000	14.30

Process weight rate (lb/hr)	Allowable emission (lb/hr)
9,000	15.50
10,000	16.65
12,000	18.70
16,000	21.60
18,000	23.40
20,000	25.10

23.4(5) *Electric furnaces for metallurgical melting.* The emissions of particulate matter to the atmosphere from electric furnaces used for metallurgical melting shall not exceed 0.1 grain per standard cubic foot of exhaust gas.

23.4(6) *Sand handling and surface finishing operations in metal processing.* This subrule shall apply to any new foundry or metal processing operation not properly termed a combustion, melting, baking or pouring operation. For purposes of this subrule, a new process is any process which has not started operation, or the construction of which has not been commenced, or the components of which have not been ordered or contracts for the construction of which have not been let on August 1, 1977. No person shall allow, cause or permit the operation of any equipment designed for sand shakeout, mulling, molding, cleaning, preparation, reclamation or rejuvenation or any equipment for abrasive cleaning, shot blasting, grinding, cutting, sawing or buffing in such a manner that particulate matter discharged from any stack exceeds 0.05 grains per dry standard cubic foot of exhaust gas, regardless of the types and number of operations that discharge from the stack.

23.4(7) *Grain handling and processing plants.* The owner or operator of equipment at a permanent installation for the handling or processing of grain, grain products and grain by-products shall not cause, allow or permit the particulate matter discharged to the atmosphere to exceed 0.1 grain per dry standard cubic foot of exhaust gas, except as follows:

a. The particulate matter discharged to the atmosphere from a grain bin vent at a country grain elevator, as "country grain elevator" is defined in 567—subrule 22.10(1), shall not exceed 1.0 grain per dry standard cubic foot of exhaust gas.

b. The particulate matter discharged to the atmosphere from a grain bin vent that was constructed, modified or reconstructed before March 31, 2008, at a country grain terminal elevator, as "country grain terminal elevator" is defined in 567—subrule 22.10(1), or at a grain terminal elevator, as "grain terminal elevator" is defined in 567—subrule 22.10(1), shall not exceed 1.0 grain per dry standard cubic foot of exhaust gas.

c. The particulate matter discharged to the atmosphere from a grain bin vent that is constructed or reconstructed on or after March 31, 2008, at a country grain terminal elevator, as "country grain terminal elevator" is defined in 567—subrule 22.10(1), or at a grain terminal elevator, as "grain terminal elevator" is defined in 567—subrule 22.10(1), shall not exceed 0.1 grain per dry standard cubic foot of exhaust gas.

23.4(8) *Lime kilns.* No person shall cause, allow or permit the operation of a kiln for the processing of limestone such that the particulate matter in the gas discharged to the atmosphere exceeds 0.1 grain per standard cubic foot of exhaust gas.

23.4(9) *Meat smokehouses.* No person shall cause, allow or permit the operation of a meat smokehouse or a group of meat smokehouses, which consume more than ten pounds of wood, sawdust or other material per hour such that the particulate matter discharged to the atmosphere exceeds 0.2 grain per standard cubic foot of exhaust gas.

23.4(10) *Phosphate processing plants.*

a. Phosphoric acid manufacture. No person shall allow, cause or permit the operation of equipment for the manufacture of phosphoric acid that was in existence on October 22, 1974, in a

manner that produces more than 0.04 pound of fluoride per ton of phosphorous pentoxide or equivalent input.

b. Diammonium phosphate manufacture. No person shall allow, cause or permit the operation of equipment for the manufacture of diammonium phosphate that was in existence on October 22, 1974, in a manner that produces more than 0.15 pound of fluoride per ton of phosphorous pentoxide or equivalent input.

c. Nitrophosphate manufacture. No person shall allow, cause or permit the operation of equipment for the manufacture of nitrophosphate in a manner that produces more than 0.06 pound of fluoride per ton of phosphorus pentoxide or equivalent input.

d. No person shall allow, cause or permit the operation of equipment for the processing of phosphate ore, rock or other phosphatic material (other than equipment used for the manufacture of phosphoric acid, diammonium phosphate or nitrophosphate) in a manner that the unit emissions of fluoride exceed 0.4 pound of fluoride per ton of phosphorous pentoxide or its equivalent input.

e. Notwithstanding *"a"* through *"d,"* no person shall allow, cause or permit the operation of equipment for the processing of phosphorous ore, rock or other phosphatic material including, but not limited to, phosphoric acid, in a manner that emissions of fluorides exceed 100 pounds per day.

f. "Fluoride" means elemental fluorine and all fluoride compounds as measured by reference methods specified in Appendix A to 40 CFR Part 60 as amended through March 12, 1996.

g. Calculation. The allowable total emission of fluoride shall be calculated by multiplying the unit emission specified above by the expressed design production capacity of the process equipment.

23.4(11) *Portland cement concrete batching plants.* No person shall cause, allow or permit the operation of a Portland cement concrete batching plant such that the particulate matter discharged to the atmosphere exceeds 0.1 grain per standard cubic foot of exhaust gas.

23.4(12) *Incinerators.* A person shall not cause, allow or permit the operation of an incinerator unless provided with appropriate control of emissions of particulate matter and visible air contaminants.

a. *Particulate matter.* A person shall not cause, allow or permit the operation of an incinerator with a rated refuse burning capacity of 1000 or more pounds per hour in a manner such that the particulate matter discharged to the atmosphere exceeds 0.2 grain per standard cubic foot of exhaust gas adjusted to 12 percent carbon dioxide.

A person shall not cause, allow or permit the operation of an incinerator with a rated refuse burning capacity of less than 1000 pounds per hour in a manner such that the particulate matter discharged to the atmosphere exceeds 0.35 grain per standard cubic foot of exhaust gas adjusted to 12 percent carbon dioxide.

b. *Visible emissions.* A person shall not allow, cause or permit the operation of an incinerator in a manner such that it produces visible air contaminants in excess of 40 percent opacity; except that visible air contaminants in excess of 40 percent opacity but less than or equal to 60 percent opacity may be emitted for periods aggregating not more than 3 minutes in any 60-minute period during an operation breakdown or during the cleaning of air pollution control equipment.

23.4(13) *Painting and surface-coating operations.* No person shall allow, cause or permit painting and surface-coating operations in a manner such that particulate matter in the gas discharge exceeds 0.01 grain per standard cubic foot of exhaust gas.

This rule is intended to implement Iowa Code section 455B.133.

567—23.5(455B) Anaerobic lagoons.

23.5(1) Applications for construction permits for animal feeding operations using anaerobic lagoons shall meet the requirements of rules 567—65.9(455B) and 65.15(455B) to 65.17(455B).

23.5(2) Criteria for approval of industrial anaerobic lagoons.

a. Lagoons designed to treat 100,000 gpd or less.

(1) The sulfate content of the water supply shall not exceed 250 mg/l. However, this paragraph does not apply to an expansion of an industrial anaerobic lagoon facility which was constructed prior to February 22, 1979.

(2) The design loading rate for the total lagoon volume shall not be less than 10 pounds nor more than 20 pounds of biochemical oxygen demand (five day) per thousand cubic feet per day.

b. Lagoons designed to treat more than 100,000 gpd.

(1) The sulfate content of the water supply shall not exceed 100 mg/l. However, this paragraph does not apply to an expansion of an industrial anaerobic lagoon facility which was constructed prior to February 22, 1979.

(2) The design loading rate for the total lagoon volume shall not be less than 10 pounds nor more than 20 pounds of biochemical oxygen demand (five day) per thousand cubic feet per day.

This rule is intended to implement Iowa Code section 455B.133.

567—23.6(455B) Alternative emission limits (the "bubble concept"). Emission limits for individual emission points included in 23.3(455B) (except 23.3(2)*"d,"*23.3(2)*"b"*(3), and 23.3(3)*"a"*(3)) and 23.4(455B) (except 23.4(12)*"b"* and 23.4(6)) may be replaced by alternative emission limits. The alternative emission limits must be consistent with 567—22.7(455B) and 567—subrule 25.1(12). Under this rule, less stringent control limits where costs of emission control are high may be allowed in exchange for more stringent control limits where costs of control are less expensive.

Rules 23.3(455B) to 23.6(455B) are intended to implement Iowa Code section 455B.133.

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[Editorial change: IAC Supplement 12/1/10]

◊ Two or more ARCs

1 Objection, see filed rule [DEQ, 4.2(4)] published IAC Supp. 1/22/77, 3/9/77.

2 Effective date of 23.2(4) delayed 70 days by the Administrative Rules Review Committee on 9/14/83.

3 11/24/10 effective date of 23.1(4), introductory paragraph, and 23.1(4) *"ev"* and *"fa"* to *"fd"* delayed 70 days by the Administrative Rules Review Committee at its meeting held November 9, 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; **ARC 9244B**, IAB 12/1/10, effective 1/5/11]

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.

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[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]

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CHAPTER 1
REPORTABLE DISEASES, POISONINGS AND CONDITIONS, AND QUARANTINE AND ISOLATION

641—1.1(139A) Definitions. For the purpose of these rules, the following definitions shall apply:

"Acute or chronic respiratory conditions due to fumes, vapors or dusts" means acute chemical bronchitis; any acute, subacute, or chronic respiratory condition due to inhalation of a chemical fume or vapor; or pneumoconioses not specifically listed elsewhere in these rules. (ICD-10 codes J63.0 to J64, J66, and J68.0 to J68.9) "Acute or chronic respiratory conditions due to fumes, vapors or dusts" excludes those respiratory conditions related to tobacco smoke exposure.

"Agriculturally related injury" means any nonhousehold injury to a farmer, farm worker, farm family member, or other individual, which occurred on a farm, or in the course of handling, producing, processing, transporting or warehousing farm commodities.

"AIDS" means AIDS as defined in Iowa Code section 141A.1.

"Area quarantine" means prohibiting ingress to and egress from a building or buildings, structure or structures, or other definable physical location, or portion thereof, to prevent or contain the spread of a suspected or confirmed quarantinable disease or to prevent or contain exposure to a suspected or known chemical, biological, radioactive, or other hazardous or toxic agent.

"Business" means and includes every trade, occupation, or profession.

"Care provider" means an individual who is trained and authorized by federal or state law to provide health care services or services of any kind in the course of the individual's official duties, for compensation or in a voluntary capacity, who is a health care provider, emergency medical care provider as defined in Iowa Code section 147A.1, firefighter, or peace officer. "Care provider" also means an individual who renders emergency care or assistance in an emergency or due to an accident as described in Iowa Code section 613.17.

"Case" means an individual who has confirmatory evidence of disease.

"Clinical laboratory" means any laboratory performing analyses on specimens taken from the body of a person in order to assess that person's health status.

"Communicable disease" means any disease spread from person to person or animal to person.

"Congenital or inherited disorder" means congenital or inherited disorder as defined in Iowa Code section 136A.2.

"Contagious or infectious disease" means hepatitis in any form, meningococcal disease, tuberculosis, and any other disease, with the exception of AIDS or HIV infection as defined in Iowa Code section 141A.1, determined to be life-threatening to a person exposed to the disease based upon a determination by the state public health medical director and epidemiologist and in accordance with guidelines of the Centers for Disease Control and Prevention of the United States Department of Health and Human Services.

"Department" means the Iowa department of public health.

"Designated officer" means a person who is designated by a department, agency, division, or service organization to act as an infection control liaison officer.

"Director" means the director of the Iowa department of public health.

"Exposure" means the risk of contracting disease.

"Fetal death" means an unintended death occurring after a gestation period of 20 completed weeks, or an unintended death of a fetus with a weight of 350 or more grams. "Fetal death" is synonymous with stillbirth.

"HBV" means hepatitis B virus.

"Health care facility" means a health care facility as defined in Iowa Code section 135C.1, an ambulatory surgical center, or a clinic.

"Health care provider" means a person licensed to practice medicine and surgery, osteopathic medicine and surgery, osteopathy, chiropractic, podiatry, nursing, dentistry, optometry, or licensed as a physician assistant, dental hygienist, or acupuncturist.

"HIV" means HIV as defined in Iowa Code section 141A.1.

"Hospital" means hospital as defined in Iowa Code section 135B.1.

"Hypersensitivity pneumonitis" means a disease in which the air sacs (alveoli) of the lungs become inflamed when certain dusts are inhaled to which the person is sensitized or allergic. "Hypersensitivity pneumonitis" includes but is not limited to farmer's lung, silo filler's disease, and toxic organic dust syndrome.

"IDSS" means the Iowa disease surveillance system, a secure Web-based statewide disease reporting and surveillance system.

"Infectious disease" means a disease caused by the entrance into the body of organisms, including but not limited to bacteria, protozoans, fungi, prions, or viruses which grow and multiply.

"Infectious tuberculosis" means pulmonary or laryngeal tuberculosis as evidenced by:

1. Isolation of M. tuberculosis complex (positive culture) from a clinical specimen or positive nucleic acid amplification test, or

2. Both radiographic evidence of tuberculosis, such as an abnormal chest X-ray, and clinical evidence, such as a positive skin test or whole blood assay test for tuberculosis infection, coughing, sputum production, fever, or other symptoms compatible with infectious tuberculosis that lead a physician to diagnose infectious tuberculosis according to currently acceptable standards of medical practice and to initiate treatment for tuberculosis.

"Injury" means physical damage or harm to the body as the result of an act or event.

"Investigation" means an inquiry conducted to determine the specific source, mode of transmission, and cause of a disease or suspected disease occurrence and to determine the specific incidence, prevalence, and extent of the disease in the affected population. "Investigation" may also include the application of scientific methods and analysis to institute appropriate control measures.

"Isolation" means the separation of persons or animals presumably or actually infected with a communicable disease, or that are disease carriers, for the usual period of communicability of that disease. Isolation shall be in such places, marked by placards if necessary, and under such conditions to prevent the direct or indirect conveyance of the infectious agent or contagion to susceptible persons.

"Local board" means the local board of health.

"Local department" means the local health department.

"Noncommunicable respiratory illnesses" means an illness indicating prolonged exposure or overexposure to asbestos, silica, silicates, aluminum, graphite, bauxite, beryllium, cotton dust or other textile material, or coal dust. "Noncommunicable respiratory illnesses" includes, but is not limited to asbestosis, coal worker's pneumoconiosis, and silicosis.

"Occupationally related asthma, bronchitis or respiratory hypersensitivity reaction" means any extrinsic asthma or acute chemical pneumonitis due to exposure to toxic agents in the workplace. (ICD-10 codes J67.0 to J67.9)

"Pesticide" means (1) any substance or mixture of substances intended for preventing, destroying, repelling, or mitigating directly or indirectly any insects, rodents, nematodes, fungi, weeds, and other forms of plant or animal life or viruses, except viruses on or in living persons, which the Iowa secretary of agriculture shall declare to be a pest; and (2) any substances intended for use as a plant growth regulator, defoliant, or desiccant. Pesticides include active and inert ingredients of herbicides, insecticides, rodenticides, repellants, fumigants, fungicides, wood treatment products, and disinfectants as well as adjuvants that are added to a pesticide formulation to improve or change properties such as deposition, persistence, or mixing ability.

"Pesticide poisoning" means any acute or subacute systemic, ophthalmologic, or dermatologic illness or injury resulting from or suspected of resulting from inhalation or ingestion of, dermal exposure to, or ocular contact with a pesticide. Laboratory confirmation is not required.

"Placard" means a warning sign to be erected and displayed on the periphery of a quarantine area, forbidding entry to or exit from the area.

"Poison control or poison information center" means any organization or program which has as one of its primary objectives the provision of toxicologic and pharmacologic information and referral services to the public and to health care providers (other than pharmacists) in response to inquiries about actual or potential poisonings.

"Public health disaster" means an incident as defined in Iowa Code section 135.140.

"Quarantinable disease" means any communicable disease which presents a risk of serious harm to public health and which may require isolation or quarantine to prevent its spread. "Quarantinable disease" includes but is not limited to cholera; diphtheria; infectious tuberculosis; plague; smallpox; yellow fever; viral hemorrhagic fevers, including Lassa, Marburg, Ebola, Crimean-Congo, South American, and others not yet isolated or named; novel influenza; and severe acute respiratory syndrome (SARS).

"Quarantine" means the limitation of freedom of movement of persons or animals that have been exposed to a quarantinable disease within specified limits marked by placards for a period of time equal to the longest usual incubation period of the disease in such manner as to prevent the spread of a quarantinable disease which affects people.

"Reportable cancers" means those cancers included in the National Cancer Institute's Surveillance, Epidemiology and End Results (SEER) Program.

"Reportable disease" means any disease designated by this chapter.

"Severe skin disorder" means those dermatoses, burns, and other severe skin disorders which result in death or which require hospitalization or other multiple courses of medical therapy.

"Sexually transmitted disease or infection" means a disease or infection as identified by this chapter that is transmitted through sexual practices. "Sexually transmitted disease or infection" includes, but is not limited to, acquired immunodeficiency syndrome (AIDS), chlamydia, gonorrhea, hepatitis B and hepatitis C, human immunodeficiency virus (HIV), human papillomavirus, and syphilis.

"Suspected case" means an individual that presents with clinical signs or symptoms indicative of a reportable or quarantinable disease.

"Toxic agent" means any noxious substance in solid, liquid or gaseous form capable of producing illness in humans including, but not limited to, pesticides, heavy metals, organic and inorganic dusts and organic solvents. Airborne toxic agents may be in the form of dusts, fumes, vapors, mists, gases or smoke.

"Toxic hepatitis" means any acute or subacute necrosis of the liver or other unspecified chemical hepatitis caused by exposure to nonmedicinal toxic agents other than ethyl alcohol including, but not limited to, carbon tetrachloride, chloroform, tetrachloroethane, trichloroethylene, phosphorus, trinitrotoluene (TNT), chloronapthalenes, methylenedianilines, ethylene dibromide, and organic solvents. (ICD-10 codes K71.0 to K71.9)

[**ARC 8231B**, IAB 10/7/09, effective 11/11/09]

641—1.2(139A) Purpose and authority.

1.2(1) *Purpose.* The purpose of this chapter is to establish rules that identify diseases, poisonings and conditions, and incidents that are to be reported to the department in accordance with Iowa Code chapters 135, 136A, 139A, 141A, and 144. These rules also establish the information to be reported, how and when to report, and who is to report. This chapter provides for disease investigation and disease control through preventive measures including but not limited to quarantine and isolation.

1.2(2) *Authority.* The director is the principal officer of the state to administer disease, poisoning and condition, and incident reporting and control. The State Health Registry of Iowa, administered by the Department of Epidemiology of the College of Public Health at the University of Iowa, is a public health authority for purposes of collecting cancer data in accordance with this chapter.

[**ARC 8231B**, IAB 10/7/09, effective 11/11/09]

REPORTABLE COMMUNICABLE AND INFECTIOUS DISEASES

641—1.3(139A,141A) Reportable communicable and infectious diseases. Reportable communicable and infectious diseases are those listed in Appendix A. The director may also designate any disease, poisoning or condition or syndrome temporarily reportable for the purpose of a special investigation.

[**ARC 8231B**, IAB 10/7/09, effective 11/11/09]

641—1.4(135,139A) Reporting of reportable communicable and infectious diseases. Each case of a reportable disease is required to be reported to the Iowa Department of Public Health, Lucas State Office Building, 321 E. 12th Street, Des Moines, Iowa 50319-0075, in a manner specified by this chapter.

1.4(1) *Who is required to report communicable and infectious diseases.*

a. Health care providers, hospitals, clinical laboratories, and other health care facilities are required to report cases of reportable communicable and infectious diseases.

b. School nurses are required to report suspected cases of reportable diseases occurring among the children supervised.

c. School officials, through the principal or superintendent as appropriate, are required to report when there is no school nurse.

d. Laboratories are required to report cases of reportable diseases and results obtained in the examination of all specimens which yield evidence of or are reactive for sexually transmitted diseases.

e. Poison control and poison information centers are required to report inquiries about cases of reportable diseases received by them.

f. Medical examiners are required to report their investigatory findings of any death which was caused by or otherwise involved a reportable disease.

g. Occupational nurses are required to report cases of reportable diseases.

h. Hospitals, health care providers and clinical laboratories outside the state of Iowa shall immediately report any confirmed or suspect case of a reportable disease, poisoning or condition in an Iowa resident.

1.4(2) *What to report.* Each report shall contain all of the following information:

a. The patient's name.

b. The patient's address.

c. The patient's date of birth.

d. The sex of the patient.

e. The race and ethnicity of the patient.

f. The patient's marital status.

g. The patient's telephone number.

h. The name and address of the laboratory.

i. The date the test was found to be positive and the collection date.

j. The name and address of the health care provider who performed the test

k. If the patient is female, whether the patient is pregnant.

l. The name of the reportable disease.

1.4(3) *How to report.*

a. Immediate reporting by telephone of diseases identified in Appendix A as immediately reportable. A health care provider and a public, private, or hospital clinical laboratory shall immediately report any confirmed or suspected case of a disease identified in Appendix A as immediately reportable to the department's disease notification hotline at 1-800-362-2736. The report shall include all information required by 1.4(2) and the following:

(1) The stage of the disease process.

(2) Clinical status.

(3) Any treatment provided for the disease.

(4) All household and other known contacts.

(5) Whether household and other known contacts have been examined and the results of such examinations.

b. Other diseases that carry serious consequences or spread rapidly. A health care facility, health care provider and a public, private, or hospital clinical laboratory shall immediately report any confirmed or suspected case of a common source epidemic or disease outbreak of unusual numbers by telephone to the department's 24/7 disease reporting telephone hotline at 1-800-362-2736.

c. Reporting of other reportable diseases. Cases of other reportable communicable or infectious diseases not included in 1.4(3)*"a"* shall be reported to the department in accordance with Appendix A by mail, telephone, facsimile, or other secure electronic means. The preferred method is secure Web-based

reporting when available. If the department determines that reporting by mail hinders the application of organized control measures to protect the public health, the department may require that the reportable disease be reported by telephone, facsimile or secure Web-based reporting.

1.4(4) *Contagious or infectious disease notification at time of death.* The purpose of this subrule is to establish contagious or infectious disease notification requirements for the information of any person handling a dead body.

a. A health care provider attending a person prior to the person's death shall, at the time of death, place with the body a written notice which specifies or signifies either "known contagious or infectious disease" or "suspected contagious or infectious disease."

b. The health care facility in which the health care provider is working shall be responsible for establishing written procedures and implementing the specific internal practices necessary to satisfy this notification requirement.

[**ARC 8231B**, IAB 10/7/09, effective 11/11/09]

REPORTABLE POISONINGS AND CONDITIONS—NONCOMMUNICABLE

641—1.5(139A,135) Reportable poisonings and conditions. Reportable poisonings and conditions are those listed in Appendix B. The director may also designate any disease, poisoning or condition or syndrome temporarily reportable for the purpose of a special investigation.

[**ARC 8231B**, IAB 10/7/09, effective 11/11/09]

641—1.6(135,139A) Reporting poisonings and conditions.

1.6(1) *Who is required to report.*

a. Health care providers, hospitals, and clinical laboratories and other health care facilities are required to report cases of reportable poisonings and conditions. Health care providers are exempted from reporting blood lead testing if the laboratory performing the analysis provides the report containing the required information to the department.

b. School nurses are required to report suspected cases of a reportable poisoning or condition occurring among the children supervised.

c. School officials, through the principal or superintendent as appropriate, are required to report when there is no school nurse.

d. Poison control and poison information centers are required to report inquiries about cases of a reportable poisoning or condition received by them.

e. Medical examiners are required to report their investigatory findings of any death which was caused by or otherwise involved a reportable poisoning or condition.

f. Occupational nurses are required to report cases of reportable poisonings and conditions.

g. Hospitals, health care providers and clinical laboratories outside the state of Iowa shall immediately report any confirmed or suspected case of a reportable poisoning or condition in an Iowa resident.

1.6(2) *What to report.* Each report shall contain all of the following information:

a. The patient's name.

b. The patient's address.

c. The patient's date of birth.

d. The sex of the patient.

e. The race and ethnicity of the patient.

f. The patient's marital status.

g. The patien's telephone number.

h. The name and address of the laboratory.

i. The collection date.

j. The analytical result.

k. In the case of blood lead testing, whether the sample is a capillary or venous blood sample.

l. For conditions not identified by a laboratory analysis, the date that the condition was diagnosed.

m. The name and address of the health care provider who performed the test.

n. If the patient is female, whether the patient is pregnant.

o. In the case of occupational conditions, the name of the patient's employer.

1.6(3) *How to report.*

a. Blood lead testing. All analytical results greater than or equal to 20 micrograms per deciliter (µg/dL) in a child under the age of six years or a pregnant woman shall be reported to the department immediately by telephone at 1-800-972-2026. All other analytical results shall be reported to the department at least weekly in an electronic format specified by the department.

b. Each instance of carbon monoxide poisoning shall be reported to the department immediately by telephone at 1-800-972-2026.

c. Reportable poisonings and conditions other than blood lead testing and carbon monoxide poisoning shall be reported to the department in accordance with Appendix B.

d. Occupational nurses shall submit cases of occupationally related reportable poisonings or conditions on report forms provided by the department.

[**ARC 8231B**, IAB 10/7/09, effective 11/11/09]

INVESTIGATION

641—1.7(135,139A) Investigation of reportable diseases. A health care provider and a public, private, or hospital clinical laboratory shall assist in a disease investigation conducted by the department, a local board, or a local department.

1.7(1) A health care provider and a clinical laboratory shall provide the department, local board, or local department with all information necessary to conduct the investigation, including but not limited to medical records; exposure histories; medical histories; contact information; and test results necessary to the investigation, including positive, pending, and negative test results.

1.7(2) Issuance of investigatory subpoenas.

a. The department may upon the written request of a local board of health, the state public health medical director and epidemiologist or designee, or the state public health veterinarian or designee, subpoena records, reports, or any other evidence necessary to conduct a disease investigation. The subpoena shall be signed by the division director of the division of acute disease prevention and emergency response or the division director's designee following review and approval of the written request for subpoena.

b. A written request for a subpoena shall contain the following:

(1) The name and address of the person, facility, or entity to which the subpoena will be directed;

(2) A specific description of the records, reports, or other evidence requested; and

(3) An explanation of why the documents sought to be subpoenaed are necessary for the department to conduct the disease investigation.

c. Each subpoena shall contain:

(1) The name and address of the person, facility, or entity to which the subpoena is directed;

(2) A description of the records, reports, or other evidence requested;

(3) The date, time, and location for production, inspection, or copying;

(4) The time within which a motion to quash or modify the subpoena must be filed;

(5) The signature, address, and telephone number of the division director;

(6) The date of issuance; and

(7) A return of service.

d. Process to challenge a subpoena.

(1) Any person who is aggrieved or adversely affected by compliance with the subpoena and who desires to challenge the subpoena must, within five days after service of the subpoena, or before the time specified for compliance if such time is less than five days, file with the department a motion to quash or modify the subpoena. The motion shall describe the reasons why the subpoena should be quashed or modified, and may be accompanied by legal briefs or factual affidavits.

(2) Upon receipt of a timely motion to quash or modify a subpoena, the department may request an administrative law judge to issue a decision. Oral argument may be scheduled at the discretion of the

administrative law judge. The administrative law judge may quash or modify the subpoena, deny the motion, or issue an appropriate protective order.

(3) A person aggrieved by a ruling of an administrative law judge who desires to challenge that ruling must appeal the ruling to the department by serving on the department director, either in person or by certified mail, a notice of appeal within ten days after the service of the decision of the administrative law judge. The department director's decision is final for purposes of judicial review.

e. Subpoenas issued under this subrule and requests, motions, and pleadings related to the issuance of subpoenas are confidential pursuant to Iowa Code sections 139A.3 and 22.7.

[**ARC 8231B**, IAB 10/7/09, effective 11/11/09]

ISOLATION AND QUARANTINE

641—1.8(139A) Isolation and quarantine. Isolation and quarantine should be consistent with guidelines provided by the Centers for Disease Control and Prevention's 2007 Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings, June 2007; http://www.cdc.gov/ncidod/dhqp/pdf/guidelines/Isolation2007.pdf.

[**ARC 8231B**, IAB 10/7/09, effective 11/11/09]

641—1.9(135,139A) Quarantine and isolation.

1.9(1) *Examination, testing, and treatment of quarantinable diseases.*

a. A health care provider who attends an individual with a suspected or active quarantinable disease shall make all reasonable efforts in accordance with guidance from a local health department or the department to examine or cause all household and other known contacts of the individual to be examined by a physician. The physician shall promptly report to the department the results of such examination. If the individual refuses or is unable to undergo examination, the health care provider shall promptly report such information to the department.

b. When required by the department, all contacts not examined by a physician, including all adult and minor contacts, shall submit to a diagnostic test or tests. If any suspicious abnormality is found, steps satisfactory to the department shall be taken to refer the individual promptly to a physician or appropriate medical facility for further evaluation and, if necessary, treatment. The referring health care provider or facility shall notify the receiving health care provider or facility of the suspicious abnormality. When requested by the department, a physician shall report the results of the examination of a contact to the case or suspected case or incident.

c. Upon order of the department or local board of health, an individual with a suspected or active quarantinable disease shall not attend the workplace or school and shall not be present at other public places until the individual receives the approval of the department or a local board of health to engage in such activity. Upon order of the department or local board of health, employers, schools and other public places shall exclude an individual with a suspected or active quarantinable disease. An individual may also be excluded from other premises or facilities if the department or a local board of health determines the premises or facilities cannot be maintained in a manner adequate to protect others against the spread of the disease.

d. A person diagnosed with or clinically suspected of having infectious tuberculosis shall complete voluntary treatment until, in the opinion of the attending physician or the state public health medical director and epidemiologist, the person's tuberculosis is cured or such person is no longer a threat to public health. If such person refuses to complete the course of voluntary treatment, the department or local board of health may issue an order compelling mandatory treatment. Such order shall include the identity of the person subject to the mandatory treatment order, a description of the treatment ordered, the medical basis upon which the treatment is ordered, and a description of the potential medical and legal consequences of violating such order. A person who violates a mandatory treatment order may be subject to the penalties provided in Iowa Code section 135.38 or 137.21 and may be placed under mandatory quarantine or isolation in accordance with the provisions of this chapter.

e. A person diagnosed with extrapulmonary tuberculosis or clinically suspected of having infectious tuberculosis who fails to comply with a physician's recommendation for diagnostic testing

may be ordered to undergo diagnostic testing by the department or local board of health. Such order shall include the identity of the person subject to mandatory diagnostic testing, a description of the diagnostic testing ordered, the medical basis upon which the diagnostic testing is ordered, and a description of the potential medical and legal consequences of violating such order. A person who violates a mandatory diagnostic testing order may be subject to the penalties provided in Iowa Code section 135.38 or 137.21 and may be placed under mandatory quarantine or isolation in accordance with the provisions of this chapter.

1.9(2) *General provisions.*

a. *Voluntary confinement.* Prior to instituting mandatory isolation or quarantine pursuant to this rule, the department or a local board of health may request that an individual or group of individuals voluntarily confine themselves to a private home or other facility.

b. *Quarantine and isolation.* The department and local boards of health are authorized to impose and enforce quarantine and isolation restrictions. Quarantine and isolation shall rarely be imposed by the department or by local boards of health. If a quarantinable disease occurs in Iowa, individuals with a suspected or active quarantinable disease and contacts to the case may be quarantined or isolated as the particular situation requires. Any quarantine or isolation imposed by the department or a local board of health shall be established and enforced in accordance with this rule.

1.9(3) *Conditions and principles.* The department and local boards of health shall adhere to all of the following conditions and principles when isolating or quarantining individuals or a group of individuals:

a. The isolation or quarantine shall be by the least restrictive means necessary to prevent the spread of a communicable or possibly communicable disease to others and may include, but not be limited to, confinement to private homes, other private premises, or public premises.

b. Isolated individuals shall be confined separately from quarantined individuals.

c. The health status of isolated or quarantined individuals shall be monitored regularly to determine if the individuals require further or continued isolation or quarantine.

d. If a quarantined individual subsequently becomes infected or is reasonably believed to have become infected with a communicable or possibly communicable disease, the individual shall be promptly removed to isolation.

e. Isolated or quarantined individuals shall be immediately released when the department or local board of health determines that the individuals pose no substantial risk of transmitting a communicable or possibly communicable disease.

f. The needs of isolated or quarantined individuals shall be addressed in a systematic and competent fashion including, but not limited to, providing adequate food; clothing; shelter; means of communicating with those in and outside of isolation or quarantine; medication; and competent medical care.

g. The premises used for isolation or quarantine shall be maintained in a safe and hygienic manner and shall be designed to minimize the likelihood of further transmission of infection or other harm to isolated or quarantined individuals.

h. To the extent possible, cultural and religious beliefs shall be considered in addressing the needs of individuals in isolation or quarantine premises and in establishing and maintaining the premises.

1.9(4) *Isolation and quarantine premises.*

a. Sites of isolation or quarantine shall be prominently placarded with isolation or quarantine signs prescribed and furnished by the department and posted on all sides of the building wherever access is possible.

b. An individual subject to isolation or quarantine shall obey the rules and orders of the department or the local board of health and shall not go beyond the isolation or quarantine premises.

c. The department or a local board of health may authorize physicians, health care workers, or others access to individuals in isolation or quarantine as necessary to meet the needs of isolated or quarantined individuals.

d. No individual, other than an individual authorized by the department or a local board of health, shall enter isolation or quarantine premises. If the department has requested the assistance of

law enforcement in enforcing the isolation or quarantine, the department shall provide law enforcement personnel with a list of individuals authorized to enter the isolation or quarantine premises.

e. Any individual entering an isolation or quarantine premises with or without authorization of the department or a local board of health may be isolated or quarantined pursuant to this rule.

1.9(5) *Isolation and quarantine by local boards of health.*

a. A local board of health may:

(1) Isolate individuals who are presumably or actually infected with a quarantinable disease;

(2) Quarantine individuals who have been exposed to a quarantinable disease;

(3) Establish and maintain places of isolation and quarantine; and

(4) Adopt emergency rules and issue orders as necessary to establish, maintain, and enforce isolation or quarantine.

b. Isolation and quarantine undertaken by a local board of health shall be accomplished according to the rules and regulations of the local board of health so long as such rules are not inconsistent with this chapter.

1.9(6) *Isolation and quarantine by the Iowa department of public health.*

a. Authority.

(1) The department, through the director, the department's medical director, or the director's or medical director's designee, may:

1. Isolate individuals or groups of individuals who are presumably or actually infected with a quarantinable disease; and

2. Quarantine individuals or groups of individuals who have been exposed to a quarantinable disease, including individuals who are unable or unwilling to undergo examination, testing, vaccination, or treatment, pursuant to Iowa Code section 135.144(9).

(2) The department may:

1. Establish and maintain places of isolation and quarantine; and

2. Adopt emergency rules and issue orders as necessary to establish, maintain, and enforce isolation or quarantine.

(3) Isolation and quarantine undertaken by the department, including isolation and quarantine undertaken by the department in the event of a public health disaster, shall be established pursuant to paragraph 1.9(6)*"b"* or *"c."*

b. Temporary isolation and quarantine without notice. The department may temporarily isolate or quarantine an individual or groups of individuals through an oral order, without notice, only if delay in imposing the isolation or quarantine would significantly jeopardize the department's ability to prevent or limit the transmission of a communicable or possibly communicable disease to others. If the department imposes temporary isolation or quarantine of an individual or groups of individuals through an oral order, the department shall issue a written order as soon as is reasonably possible and in all cases within 24 hours of issuance of the oral order if continued isolation or quarantine is necessary to prevent or limit the transmission of a communicable or possibly communicable disease.

c. Written order. The department may isolate or quarantine an individual or groups of individuals through a written order issued pursuant to this rule.

(1) The written order shall include all of the following:

1. The identity of the individual, individuals, or groups of individuals subject to isolation or quarantine.

2. The premises subject to isolation or quarantine.

3. The date and time at which isolation or quarantine commences.

4. The suspected communicable disease.

5. A description of the less restrictive alternatives that were attempted and were unsuccessful, or the less restrictive alternatives that were considered and rejected, and the reasons such alternatives were rejected.

6. A statement of compliance with the conditions and principles for isolation and quarantine specified in subrule 1.9(3).

7. The legal authority under which the order is requested.

8. The medical basis upon which isolation or quarantine is justified.

9. A statement advising the individual, individuals, or groups of individuals of the right to appeal the written order pursuant to subrule 1.9(7) and the rights of individuals and groups of individuals subject to quarantine and isolation as listed in subrule 1.9(8).

10. A copy of this chapter and the relevant definitions.

(2) A copy of the written order shall be provided to the individual to be isolated or quarantined within 24 hours of issuance of the order in accordance with any applicable process authorized by the Iowa Rules of Civil Procedure. If the order applies to a group or groups of individuals and it is impractical to provide individual copies, the order may be posted in a conspicuous place in the isolation or quarantine premises.

1.9(7) *Appeal from order imposing isolation or quarantine.*

a. *Contested case.* The subject of a department order imposing isolation or quarantine may appeal a written order and has the right to a contested case hearing regarding such appeal. The subject of a department order imposing isolation or quarantine may appeal the order by submitting a written appeal within ten days of receipt of the written order. The appeal shall be addressed to the Department of Public Health, Division of Epidemiology, Emergency Medical Services, and Disaster Operations, Lucas State Office Building, Des Moines, Iowa 50319-0075. Unless stayed by order of the director or a district court, the written order for quarantine or isolation shall remain in force and effect until the appeal is finally determined and disposed of upon its merits.

b. *Presiding officer.* The presiding officer in a contested case shall be the director or the director's designee. The director or the director's designee may be assisted by an administrative law judge in conducting the contested case hearing. The decision of the director or the director's designee shall be the department's final decision and is subject to judicial review in accordance with the provisions of Iowa Code chapter 17A.

c. *Proceeding.* The contested case hearing shall be conducted in accordance with the provisions contained at 641—Chapter 173. The hearing shall be held as soon as is practicable, and in no case later than ten days from the date of receipt of the appeal. The hearing may be held by telephonic or other electronic means if necessary to prevent additional exposure to the communicable or possibly communicable disease. In extraordinary circumstances and for good cause shown, the department may apply to continue the hearing date for up to ten additional days on a petition filed pursuant to this rule. The presiding officer may use discretion in granting a continuance giving due regard to the rights of the affected individuals, the protection of the public's health, and the availability of necessary witnesses and evidence.

d. *Judicial review.* The aggrieved party to the final decision of the department may petition for judicial review of that action pursuant to Iowa Code chapter 17A. Petitions for judicial review shall be filed within 30 days after the decision becomes final.

e. *Immediate judicial review of department order.* The department acknowledges that in certain circumstances the subject or subjects of a department order may desire immediate judicial review of a department order in lieu of proceeding with the contested case process. The department recognizes that the procedural step of pursuing exhaustion of administrative remedies may be inadequate for purposes of Iowa Code section 17A.19, and the department may consent to immediate jurisdiction of the district court when requested by the subject or subjects of a department order and justice so requires. Unless stayed by order of the director or a district court, the written order for quarantine or isolation shall remain in force and effect until the judicial review is finally determined and disposed of upon its merits.

1.9(8) *Rights of individuals and groups of individuals subject to isolation or quarantine.* Any individual or group of individuals subject to isolation or quarantine shall have the following rights:

a. The right to be represented by legal counsel.

b. The right to be provided with prior notice of the date, time, and location of any hearing.

c. The right to participate in any hearing. The hearing may be held by telephonic or other electronic means if necessary to prevent additional exposure to the communicable or possibly communicable disease.

d. The right to respond and present evidence and argument on the individual's own behalf in any hearing.

e. The right to cross-examine witnesses who testify against the individual.

f. The right to view and copy all records in the possession of the department which relate to the subject of the written order.

1.9(9) *Consolidation of claims.* In any proceeding brought pursuant to this rule, to promote the fair and efficient operation of justice and having given due regard to the rights of the affected individuals, the protection of the public's health, and the availability of necessary witnesses and evidence, the department or a court may order the consolidation of individual claims into group claims, if all of the following conditions exist:

a. The number of individuals involved or to be affected is so large that individual participation is impractical.

b. There are questions of law or fact common to the individual claims or rights to be determined.

c. The group claims or rights to be determined are typical of the affected individuals' claims or rights.

d. The entire group will be adequately represented in the consolidation.

1.9(10) *Implementation and enforcement of isolation and quarantine.*

a. *Jurisdictional issues.* The department has primary jurisdiction to isolate or quarantine individuals or groups of individuals if the communicable disease outbreak has affected more than one county or has multicounty, statewide, or interstate public health implications. When imposing isolation or quarantine, the department shall coordinate with the local health department as appropriate. If isolation or quarantine is imposed by the department, a local board of health or local health department may not alter, amend, modify, or rescind the isolation or quarantine order.

b. *Assistance of local boards of health and local health departments.* If isolation or quarantine is imposed by the department, the local boards of health and the local health departments in the affected areas shall assist in the implementation of the isolation or quarantine order.

c. *Assistance of law enforcement.* Pursuant to Iowa Code section 135.35, all peace officers of the state shall enforce and execute a lawful department order for isolation or quarantine within their respective jurisdictions. The department shall take all reasonable measures to minimize the risk of exposure to peace officers and others assisting with enforcement of an isolation or quarantine order.

d. *Penalty.* Pursuant to Iowa Code section 135.38, any individual who knowingly violates a lawful department order for isolation or quarantine, whether written or oral, shall be guilty of a simple misdemeanor. The court-ordered sentence may include a fine of up to $500 and imprisonment not to exceed 30 days.

e. *Enforcement action.* The department may file a civil action in Polk County district court or in the district court for the county in which the individual resides or is located to enforce a department order for isolation or quarantine. Such action shall be filed in accordance with the Iowa Rules of Civil Procedure.

[**ARC 8231B**, IAB 10/7/09, effective 11/11/09]

641—1.10 and **1.11** Reserved.

641—1.12(135,137,139A) Quarantine and isolation—model rule for local boards.

1.12(1) *Applicability.* The provisions of rule 641—1.12(135,137,139A) are applicable in jurisdictions in which a local board has adopted this rule by reference in accordance with Iowa Code section 137.6. This rule shall not be construed to require a local board to adopt this model rule.

1.12(2) *Definitions.*

"Board" means [insert the name of the city, county, or district board of health].

"Department" means the Iowa department of public health.

"Isolation" means the separation of persons or animals presumably or actually infected with a communicable disease, or that are disease carriers, for the usual period of communicability of that

disease. Isolation shall be in such places, marked by placards if necessary, and under such conditions to prevent the direct or indirect conveyance of the infectious agent or contagion to susceptible individuals.

"Quarantinable disease" means any communicable disease which presents a risk of serious harm to public health and which may require isolation or quarantine to prevent its spread. "Quarantinable disease" includes but is not limited to cholera; diphtheria; infectious tuberculosis; plague; smallpox; yellow fever; viral hemorrhagic fevers, including Lassa, Marburg, Ebola, Crimean-Congo, South American, and others not yet isolated or named; novel influenza; and severe acute respiratory syndrome (SARS).

"Quarantine" means the limitation of freedom of movement of persons or animals that have been exposed to a communicable disease, within specified limits marked by placards, for a period of time equal to the longest usual incubation period of the disease. The limitation of movement shall be in such manner as to prevent the spread of a communicable disease.

1.12(3) *General provisions.*

a. Voluntary confinement. Prior to instituting mandatory isolation or quarantine pursuant to this rule, the board may request that an individual or group of individuals voluntarily confine themselves to a private home or other facility.

b. Quarantine and isolation. The board is authorized to impose and enforce quarantine and isolation restrictions. Quarantine and isolation shall rarely be imposed by the board. If a quarantinable disease occurs in Iowa, individuals with a suspected or active quarantinable disease and contacts to the case may be quarantined or isolated as the particular situation requires. Any quarantine or isolation imposed by the board shall be established and enforced in accordance with this rule.

c. The local board of health shall notify, consult and work cooperatively with the Iowa department of agriculture and land stewardship and the state veterinarian office on issues relating to isolation and quarantine of animals.

1.12(4) *Conditions and principles.* The board shall adhere to all of the following conditions and principles when isolating or quarantining individuals or a group of individuals:

a. The isolation or quarantine shall be by the least restrictive means necessary to prevent the spread of a communicable or possibly communicable disease to others and may include, but is not limited to, confinement to private homes, other private premises, or public premises.

b. Isolated individuals shall be confined separately from quarantined individuals.

c. The health status of isolated or quarantined individuals shall be monitored regularly to determine if the individuals require further or continued isolation or quarantine.

d. If a quarantined individual subsequently becomes infected or is reasonably believed to have become infected with a communicable or possibly communicable disease, the individual shall be promptly removed to isolation.

e. Isolated or quarantined individuals shall be immediately released when the board determines that the individuals pose no substantial risk of transmitting a communicable or possibly communicable disease.

f. The needs of isolated or quarantined individuals shall be addressed in a systematic and competent fashion including, but not limited to, providing adequate food; clothing; shelter; means of communicating with those in and outside of isolation or quarantine; medication; and competent medical care.

g. The premises used for isolation or quarantine shall be maintained in a safe and hygienic manner and shall be designed to minimize the likelihood of further transmission of infection or other harm to isolated or quarantined individuals.

h. To the extent possible, cultural and religious beliefs shall be considered in addressing the needs of individuals in isolation and quarantine premises and in establishing and maintaining the premises.

1.12(5) *Isolation and quarantine premises.*

a. Sites of isolation or quarantine shall be prominently placarded with isolation or quarantine signs prescribed and furnished by the department and posted on all sides of the building wherever access is possible.

b. An individual subject to isolation or quarantine shall obey the rules and orders of the board and shall not go beyond the isolation or quarantine premises.

c. The department or the board may authorize physicians, health care workers, or others access to individuals in isolation or quarantine as necessary to meet the needs of isolated or quarantined individuals.

d. No individual, other than an individual authorized by the department or the board, shall enter an isolation or quarantine premises. If the department has requested the assistance of law enforcement in enforcing the isolation or quarantine, the department shall provide law enforcement personnel with a list of individuals authorized to enter the isolation or quarantine premises.

e. Any individual entering an isolation or quarantine premises with or without authorization of the department or the board may be isolated or quarantined pursuant to this rule.

1.12(6) *Isolation and quarantine.*

a. Authority. The board may:

(1) Isolate individuals who are presumably or actually infected with a quarantinable disease;

(2) Quarantine individuals who have been exposed to a quarantinable disease;

(3) Establish and maintain places of isolation and quarantine; and

(4) Adopt emergency rules and issue orders as necessary to establish, maintain, and enforce isolation or quarantine.

b. Isolation and quarantine undertaken by the board shall be accomplished in accordance with this rule.

c. Temporary isolation and quarantine without notice. The board may temporarily isolate or quarantine an individual or groups of individuals through an oral order, without notice, only if delay in imposing the isolation or quarantine would significantly jeopardize the board's ability to prevent or limit the transmission of a communicable or possibly communicable disease to others. If the board imposes temporary isolation or quarantine of an individual or groups of individuals through an oral order, the board shall issue a written order as soon as is reasonably possible and in all cases within 24 hours of issuance of the oral order if continued isolation or quarantine is necessary to prevent or limit the transmission of a communicable or possibly communicable disease.

d. Written order. The board may isolate or quarantine an individual or groups of individuals through a written order issued pursuant to this rule.

(1) The written order shall include all of the following:

1. The identity of the individual, individuals, or groups of individuals subject to isolation or quarantine.

2. The premises subject to isolation or quarantine.

3. The date and time at which isolation or quarantine commences.

4. The suspected communicable disease.

5. A description of the less restrictive alternatives that were attempted and were unsuccessful, or the less restrictive alternatives that were considered and rejected, and the reasons such alternatives were rejected.

6. A statement of compliance with the conditions and principles for isolation and quarantine specified in subrule 1.12(4).

7. The legal authority under which the order is imposed.

8. The medical basis upon which isolation or quarantine is justified.

9. A statement advising the individual, individuals, or groups of individuals of the right to appeal the written order pursuant to subrule 1.12(7) and the rights of individuals and groups of individuals subject to quarantine and isolation as listed in subrule 1.12(8).

10. A copy of this rule and the relevant definitions.

(2) A copy of the written order shall be provided to the individual to be isolated or quarantined within 24 hours of issuance of the order in accordance with any applicable process authorized by the Iowa Rules of Civil Procedure. If the order applies to a group or groups of individuals and it is impractical to provide individual copies, the order may be posted in a conspicuous place in the isolation or quarantine premises.

1.12(7) *Appeal from order imposing isolation or quarantine.*

a. *Appeal.* The subject of a board order imposing isolation or quarantine may appeal a written order by submitting a written appeal within ten days of receipt of the written order. The appeal shall be addressed to [insert name of board and board address]. Unless stayed by order of the board or a district court, the written order for quarantine or isolation shall remain in force and effect until the appeal is finally determined and disposed of upon its merits.

b. *Proceeding.* The appeal proceeding shall be conducted in accordance with this rule [or insert specific board rule governing appeal proceedings]. The proceeding shall be held as soon as is practicable, and in no case later than ten days from the date of receipt of the appeal. The hearing may be held by telephonic or other electronic means if necessary to prevent additional exposure to the communicable or possibly communicable disease. In extraordinary circumstances and for good cause shown, the board may continue the proceeding date for up to ten days, giving due regard to the rights of the affected individuals, the protection of the public's health, and the availability of necessary witnesses and evidence. At the appeal proceeding, the subject of the appeal shall have the right to introduce evidence on all issues relevant to the order. The board, by majority vote, may modify, withdraw, or order compliance with the order under appeal.

c. *Judicial review.* The aggrieved party to the final decision of the board may petition for judicial review of that action by filing an action in the appropriate district court. Petitions for judicial review shall be filed within 30 days after the decision becomes final.

d. *Immediate judicial review of board order.* The board acknowledges that in certain circumstances the subject or subjects of a board order may desire immediate judicial review of a board order in lieu of proceeding with the board's appeal process. The board may consent to immediate jurisdiction of the district court when requested by the subject or subjects of a board order and justice so requires. Unless stayed by order of the board or a district court, the written order for quarantine or isolation shall remain in force and effect until the judicial review is finally determined and disposed of upon its merits.

1.12(8) *Rights of individuals and groups of individuals subject to isolation or quarantine.* Any individual or group of individuals subject to isolation or quarantine shall have the following rights:

a. The right to be represented by legal counsel.

b. The right to be provided with prior notice of the date, time, and location of any hearing.

c. The right to participate in any hearing. The hearing may be held by telephonic or other electronic means if necessary to prevent additional exposure to the communicable or possibly communicable disease.

d. The right to respond and present evidence and argument on the individual's own behalf in any hearing.

e. The right to cross-examine witnesses who testify against the individual.

f. The right to view and copy all records in the possession of the board which relate to the subject of the written order.

1.12(9) *Consolidation of claims.* In any proceeding brought pursuant to this rule, to promote the fair and efficient operation of justice and having given due regard to the rights of the affected individuals, the protection of the public's health, and the availability of necessary witnesses and evidence, the board or a court may order the consolidation of individual claims into group claims, if all of the following conditions exist:

a. The number of individuals involved or to be affected is large enough that consolidation would be the best use of resources.

b. There are questions of law or fact common to the individual claims or rights to be determined.

c. The group claims or rights to be determined are typical of the affected individuals' claims or rights.

d. The entire group will be adequately represented in the consolidation.

1.12(10) *Implementation and enforcement of isolation and quarantine.*

a. *Jurisdictional issues.* The department has primary jurisdiction to isolate or quarantine individuals or groups of individuals if the communicable disease outbreak has affected more than one

county or has multicounty, statewide, or interstate public health implications. If isolation or quarantine is imposed by the department, the board may not alter, amend, modify, or rescind the isolation or quarantine order.

b. *Assistance of local boards of health and local health departments.* If isolation or quarantine is imposed by the department, the local boards of health and the local health departments in the affected areas shall assist in the implementation of the isolation or quarantine order.

c. *Penalty.* Pursuant to Iowa Code sections 137.21 and 139A.25(1), any individual who violates a lawful board order for isolation or quarantine, whether written or oral, shall be guilty of a simple misdemeanor. The court-ordered sentence may include a fine of up to $500 and imprisonment not to exceed 30 days.

d. *Enforcement action.* The board, through the office of the county attorney, may file a civil action in the appropriate district court to enforce a board order for isolation or quarantine. Such action shall be filed in accordance with the Iowa Rules of Civil Procedure.

[**ARC 8231B**, IAB 10/7/09, effective 11/11/09]

641—1.13(135,139A) Area quarantine.

1.13(1) *General provisions.* The department and local boards of health are authorized to impose and enforce area quarantine in accordance with this rule. Area quarantine shall rarely be imposed by the department or by local boards of health.

1.13(2) *Conditions and principles.* The department and local boards of health shall adhere to all of the following conditions and principles when imposing and enforcing area quarantine:

a. Area quarantine shall be imposed by the least restrictive means necessary to prevent or contain the spread of a suspected or confirmed quarantinable disease or suspected or known hazardous or toxic agent.

b. Area quarantine shall be immediately terminated when the department or a local board of health determines that no substantial risk of exposure to a quarantinable disease or hazardous or toxic agent continues to exist.

c. The geographic boundaries of an area quarantine shall be established by risk assessment procedures including medical and scientific analysis of the quarantinable disease or hazardous or toxic agent, the location of the affected area, the risk of spread or contamination, and other relevant information.

1.13(3) *Area quarantine sites.*

a. Sites of area quarantine shall be prominently identified to restrict ingress to and egress from the area, to the extent practicable. The department or a local board of health may placard or otherwise identify the site, or may request the assistance of law enforcement in identifying the site.

b. No individual, other than an individual authorized by the department or a local board of health, shall enter a building, structure, or other physical location subject to area quarantine. The department or a local board of health may authorize public health officials, environmental specialists, health care providers, or others access to an area quarantine site as necessary to conduct public health investigations, to decontaminate the site, or for other public health purposes. Notwithstanding any provision in this chapter to the contrary, law enforcement, fire service, and emergency medical service providers may enter an area quarantine site to provide emergency response services or to conduct emergency law enforcement investigations or other emergency activities without authorization by the department or a local board of health. If the department has requested the assistance of law enforcement in enforcing the area quarantine, the department shall provide law enforcement personnel with a list of individuals authorized to enter the area quarantine site.

c. An individual authorized to enter an area quarantine site may be required to wear personal protective equipment as appropriate.

d. No individual, other than an individual authorized by the department or a local board of health, shall remove any item or object from a building, structure, or other physical location subject to area quarantine.

e. An individual entering an area quarantine site without authorization of the department or a local board of health may be isolated or quarantined pursuant to rule 641—1.9(135,139A) and may be found guilty of a simple misdemeanor.

1.13(4) *Area quarantine by local boards of health or the department of public health.*

a. Authority.

(1) The department, through the director, the department's medical director, or the director or medical director's designee, may impose area quarantine through oral or written order. Prior to imposing area quarantine, the department shall attempt to notify the local board or boards of health in the affected geographic area. If attempts to notify the local boards of health are initially unsuccessful, the department shall continue to make regular notification attempts until successful.

(2) A local board of health may impose area quarantine through oral or written order. Prior to imposing area quarantine, a local board of health shall attempt to notify the department by contacting the director, medical director, or department duty officer by telephone. If attempts to notify the department are initially unsuccessful, the local board of health shall continue to make regular notification attempts until successful.

b. Temporary area quarantine without notice. The department or a local board of health may temporarily impose area quarantine through an oral order, without notice, only if delay in imposing area quarantine would significantly jeopardize the department's or local board's ability to prevent or contain the spread of a suspected or confirmed quarantinable disease or to prevent or contain exposure to a suspected or known hazardous or toxic agent. If the department or local board imposes temporary area quarantine through an oral order, a written order shall be issued as soon as is reasonably possible and in all cases within 24 hours of issuance of the oral order if continued area quarantine is necessary.

c. Written order. The department or local board may impose area quarantine through a written order issued pursuant to this rule.

(1) The written order shall include all of the following:

1. The building or buildings, structure or structures, or other definable physical location, or portion thereof, subject to area quarantine.

2. The date and time at which area quarantine commences and the date and time at which the area quarantine shall be terminated, if known.

3. The suspected or confirmed quarantinable disease or the chemical, biological, radioactive, or other hazardous or toxic agent.

4. A statement of compliance with the conditions and principles for area quarantine specified in subrule 1.13(2).

5. The legal authority under which the order is imposed.

6. The medical or scientific basis upon which area quarantine is justified.

7. A statement advising the owner or owners of the building or buildings, structure or structures, or other definable physical location subject to area quarantine of the right to appeal the written order pursuant to subrule 1.13(5) and the rights of owners of sites subject to area quarantine pursuant to subrule 1.13(6).

8. A copy of 641—Chapter 1 and the relevant provisions of this rule.

(2) A copy of the written order shall be provided to the owner or owners of the building or buildings, structure or structures, or other definable physical location subject to area quarantine within 24 hours of issuance of the order in accordance with any applicable process authorized by the Iowa Rules of Civil Procedure; or, if the order applies to a group of owners and it is impractical to provide individual notice to each owner, the written order shall be posted in a conspicuous place at the site of area quarantine.

1.13(5) *Appeal from order imposing area quarantine.*

a. Contested case. The subject of a department order imposing area quarantine may appeal a written order and has the right to a contested case hearing regarding such appeal. The subject of a department order imposing area quarantine may appeal the order by submitting a written appeal within 10 days of receipt or other notice of the written order. The appeal shall be addressed to the Local Board of Health or to the Department of Public Health, Division of Acute Disease Prevention and Emergency Response, Lucas State Office Building, Des Moines, Iowa 50319-0075. Unless stayed by order of the

director or a district court, the written order for area quarantine shall remain in force and effect until the appeal is finally determined and disposed of upon its merits.

b. *Presiding officer.* The presiding officer in a contested case shall be the director or the director's designee. The director or the director's designee may be assisted by an administrative law judge in conducting the contested case hearing. The decision of the director or the director's designee shall be the agency's final decision and is subject to judicial review in accordance with the provisions of Iowa Code chapter 17A.

c. *Proceeding.* The contested case hearing shall be conducted in accordance with the provisions contained at 641—Chapter 173. The hearing shall be held as soon as is practicable, and in no case later than 10 days from the date of receipt of the appeal. In extraordinary circumstances and for good cause shown, the department may apply to continue the hearing date on a petition filed pursuant to this paragraph for up to 10 days, which continuance the presiding officer may grant in the presiding officer's discretion giving due regard to the rights of the affected individuals, the protection of the public's health, and the availability of necessary witnesses and evidence.

d. *Judicial review.* The aggrieved party to the final decision of the department may petition for judicial review of that action pursuant to Iowa Code chapter 17A. Petitions for judicial review shall be filed within 30 days after the decision becomes final.

e. *Immediate judicial review of department order.* The department or local board acknowledges that in certain circumstances the subject or subjects of a department order may desire immediate judicial review of a department order in lieu of proceeding with the contested case process. The department recognizes that the procedural step of pursuing exhaustion of administrative remedies may be inadequate for purposes of Iowa Code section 17A.19, and the department may consent to immediate jurisdiction of the district court when requested by the subject or subjects of a department order and justice so requires. Unless stayed by order of the director or a district court, the written order for area quarantine shall remain in force and effect until the judicial review is finally determined and disposed of upon its merits.

1.13(6) *Rights of owners of sites subject to area quarantine.* An owner of a building, structure, or other physical location subject to area quarantine shall have the following rights:

a. The right to be represented by legal counsel.

b. The right to be provided with prior notice of the date, time, and location of any hearing.

c. The right to participate in any hearing.

d. The right to respond and present evidence and argument on the owner's own behalf in any hearing.

e. The right to cross-examine witnesses who testify against the owner or individual.

f. The right to view and copy all records in the possession of the department which relate to the subject of the written order.

1.13(7) *Consolidation of claims.* In any proceeding brought pursuant to this rule, to promote the fair and efficient operation of justice and having given due regard to the rights of the affected individuals, the protection of the public's health, and the availability of necessary witnesses and evidence, the department or a court may order the consolidation of individual claims into group claims, if all of the following conditions exist:

a. The number of individuals involved or who may be affected is so large that individual participation is impractical.

b. There are questions of law or fact common to the individual claims or rights to be determined.

c. The group claims or rights to be determined are typical of the affected individuals' claims or rights.

d. The entire group will be adequately represented in the consolidation.

1.13(8) *Implementation and enforcement of area quarantine.*

a. *Jurisdictional issues.* The department has primary jurisdiction to impose area quarantine if the quarantinable disease or hazardous or toxic agent has affected more than one county and implicates multicounty or statewide public health concerns. If area quarantine is imposed by the department, a local board of health or local health department may not alter, amend, modify, or rescind the area quarantine order.

b. Assistance of local boards of health and local health departments. If area quarantine is imposed by the department, the local boards of health and the local health departments in the affected areas shall assist in the implementation of the area quarantine.

c. Assistance of law enforcement. Pursuant to Iowa Code section 135.35, all peace officers of the state shall enforce and execute a lawful department order for area quarantine within their respective jurisdictions. The department shall take all reasonable measures to minimize the risk of individual exposure of peace officers and others assisting with enforcement of an area quarantine order.

d. Emergency response, investigation, and decontamination—authority of other agencies. Emergency response, investigation, and decontamination activities in and around an area quarantine site shall be conducted by law enforcement, fire service, emergency medical service providers, or other appropriate federal, state, or local officials in accordance with federal and state law and accepted procedures and protocols for emergency response, investigation, and decontamination. This rule shall not be construed to limit the authority of law enforcement, fire service, emergency medical service providers, or other federal, state, or local officials to conduct emergency response, investigation, or decontamination activities to the extent authorized by federal and state law and accepted procedures and protocols.

e. Penalty. Pursuant to Iowa Code section 135.38, any individual who knowingly violates a lawful department order for area quarantine, whether written or oral, shall be guilty of a simple misdemeanor. The court-ordered sentence may include a fine of up to $500 and imprisonment not to exceed 30 days.

f. Enforcement action. To enforce a department order for quarantine, the department may file a civil action in Polk County District Court or in the district court for the county in which the area quarantine will be enforced. Such action shall be filed in accordance with the Iowa Rules of Civil Procedure.

[**ARC 8231B**, IAB 10/7/09, effective 11/11/09]

SPECIFIC NONCOMMUNICABLE CONDITIONS

641—1.14(139A) Cancer. Each occurrence of a reportable cancer that is diagnosed or treated in an Iowa resident or occurs in a nonresident who is diagnosed or treated in an Iowa facility shall be reported to the State Health Registry of Iowa, administered by the Department of Epidemiology of the College of Public Health at the University of Iowa, by mail, telephone or electronic means.

1.14(1) *Who is required to report.* Occurrences of reportable cancers shall be reported by registrars employed by the State Health Registry of Iowa, registrars employed by health care facilities, and health care providers involved in the diagnosis, care, or treatment of individuals with a reportable cancer.

1.14(2) *What to report.* The content of the reports shall include, but not be limited to, follow-up data and demographic, diagnostic, treatment, and other medical information. Tissue samples may also be submitted under the authority of this rule.

1.14(3) *How to report.* For these particular diseases, physicians and other health practitioners should not send a report to the department.

a. The department has delegated to the State Health Registry of Iowa the responsibility for collecting these data through review of records from hospitals, radiation treatment centers, outpatient surgical facilities, oncology clinics, pathology laboratories, and physician offices.

b. Prior to collecting the data from an office or facility, the State Health Registry of Iowa shall work with the office or facility to develop a process for abstracting records which is agreeable to the office or facility.

c. Where applicable, reportable cancers shall be reported on forms developed and distributed by the State Health Registry of Iowa.

d. Data will be supplemented with information obtained from records from hospitals, radiation treatment centers, outpatient surgical centers, oncology clinics, pathology laboratories, and physician offices through an abstracting process developed by the State Health Registry of Iowa.

[**ARC 8231B**, IAB 10/7/09, effective 11/11/09]

641—1.15(144) Congenital and inherited disorders. Each occurrence of a congenital and inherited disorder that is diagnosed or treated in an Iowa resident or occurs in a nonresident who is diagnosed or treated in an Iowa facility is a reportable condition, and records of these congenital and inherited disorders shall be abstracted and maintained in a central registry. Congenital and inherited disorder surveillance shall be performed in order to determine the occurrence and trends of congenital and inherited disorders, to conduct thorough and complete epidemiological surveys, to assist in the planning for and provision of services to children with congenital and inherited disorders and their families, and to identify environmental and genetic risk factors for congenital and inherited disorders.

1.15(1) *Who is required to report.* Occurrences of reportable congenital and inherited disorders shall be reported by registrars employed by the Iowa Registry for Congenital and Inherited Disorders, registrars employed by health care facilities, and health care providers involved in the diagnosis, care, or treatment of individuals with reportable congenital and inherited disorders.

1.15(2) *What to report.* The content of the reports shall include, but not be limited to, follow-up data and demographic, diagnostic, treatment, and other medical information. Tissue samples may also be submitted under the authority of this rule.

1.15(3) *How to report.*

a. The department has delegated to the Iowa Registry for Congenital and Inherited Disorders the responsibility for collecting these data through review of records from hospitals, radiation treatment centers, outpatient surgical facilities, oncology clinics, pathology laboratories, and physician offices.

b. Prior to collecting the data from an office or facility, the Iowa Registry for Congenital and Inherited Disorders shall work with the office or facility to develop a process for abstracting records.

1.15(4) *Fetal death (stillbirth).* Each occurrence of a fetal death that occurs in an Iowa resident or occurs in a nonresident who is identified in an Iowa facility is a reportable condition.

a. Providers shall complete the fetal death certificate supplied by the department.

b. Fetal death certificates are to be filed with the department's bureau of vital records within seven days.

[**ARC 8231B**, IAB 10/7/09, effective 11/11/09]

641—1.16(139A) Agriculturally related injury.

1.16(1) *Who is required to report.*

a. Health care providers are required to report all cases of agriculturally related injury attended by them.

b. Clinics, hospitals and other health care facilities are required to report all cases of agriculturally related injury treated at their facility.

c. Health care providers who reside and health care facilities that are located outside the state of Iowa shall report all cases of agriculturally related injury of an Iowa resident that are attended or treated by them.

d. Medical examiners are required to report their investigatory findings of any death occurring within the state of Iowa which was caused by or otherwise involved a reportable agriculturally related injury.

1.16(2) *What to report.* Each report shall contain all of the following information:

a. The patient's name.

b. The patient's address.

c. The patient's date of birth.

d. The sex of the patient.

e. The race and ethnicity of the patient.

f. The patient's marital status.

g. The patient's telephone number.

h. If the patient is female, whether the patient is pregnant.

i. In the case of occupational conditions, the name of the patient's employer.

j. The date that the injury occurred.

k. The name and address of the health care provider who diagnosed and treated the injury, and the name of the reporting site, clinic, or hospital.

l. Injury diagnosis and description, including diagnostic and external cause of injury codes utilizing the international classification of diseases (ICD) coding system.

m. Severity of injury.

1.16(3) *How to report.*

a. All data shall be reported to the department at least quarterly using formats approved by the department. Reports, using the Iowa Agricultural Injury Report Form found at www.idph.state.ia.us, may be submitted by facsimile to (515)281-4529, or by mail to the Iowa Department of Public Health, Bureau of Lead Poisoning Prevention, Occupational Safety and Health Surveillance Program, Lucas State Office Building, 321 E. 12th Street, Des Moines, Iowa 50319-0075. Information may also be reported by telephone to 1-800-972-2026 during normal office hours.

b. Trauma centers may report using the Iowa Trauma Patient Registry COLLECTOR software by indicating "Yes" for farm and agriculturally related injury. For more information about using the Iowa Trauma Patient Registry for reporting, contact the Iowa Department of Public Health Bureau of Emergency Medical Services at 1-800-728-3367.

[**ARC 8231B**, IAB 10/7/09, effective 11/11/09]

CONFIDENTIALITY

641—1.17(139A,22) Confidentiality.

1.17(1) A report or other information provided to or maintained by the department, a local board, or a local department which identifies a person infected with or exposed to a reportable or other disease or health condition is confidential and shall not be accessible to the public.

1.17(2) The identity of a business named in a report or investigation is confidential and shall not be accessible to the public. If information contained in a report or other information provided to or maintained by the department, a local board, or a local department concerns a business, information disclosing the identity of the business may be released to the public when the state public health medical director and epidemiologist or the director determines such a release of information necessary for the protection of the public.

1.17(3) Reportable disease records and information, with the exception of AIDS and HIV records, which identify a person or a business named in a report, may be disclosed under the following limited circumstances:

a. By and between department employees and agents who have a need for the record in the performance of their duties.

b. By and between department employees and agents and local boards of health and local health departments as necessary to conduct an investigation.

c. By and between department employees and agents and health care providers, laboratories, and hospitals as necessary to conduct an investigation.

d. By and between department employees and agents and employees and agents of federal, state, and local agencies as necessary to conduct an investigation.

e. Reportable disease information may be included in a quarantine or isolation order or placard as necessary to prevent the spread of a quarantinable disease.

f. Pursuant to rule 641—175.9(17A,22) or 641—175.10(17A,22).

[**ARC 8231B**, IAB 10/7/09, effective 11/11/09]

These rules are intended to implement Iowa Code chapters 135, 136A, 139A, 141A and 144.

APPENDIX A
Iowa Department of Public Health
Table of Reportable Communicable and Infectious Diseases

Report cases of the diseases listed in the following table to the department within the time frame specified in the When to Report column and by the reporting method in the How to Report column.

To report diseases immediately, use the 24/7 disease reporting telephone hotline: 1-800-362-2736.

IMMEDIATELY report diseases, syndromes, poisonings and conditions of any kind suspected or caused by a biological, chemical, or radiological agent or toxin when there is reasonable suspicion that the disease, syndrome, poisoning or condition may be the result of a deliberate act such as terrorism.

IMMEDIATELY report to the department outbreaks of any kind, diseases that occur in unusual numbers or circumstances, unusual syndromes, or uncommon diseases. Outbreaks may be infectious, environmental or occupational in origin and include food-borne outbreaks or illness secondary to chemical exposure (e.g., pesticides, anhydrous ammonia).

Report diseases by:
Entering into the Iowa Disease Surveillance System (IDSS): For IDSS-related questions, call the Center for Acute Disease Epidemiology (CADE) at 1-800-362-2736.

Fax: (515)281-5698

Mail:
Iowa Department of Public Health
Center for Acute Disease Epidemiology
Lucas State Office Building
321 E. 12th Street
Des Moines, Iowa 50319

Isolates shall be sent to:
University Hygienic Laboratory
102 Oakdale Campus, H101 OH
Iowa City, Iowa 52242

For specimen submission questions, call (319)335-4500 or go to http://www.uhl.uiowa.edu/.

Diseases	When to Report	How to Report
Acquired immune deficiency syndrome (AIDS) and AIDS-defining conditions	7 days	Report by mail ● Health care providers: use the Pediatric or Adult Confidential Case Report Form ● Laboratories: send copy of lab report or the Iowa Confidential Report of Sexually Transmitted Disease & HIV Infection. Mark envelope "Attention 03" **For HIV/AIDS-related questions, call (515)242-5141**
Anthrax	1 day	Phone, IDSS, or fax

Diseases	When to Report	How to Report
Arboviral disease (includes West Nile Disease, St. Louis, LaCrosse, WEE, EEE, VEE encephalitis)	3 days	Phone, IDSS, fax or mail
Botulism	**Immediately**	24/7 disease reporting telephone hotline: 800-362-2736
Brucellosis (Burcella)	3 days	Phone, IDSS, fax or mail
Campylobacteriosis (Campylobacter)	3 days	Phone, IDSS, fax or mail
Chlamydia	3 days	Use the Iowa Confidential Report of Sexually Transmitted Disease and HIV Infection
Cholera	**Immediately**	24/7 disease reporting telephone hotline: 800-362-2736
Cryptosporidiosis	3 days	Phone, IDSS, fax or mail
Cyclospora	3 days	Phone, IDSS, fax or mail
Diphtheria	**Immediately**	24/7 disease reporting telephone hotline: 800-362-2736
Enterococcus invasive disease	3 days	Laboratories send isolate to the UHL
Escherichia coli shiga toxin-producing and related diseases (includes HUS and TTP)	3 days	Phone, IDSS, fax or mail Laboratories send isolate to the UHL
Giardiasis (Giardia)	3 days	Phone, IDSS, fax or mail
Gonorrhea	3 days	Use the Iowa Confidential Report of Sexually Transmitted Disease and HIV Infection
Group A Streptococcus invasive disease	3 days	Send isolate to the UHL
Haemophilus influenza type B invasive disease	**Immediately**	24/7 disease reporting telephone hotline: 800-362-2736 Laboratories send isolate to the UHL
Hansen's disease (leprosy)	3 days	Phone, IDSS, fax or mail
Hantavirus syndromes	3 days	Phone, IDSS, fax or mail
Hepatitis A	1 day	Phone, IDSS or fax
Hepatitis B, C, D, E	3 days	Phone, IDSS, fax or mail
Human immunodeficiency virus (HIV) cases Death of a person with HIV Perinatally exposed newborn and child (newborn and child who was born to an HIV-infected mother)	7 days	Report by mail ● Health care providers: use the Pediatric or Adult Confidential Case Report Form ● Laboratories: send copy of lab report or the Iowa Confidential Report of Sexually Transmitted Disease & HIV Infection. Mark envelope "Attention 03" **For HIV/AIDS-related questions, call (515)242-5141**
Legionellosis (Legionella)	3 days	Phone, IDSS, fax or mail
Listeria monocytogenes invasive disease	1 day	Phone, IDSS, or fax Laboratories send isolate to the UHL
Lyme disease	3 days	Phone, IDSS, fax or mail
Malaria	3 days	Phone, IDSS, fax or mail
Measles (rubeola)	**Immediately**	24/7 disease reporting telephone hotline: 800-362-2736
Meningococcal invasive disease	**Immediately**	24/7 disease reporting telephone hotline: 800-362-2736 Laboratories send isolate to the UHL
Mumps	3 days	Phone, IDSS, fax or mail
Pertussis	3 days	Phone, IDSS, fax or mail

Diseases	When to Report	How to Report
Plague	**Immediately**	24/7 disease reporting telephone hotline: 800-362-2736
Poliomyelitis	**Immediately**	24/7 disease reporting telephone hotline: 800-362-2736
Psittacosis	3 days	Phone, IDSS, fax or mail
Rabies, animal	3 days	Phone, IDSS, fax or mail
Rabies, human	**Immediately**	24/7 disease reporting telephone hotline: 800-362-2736
Rocky Mountain spotted fever	3 days	Phone, IDSS, fax or mail
Rubella (including congenital)	1 day	Phone, IDSS, fax or mail
Salmonellosis (Salmonella)	3 days	Phone, IDSS, fax or mail Laboratories send isolate to the UHL
Severe acute respiratory syndrome (SARS)	**Immediately**	24/7 disease reporting telephone hotline: 800-362-2736
Shigellosis (Shigella)	3 days	Phone, IDSS, fax or mail Laboratories send isolate to the UHL
Smallpox	**Immediately**	24/7 disease reporting telephone hotline: 800-362-2736
Staphylococcus aureus invasive disease: Methicillin-resistant invasive disease (number of S. aureus isolates should be reported to the department quarterly)	3 days	Laboratories send isolate to the UHL Mail the number of staphylococcus isolated quarterly to UHL
Vancomycin-resistant S. aureus	**Immediately**	24/7 disease reporting telephone hotline: 800-362-2736
Streptococcus pneumoniae invasive disease	3 days	Laboratories send isolate to the UHL
Syphilis	3 days	Use the Iowa Confidential Report of Sexually Transmitted Disease and HIV Infection
Tetanus	3 days	Phone, IDSS, fax or mail
Toxic Shock Syndrome	3 days	Phone, IDSS, fax or mail
Trichinosis	3 days	Phone, IDSS, fax or mail
Tuberculosis	3 days	Phone, IDSS, fax or mail
Typhoid fever	1 day	Phone, IDSS or fax
Yellow fever	**Immediately**	24/7 disease reporting telephone hotline: 800-362-2736

APPENDIX B
Iowa Department of Public Health
Table of Reportable Poisonings and Conditions

Report cases of the poisonings and conditions listed in the following table to the department within the time frame specified in the When to Report column and by the reporting method in the How to Report column.

To report diseases immediately, use the 24/7 disease reporting telephone hotline: 1-800-362-2736.

IMMEDIATELY report diseases, syndromes, poisonings and conditions of any kind suspected or caused by a biological, chemical, or radiological agent or toxin when there is reasonable suspicion that the disease, syndrome, poisoning or condition may be the result of a deliberate act such as terrorism.

IMMEDIATELY report to the department outbreaks of any kind, diseases that occur in unusual numbers or circumstances, unusual syndromes, or uncommon diseases. Outbreaks may be infectious, environmental or occupational in origin and include food-borne outbreaks or illness secondary to chemical exposure (e.g., pesticides, anhydrous ammonia).

Mailing address:
Bureau of Lead Poisoning Prevention Division of Environmental Health
Iowa Department of Public Health
321 East 12th Street
Des Moines Iowa 50319-0075

Telephone: 1-800-972-2026

Fax: (515)281-4529

Poisoning or Condition	Cases to Report	When to Report	How to Report
Arsenic poisoning	Blood arsenic values equal to or greater than 70 µg/L Urine arsenic values equal to or greater than 100 µg/g of creatinine	Weekly	Format specified by department. Web-based reporting if available. Alternatives include by mail, telephone, and facsimile.
Blood lead testing	All analytical results greater than or equal to 20 micrograms per deciliter (µg/dL) in a child under the age of 6 years or a pregnant woman	Daily	By telephone: 800-972-2026
	All other analytical values for all blood lead analyses	Weekly	Electronic format specified by the department
Cadmium poisoning	Blood cadmium values equal to or greater than 5 µg/L Urine cadmium values equal to or greater than 3 µg/g of creatinine	Weekly	Format specified by department. Web-based reporting if available. Alternatives include by mail, telephone, and facsimile.

Poisoning or Condition	Cases to Report	When to Report	How to Report
Carbon monoxide (CO) poisoning	Blood carbon monoxide level equal to or greater than 10% carboxyhemoglobin or its equivalent with a breath analyzer test, or a clinical diagnosis of CO poisoning regardless of any test results	Daily	By telephone: 800-972-2026
Hypersensitivity pneumonitis	All cases	Weekly	Format specified by department. Web-based reporting if available. Alternatives include by mail, telephone, and facsimile.
Mercury poisoning	Blood mercury values equal to or greater than 2.8 µg/dL Urine mercury values equal to or greater than 20 µg/L	Weekly	Format specified by department. Web-based reporting if available. Alternatives include by mail, telephone, and facsimile.
Methemoglobinemia	Blood analyses showing greater than 5% of total hemoglobin present as methemoglobin	Weekly	Format specified by department. Web-based reporting if available. Alternatives include by mail, telephone, and facsimile.
Noncommunicable respiratory illness	All cases	Weekly	Format specified by department. Web-based reporting if available. Alternatives include by mail, telephone, and facsimile.
Occupationally related asthma, bronchitis or respiratory hypersensitivity reaction	All cases	Weekly	Format specified by department. Web-based reporting if available. Alternatives include by mail, telephone, and facsimile.
Pesticide poisoning (including pesticide-related contact dermatitis)	All cases	Weekly	Format specified by department. Web-based reporting if available. Alternatives include by mail, telephone, and facsimile.
Severe skin disorder	All cases	Weekly	Format specified by department. Web-based reporting if available. Alternatives include by mail, telephone, and facsimile.
Toxic hepatitis	All cases	Weekly	Format specified by department. Web-based reporting if available. Alternatives include by mail, telephone, and facsimile

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CHAPTER 9
OUTPATIENT DIABETES EDUCATION PROGRAMS
[Prior to 7/29/87, Health Department[470], Ch 9]

641—9.1(135) Scope. The scope of this chapter is to describe the standards for outpatient diabetes self-management education programs and the procedures programs must follow for certification by the Iowa department of public health that will allow for third-party reimbursement.

641—9.2(135) Definitions. For the purpose of these rules, the following terms shall have the meaning set forth below.

"AADE" means the American Association of Diabetes Educators.

"Accredited" means that a program is currently accredited by the American Association of Diabetes Educators.

"ADA" means the American Diabetes Association.

"Certification" means the review and approval and assignment of a program site number of an outpatient diabetes education program which meets minimum standards.

"Certified diabetes educator" means a person currently certified by the National Certification Board for Diabetes Educators.

"Department" means the Iowa department of public health.

"Diabetes mellitus" includes the following:

1. "Type I diabetes" means insulin-dependent diabetes (IDDM) requiring lifelong treatment with insulin.
2. "Type II diabetes" means noninsulin-dependent diabetes often managed by food plan, exercise, weight control, and in some instances, oral medications or insulin.
3. "Gestational diabetes" means diabetes diagnosed during pregnancy.
4. "Impaired glucose tolerance" means a condition in which blood glucose levels are higher than normal, diagnosed by a physician, and treated with food plan, exercise or weight control.
5. "Secondary diabetes" means diabetes induced by drugs or chemicals as well as by pancreatic or endocrine disease and treated appropriately.

"Director" means the director of the Iowa department of public health.

"Licensed dietitian" means a person currently licensed to practice dietetics under Iowa Code chapter 152A.

"Participant" means a patient who is referred to, is active in, or has completed the educational diabetes program.

"Pharmacist" means a person currently licensed to practice pharmacy under Iowa Code chapter 155.

"Physician" means a person currently licensed to practice medicine and surgery, osteopathic medicine and surgery, or osteopathy under Iowa Code chapters 148 and 150A.

"Primary instructor" means an instructor with major or broad teaching responsibility.

"Professional health educator" means a person having successfully completed a degree designated "health education" from an accredited college or university.

"Program" means an outpatient diabetes self-management education program in which instruction shall be provided which shall enable people with diabetes and their families to understand the diabetes disease process and the daily management of diabetes.

"Program coordinator" means the person responsible for the direction and supervision of a program including, but not limited to, planning, arranging implementation, and assuring quality.

"Program staff" means the program coordinator, program physician, primary and supporting instructors, and advisory committee members.

"Recognized" means that a program is currently recognized by the American Diabetes Association.

"Registered nurse" means a person currently licensed to practice professional nursing under Iowa Code chapter 152.

"Standards" means the outpatient diabetes education program standards developed by the department.

"Supporting instructor" means an instructor who teaches only one or two specific topics of the program, on a voluntary or paid basis.
[**ARC 9249B**, IAB 12/1/10, effective 1/5/11]

641—9.3(135) Powers and duties. The department shall be responsible for taking the following actions:

9.3(1) Develop minimum standards in coordination with the American Diabetes Association and the American Association of Diabetes Educators.

9.3(2) Annually review and update the standards as needed, and provide revised standards to programs and others.

9.3(3) Develop certification packages.

a. Certification packages shall be provided on request to programs and to the general public.

b. The package shall contain certification procedures, rules, and standardized forms.

c. The certification package is available from the Bureau of Chronic Disease Prevention and Management, Division of Health Promotion and Chronic Disease Prevention, Iowa Department of Public Health, Lucas State Office Building, 321 East 12th Street, Des Moines, Iowa 50319-0075.

9.3(4) Evaluate each application submitted and determine adequacy of program for certification.

9.3(5) Assign a program site number and an expiration date and issue a certificate to each program that meets the standards. A certificate shall be valid for three years from issuance unless specified otherwise on the certificate or unless sooner revoked.

9.3(6) Maintain a list of certified programs.
[**ARC 9249B**, IAB 12/1/10, effective 1/5/11]

641—9.4(135) Application procedures for American Diabetes Association-recognized and American Association of Diabetes Educators-accredited programs. When a program is recognized by the American Diabetes Association or accredited by the American Association of Diabetes Educators, the program shall apply for certification to the department by submitting a copy of the Certificate of Recognition provided by ADA or the Certificate of Accreditation provided by AADE, the name, address and telephone number for the program, the name of the program coordinator and the name of the program physician. In addition, since the ADA recognition and the AADE accreditation programs do not require the participation of a pharmacist but the Iowa law does, ADA-recognized and AADE-accredited programs shall submit the name(s), license number(s) and continuing education hours of the pharmacist(s) who serves as program staff. A pharmacist shall be a primary or supporting instructor or advisory committee member and shall meet the education requirements in 9.8(6), 9.8(7) or 9.8(8).
[**ARC 9249B**, IAB 12/1/10, effective 1/5/11]

641—9.5(135) Renewal procedures for American Diabetes Association-recognized and American Association of Diabetes Educators-accredited programs. Programs shall renew their certification every four years, at least 30 days prior to the expiration date. To apply for renewal of certification, the ADA-recognized program or the AADE-accredited program shall submit a copy of the new ADA Certificate of Recognition or AADE Certificate of Accreditation, the name, address and telephone number for the program, the name of the program coordinator, the name of the program physician, and the name(s), license number(s), and continuing education hours of the pharmacist(s) who serves as program staff. A pharmacist shall be a primary or supporting instructor or advisory committee member and shall meet the continuing education requirements in 9.9(7).
[**ARC 9249B**, IAB 12/1/10, effective 1/5/11]

641—9.6(135) Application procedures for programs not recognized by the American Diabetes Association or accredited by the American Association of Diabetes Educators.

9.6(1) Each program shall apply for certification with the department.

9.6(2) Applications from programs not recognized by ADA or accredited by AADE shall provide the following information:

a. Name, address and telephone number for the program, program physician and program coordinator.

b. Identification of the target population, an estimate of the program caseload, estimated number of programs to be conducted annually, minimum and maximum class size, and a calendar identifying the hours per day and number of days per week scheduled in individual or group instruction to meet the minimum course requirements.

c. A description of goals and objectives, participant referral mechanism, and means of coordinating between the community, physicians, and program staff.

d. Evaluation methods designed by individual programs and samples of documents to be used.

e. A description of the curriculum designed to instruct the participant with diabetes how to achieve self-management competency. The curriculum shall cover the same content areas as are required by the ADA for recognition or the AADE for accreditation including:

(1) Diabetes overview: includes content about the diabetes disease process, pathophysiology and treatment/management options.

(2) Stress and psychological adjustment: includes developing personal strategies to address psychological issues, healthy coping, and problem solving.

(3) Family involvement and social support: includes strategies for safety and risk reduction and creating healthy environments and social supports.

(4) Nutrition: includes incorporating nutritional management (healthy eating) into lifestyle.

(5) Exercise and activity: includes incorporating physical activity (being active) into lifestyle.

(6) Medications: includes using medications safely and for maximum therapeutic benefit.

(7) Monitoring and use of results: includes monitoring blood glucose and other health indicators or parameters and interpreting and using the results for self-management decision making.

(8) Reducing risks: includes prevention, detection, and treatment of acute complications and chronic complications as well as foot, skin and dental care.

(9) Behavior change strategies, goal setting, risk-factor reduction, and problem solving: includes personal goals and strategies to address risks and build positive habits.

(10) Preconception care, pregnancy, and gestational diabetes.

(11) Use of health care systems and community resources.

[**ARC 9249B**, IAB 12/1/10, effective 1/5/11]

641—9.7(135) Diabetes program management for programs not recognized by the American Diabetes Association or accredited by the American Association of Diabetes Educators.

9.7(1) Pertinent information related to the recent medical history, physical examination, and test results performed by the participant's health care provider shall be provided when the participant is referred to the program. Program staff shall remain in contact with the participant's health care provider and shall make recommendations relative to the medical care and treatment of the participant's diabetes when appropriate.

9.7(2) When the participant completes the program, arrangements shall be made by program staff for optimal follow-up care.

9.7(3) Program staff members shall take an active role in the care of the participant's diabetes during the course of the program to optimize diabetes control. The program staff shall be prepared to make necessary recommendations to the referring health care provider in the participant's diabetes management which may include the following:

a. Changes in the insulin regimen.

b. Changes in the medications.

c. Changes in the food plan.

d. Changes in exercise.

9.7(4) Written materials supporting the program curriculum are to be made available to the participants. Educational materials from commercial sources shall be carefully evaluated by staff and be consistent with the program curriculum.

[**ARC 9249B**, IAB 12/1/10, effective 1/5/11]

641—9.8(135) Program staff for programs not recognized by the American Diabetes Association or accredited by the American Association of Diabetes Educators.

9.8(1) A program coordinator and a program physician shall be designated.

a. The program coordinator shall provide direction and supervision of the program, including, but not limited to, planning, arranging implementation, and assuring quality. If the program coordinator is an instructor, the program coordinator shall be a health care professional and meet the requirements for primary or supporting instructor.

b. The program physician shall provide medical direction for the program. The program physician shall maintain contact with the participant's attending physician and shall make recommendations relative to the medical care and treatment of the participant's diabetes where appropriate.

9.8(2) The program shall have an advisory committee composed of at least one physician, one registered nurse, one licensed dietitian and one pharmacist to oversee the program. It is recommended the advisory committee include an individual with behavioral science expertise, a consumer, and a community representative. The advisory committee shall participate in the annual planning process, including determination of target audience, program objectives, participant access mechanisms, instructional methods, resource requirements, participant follow-up mechanisms, and program evaluation.

9.8(3) The primary instructors shall be one or more of the following health care professionals: physicians, registered nurses, licensed dietitians, and pharmacists who are knowledgeable about the disease process of diabetes and the treatment of diabetes. If there is only one primary instructor, there shall be at least one supporting instructor. The supporting instructor shall be from one of the four professions listed as possible primary instructors, but a different profession from the single primary instructor.

9.8(4) The program may have additional supporting instructors including, but not limited to, dentist, exercise physiologist, health educator, ophthalmologist, pediatric diabetologist, podiatrist, psychologist, psychiatrist, or social worker.

9.8(5) The names and license or registration numbers of the program physician, program coordinator, and all primary and supporting instructors shall be included with the program application.

9.8(6) All primary instructors shall show evidence of knowledge about the disease process of diabetes and the treatment and management of people with diabetes by documentation of one or more of the following:

a. Within the last three years, completion of a minimum of 24 hours of continuing education in diabetes, diabetes management, or diabetes education; or

b. Equivalent training or experience including, but not limited to, endocrinology fellowship training or masters level preparation in diabetes nursing/nutrition. Unsupervised teaching of patients is not an acceptable equivalent.

c. Current certification as a certified diabetes educator.

9.8(7) All supporting instructors shall show evidence of knowledge about the disease process of diabetes and the treatment and management of people with diabetes by documentation of completion of a minimum of 12 hours of continuing education in diabetes, diabetes management, or diabetes education within the last three years or have current certification as a certified diabetes educator.

9.8(8) The four professionals required in 9.8(2) to be on the advisory committee shall have completed six hours of continuing education in diabetes within the past three years.

9.8(9) The program coordinator shall determine that each primary or supporting instructor has current licensure or registration required to practice in Iowa.

9.8(10) The program coordinator shall determine that new primary or supporting instructors, who join the program staff during a certification period, meet the requirements for initial certification in 9.8(6) or 9.8(7) within six months of when they join the program staff.

[**ARC 9249B**, IAB 12/1/10, effective 1/5/11]

641—9.9(135) Renewal application procedures for programs not recognized by the American Diabetes Association or accredited by the American Association of Diabetes Educators. Every

four years, programs shall provide the following information to the department at least 30 days prior to the expiration date.

9.9(1) Name, address and telephone number of the program, program physician and program coordinator.

9.9(2) Identification of the target population, an estimate of program caseload, and the number of participants served in the certification period.

9.9(3) A description of goals and objectives, participant referral mechanism, and means of coordinating between the community, physicians, and program staff.

9.9(4) A description of the program evaluation process.

9.9(5) A description of any changes from the previous application.

9.9(6) A list of new program staff by name, license number or registration number, and position with the program. New staff who will serve as primary instructors shall submit documentation of their training in diabetes as addressed in 9.8(6). New staff serving as supporting instructors shall submit documentation of their training as addressed in 9.8(7).

9.9(7) Documentation of continuing education hours accrued since the previous application for current staff and new staff.

a. All primary instructors shall complete a minimum of 18 hours of continuing education in diabetes, diabetes management or diabetes education within the past three years.

b. All supporting instructors shall complete a minimum of nine hours of continuing education in diabetes, diabetes management, or diabetes education within the past three years.

c. The four professionals required in 9.8(2) to be on the advisory committee shall complete a minimum of five hours of continuing education in diabetes within the past three years.

[**ARC 9249B**, IAB 12/1/10, effective 1/5/11]

641—9.10(135) Annual report. Summary data shall be completed annually by each program and sent to the department. The data shall include but not be limited to the number of times the program was presented, the number of outpatients that participated, and a summarized description of program participants including type of diabetes, age, race and sex.

[**ARC 9249B**, IAB 12/1/10, effective 1/5/11]

641—9.11(135) Enforcement.

9.11(1) The department may annually or more frequently conduct on-site visits of certified programs.

9.11(2) The department shall furnish a written report of each visit to the program coordinator.

9.11(3) Programs determined by the department to no longer meet the minimum standards for certification shall be given 30 days following receipt of the department's notification of deficiencies to submit a plan of correction.

9.11(4) Notification of cancellation shall be provided to the Iowa insurance division of the Iowa department of commerce and the public.

641—9.12(135) Complaints.

9.12(1) The department shall accept complaints of alleged problems relating to certified outpatient diabetes self-management programs. The information shall state in a reasonably specific manner the basis of the complaints and be presented in writing, in person or by telephone to: Bureau of Chronic Disease Prevention and Management, Division of Health Promotion and Chronic Disease Prevention, Iowa Department of Public Health, Lucas State Office Building, 321 East 12th Street, Des Moines, Iowa 50319-0075; (515)281-5616.

9.12(2) The department shall, within 20 working days of the receipt of the complaint, contact the program coordinator for initial evaluation of the specific matters alleged in the complaint. The program shall receive a written report of the results of department activities relating to the complaint investigation. The complainant shall be promptly informed of the results of the investigation or any action taken by the department.

[**ARC 9249B**, IAB 12/1/10, effective 1/5/11]

641—9.13(135) Appeal process.

9.13(1) *Denial.* Programs shall receive written notice by certified mail, return receipt requested, setting forth the reason(s) for denial. The denial shall become effective 30 days after receipt by the aggrieved party unless the grievant within that 30-day period gives written notice to the department requesting a hearing in which case the notice shall be deemed to be suspended.

9.13(2) *Revocation.* Programs shall receive written notice by certified mail, return receipt requested, setting forth the reason(s) for revocation. The revocation shall become effective 30 days after receipt by the aggrieved party unless the grievant within that 30-day period gives written notice to the department requesting a hearing in which case the notice shall be deemed to be suspended.

9.13(3) *Contested case.* Upon receipt of an appeal that meets contested case status, the appeal shall be forwarded within five working days to the department of inspections and appeals pursuant to the rule adopted by that agency regarding the transmission of contested cases. The information upon which the adverse action is based and any additional information which may be provided by the aggrieved party shall also be provided to the department of inspections and appeals.

641—9.14(135) Formal contest.

9.14(1) *Hearing.* The hearing shall be conducted according to the procedural rules of the department of inspections and appeals found in 481—Chapter 10.

9.14(2) *Decision of administrative law judge.* When the administrative law judge makes a proposed decision and order, it shall be served by certified mail, return receipt requested, or delivered by personal service. That proposed decision and order then becomes the department's final agency action without further proceedings ten days after it is received by the aggrieved party unless an appeal to the director is taken as provided in 9.14(3).

9.14(3) *Appeal to director.* Any appeal to the director for review of the proposed decision and order of the administrative law judge shall be filed in writing and mailed to the director by certified mail, return receipt requested, or delivered by personal service within ten days after the receipt of the administrative law judge's proposed decision and order by the aggrieved party. A copy of the appeal shall also be mailed to the administrative law judge. Any request for an appeal shall state the reason for appeal.

9.14(4) *Record of hearing.* Upon receipt of an appeal request, the administrative law judge shall prepare the record of the hearing for submission to the director. The record shall include the following:

a. All pleadings, motions and rules.

b. All evidence received or considered and all other submissions by recording or transcript.

c. A statement of all matters officially noticed.

d. All questions and offers of proof, objections and rulings thereon.

e. All proposed findings and exceptions.

f. The proposed decision and order of the administrative law judge.

9.14(5) *Decision of director.* The decision and order of the director becomes the department's final agency action upon receipt by the aggrieved party and shall be delivered by certified mail, return receipt requested, or by personal service.

9.14(6) *Exhausting administrative remedies.* It is not necessary to file an application or a rehearing to exhaust administrative remedies when appealing to the director or the district court as provided in Iowa Code section 17A.19. The aggrieved party to the final agency action of the department who has exhausted all administrative remedies may petition for judicial review of that action pursuant to Iowa Code chapter 17A.

9.14(7) *Petition for judicial review.* Any petition for judicial review of a decision and order shall be filed in the district court within 30 days after the decision and order becomes final. A copy of the notice of appeal shall be sent to the director by certified mail, return receipt requested, or by personal service. The address is: Iowa Department of Public Health, Lucas State Office Building, 321 East 12th Street, Des Moines, Iowa 50319-0075.

[**ARC 9249B**, IAB 12/1/10, effective 1/5/11]

These rules are intended to implement Iowa Code section 135.11.

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[1] Objection to 9.6(2) filed 7/11/85, IAB 7/31/85.
[2] See IAB, Inspections and Appeals Department.

CHAPTER 90
IOWA CHILD DEATH REVIEW TEAM

641—90.1(135) Purpose. The purpose of the Iowa child death review team is to aid in the reduction of preventable deaths of children under the age of 18 years through the identification of unsafe consumer products; identification of unsafe environments; identification of factors that play a role in accidents, homicides and suicides which may be eliminated or counteracted; and promotion of communication, discussion, cooperation, and exchange of ideas and information among agencies investigating child deaths.
[**ARC 9248B**, IAB 12/1/10, effective 1/5/11]

641—90.2(135) Definitions.

"Team" means the Iowa child death review team.

"Unexcused absence" means failure by a team member to notify the chairperson of an anticipated absence from a team meeting.

641—90.3(135) Agency. The Iowa child death review team is established as part of the office of the state medical examiner. The office of the state medical examiner shall provide staffing and administrative support to the team as needed to collect data, organize meetings, and issue an annual report.
[**ARC 9248B**, IAB 12/1/10, effective 1/5/11]

641—90.4(135) Membership. The membership of the review team is subject to the provisions of Iowa Code sections 69.16 and 69.16A, relating to political affiliation and gender balance. Review team members who are not designated by another appointing authority shall be appointed by the state medical examiner. Membership terms shall be for three years. Members may not serve more than two consecutive terms.

90.4(1) The review team shall include the following:

a. The state medical examiner's designee.

b. A certified or licensed professional who is knowledgeable concerning sudden infant death syndrome.

c. A pediatrician who is knowledgeable concerning deaths of children.

d. A family practice physician who is knowledgeable concerning deaths of children.

e. One mental health professional who is knowledgeable concerning deaths of children.

f. One social worker who is knowledgeable concerning deaths of children.

g. A certified or licensed professional who is knowledgeable concerning domestic violence.

h. A professional who is knowledgeable concerning substance abuse.

i. A local law enforcement official.

j. A county attorney.

k. An emergency room nurse who is knowledgeable concerning the deaths of children.

l. A perinatal expert.

m. A representative of the health insurance industry.

n. One other appointed at large.

The state medical examiner's office may temporarily appoint other members to serve as experts, as needed, on a case-by-case basis.

90.4(2) Vacancies shall be filled in the same manner in which the original appointments were made. An appointment shall complete the original member's term.

90.4(3) Three consecutive unexcused absences shall be grounds for the state medical examiner to consider dismissal of the team member and to appoint another. The chairperson of the team is charged with providing notification of absences.
[**ARC 9248B**, IAB 12/1/10, effective 1/5/11]

641—90.5(135) Officers. The review team shall elect a chairperson, a vice chairperson, and other officers as deemed necessary by the review team. Officers shall be elected at the first meeting of each

fiscal year. Vacancy in the office of the chairperson shall be filled by elevation of the vice chairperson. Vacancy in the office of the 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 9248B**, IAB 12/1/10, effective 1/5/11]

641—90.6(135) Meetings. The team shall meet as determined by the state medical examiner or as determined by the review team.
[**ARC 9248B**, IAB 12/1/10, effective 1/5/11]

641—90.7(135) Expenses of team members. The state medical examiner's office shall reimburse members of the team for travel expenses according to state guidelines.
[**ARC 9248B**, IAB 12/1/10, effective 1/5/11]

641—90.8(135) Team responsibilities. The state medical examiner's office will be responsible for the collection of data for sudden unexpected or nonnatural deaths for all children under the age of 18 years that occur in the state of Iowa. The state medical examiner's office will review all child deaths in Iowa and will refer those deemed preventable for additional review by the child death review team. The state medical examiner's office will be responsible for data entry. The team shall perform the following responsibilities:

90.8(1) Collect, review, and analyze child death certificates and child death data, including patient records, other pertinent confidential information, and other information the review team deems appropriate concerning deaths of children under 18 years of age which have been deemed preventable by the state medical examiner's office. An annual report will be prepared for the governor and the general assembly concerning the cause and manner of child deaths. The report shall include factual information obtained through review and recommendations regarding prevention of child deaths.

90.8(2) Recommend to the governor and the general assembly interventions to prevent deaths of children based on an analysis of the cause and manner of such deaths.

90.8(3) Recommend to the agencies represented on the review team and to other agencies changes which may prevent child deaths.

90.8(4) Maintain the confidentiality of any patient records or other confidential information reviewed.

90.8(5) If deemed appropriate by the team at any point in the review, the team may recommend to the department of human services, appropriate law enforcement agencies, and any person involved with child protection interventions that may prevent harm to a child who is related to or is living in the same home as a child whose case is reviewed by the team.

90.8(6) Develop protocols for a child fatality review committee (see 641—Chapter 92) to be appointed by the state medical examiner on an ad hoc basis to immediately review the child abuse assessments which involve the fatality of a child under the age of 18 years. The state medical examiner shall appoint a medical examiner, a pediatrician, and a person involved with law enforcement to the committee.

90.8(7) The team may establish subcommittees to which the team may delegate some or all of the team's responsibilities set out in this rule.
[**ARC 9248B**, IAB 12/1/10, effective 1/5/11]

641—90.9(135) Liaisons.

90.9(1) The following individuals shall each designate a liaison to assist the team in fulfilling its responsibilities.

a. Director of public health.

b. Director of human services.

c. Commissioner of public safety.
d. Administrator of the bureau of vital records of the Iowa department of public health.
e. Attorney general.
f. Director of transportation.
g. Director of the department of education.

90.9(2) The chairperson shall designate a liaison from the public at large.

90.9(3) The membership terms of the liaisons shall be for three years. The liaisons may not serve more than two consecutive terms.

[**ARC 9248B**, IAB 12/1/10, effective 1/5/11]

641—90.10(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 child deaths, including disclosure of information which is confidential under Iowa Code chapter 22 or any other provisions of state law. 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.

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, hospital records, physician's records, school records, day-care records, autopsy records, child abuse registry, investigation or assessment records, state public assistance records, traffic records, public safety records, law enforcement records, fire marshal's records, birth records, death records, and other relevant records necessary to conduct a complete review.

A person in possession or control of medical, investigative or other information pertaining to a child death and child abuse review 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 child death review team. Information and records which are confidential under Iowa Code section 22.7and chapter 235A, and information or records received from the confidential records, remain confidential under this rule. A person does not incur legal liability by reason of releasing information to the department as required under and in compliance with this rule.

641—90.11(135) Immunity and liability. 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. 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.

A person who releases or discloses confidential data, records, or any other type of information in violation of this chapter is guilty of a serious misdemeanor.

These rules are intended to implement Iowa Code Supplement section 135.43.

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CHAPTER 111
IOWA NEEDS NURSES NOW INFRASTRUCTURE ACCOUNT

641—111.1(135) Scope and purpose. The Iowa needs nurses now infrastructure account is established to award grants for clinical simulators, laboratory facilities, health information technology and other infrastructure to improve the education of nurses and nurse educators in the state and to enhance the clinical experience for nurses. Moneys in the account shall consist of moneys appropriated or allocated for deposit in or received by the fund or the account and specifically dedicated to the Iowa needs nurses now infrastructure account for the purposes of the account. Grants from the account may not be used for the construction of buildings. Grants awarded shall authorize the use of a reasonable portion of the grant moneys for training in the use of the infrastructure purchased with the grant moneys. These rules shall be implemented only to the extent funding is available.
[**ARC 9247B**, IAB 12/1/10, effective 1/5/11]

641—111.2(135) Definitions. For the purposes of these rules, the following definitions shall apply:

"Department" means the Iowa department of public health.

"Iowa Needs Nurses Now Coalition" means the coalition of nurse, health, education and business leaders who understand that nurses are important to families and communities.
[**ARC 9247B**, IAB 12/1/10, effective 1/5/11]

641—111.3(135) Eligibility and criteria. To be eligible for an Iowa needs nurses now infrastructure grant, an organization shall:

111.3(1) Be an educational institution with prelicensure nursing education programs approved by the Iowa board of nursing.

111.3(2) Address the long-term sustainability of the infrastructure project to be funded through the grant.
[**ARC 9247B**, IAB 12/1/10, effective 1/5/11]

641—111.4(135) Review process.

111.4(1) The department shall follow requirements for competitive selection contained in 641—Chapter 176 in awarding grants pursuant to this chapter.

111.4(2) The department shall establish a request for proposal and application process for organizations eligible to receive funding. The review process and review criteria shall be described in the request for proposal.

111.4(3) The department shall establish a committee to review proposals and make recommendations to the department. The committee membership may include representation from the following:

a. Iowa board of nursing;

b. Iowa Nurses Association;

c. Iowa Needs Nurses Now Coalition; and

d. Iowa department of education.

111.4(4) The department shall consider financial need of the applying entity as a criterion in determining grant awards.

111.4(5) The department shall consider geographic areas where there is limited access to clinical facilities due to geographic location or limited patient census to support eligible students as a criterion in determining grant awards.

111.4(6) The department shall consider collaboration between education programs and clinical facilities as a criterion in determining grant awards.
[**ARC 9247B**, IAB 12/1/10, effective 1/5/11]

641—111.5(135) Performance standards. A grantee shall provide clinical experiences for nurses and nurse educators that:

1. Expand the capacity of its nursing program in terms of opportunities for increased learning by the students completing the program.

2. Offer educational opportunities in geographic areas where there is limited access to clinical facilities due to geographic location or limited patient census to support eligible students.

3. Enhance learning opportunities for the students in the nursing program.

[**ARC 9247B**, IAB 12/1/10, effective 1/5/11]

641—111.6(135) Appeals. An applicant may appeal the denial of a properly submitted grant application. Appeals shall be governed by rule 641—176.8(135,17A).

[**ARC 9247B**, IAB 12/1/10, effective 1/5/11]

These rules are intended to implement 2009 Iowa Code Supplement section 135.175(5) as amended by 2010 Iowa Acts, Senate File 2384, section 5.

[Filed ARC 9247B (Notice ARC 9096B, IAB 9/22/10), IAB 12/1/10, effective 1/5/11]

CHAPTER 179
Reserved

CHAPTER 180
HOSPITAL PROTOCOL FOR DONOR REQUESTS
Rescinded IAB 4/4/90, effective 5/9/90; see 641—51.4(5) to 641—51.4(11)

CHAPTERS 181 to 185
Reserved

CHAPTER 186
GOVERNMENTAL PUBLIC HEALTH ADVISORY BODIES

641—186.1(135A) Purpose. The governmental public health advisory council and the governmental public health evaluation committee shall advise the department regarding the coordination and implementation of the voluntary accreditation of designated local public health agencies and of the department and the evaluation of the accreditation program and governmental public health system.
[**ARC 9246B**, IAB 12/1/10, effective 1/5/11]

641—186.2(135A) Definitions. For the purposes of this chapter, the following definitions apply:

"Committee" means the governmental public health evaluation committee as established in 2009 Iowa Code Supplement section 135A.5.

"Council" means the governmental public health advisory council as established in 2009 Iowa Code Supplement section 135A.4.

"Department" means the Iowa department of public health.

"Designated local public health agency" means an entity that is either governed by or contractually responsible to a local board of health and designated by the local board to comply with the Iowa public health standards for a jurisdiction.

"Director" means the director of the Iowa department of public health.
[**ARC 9246B**, IAB 12/1/10, effective 1/5/11]

641—186.3(135A) Roles and responsibilities of advisory bodies. Two advisory bodies shall provide guidance to the department regarding the governmental public health system.

186.3(1) A governmental public health advisory council is established to advise the department and make policy recommendations to the department concerning administration, implementation, and coordination of 2009 Iowa Code Supplement chapter 135A and to make recommendations to the department regarding the governmental public health system.

186.3(2) The council shall annually provide a report to the department by July 1.

186.3(3) A governmental public health evaluation committee is established to develop and implement the evaluation of the governmental public health system and voluntary accreditation program as described in 2009 Iowa Code Supplement section 135A.5.

186.3(4) The committee shall annually provide a report to the department by July 1.

186.3(5) Recommendations from the council and committee shall be provided to the director in writing. The director may provide those recommendations to the state board of health.

186.3(6) Communication. The council and committee shall ensure communication between the two bodies by:

a. Providing regular updates to the other body through written reports at each meeting.

b. Stipulating that the chairperson and vice chairperson of the committee and council hold semiannual conference calls.

c. Meeting together at least biennially.

d. Responding to requests from one body to the other that shall be made in writing and appear in new business on the agenda of the next regularly scheduled meeting.
[**ARC 9246B**, IAB 12/1/10, effective 1/5/11]

641—186.4(135A) Officers.

186.4(1) The officers of the council and committee shall be a chairperson and vice chairperson for each body.

a. The officers shall be elected at the first meeting each September.

b. Vacancy in the office of chairperson shall be filled by the vice chairperson.

c. Vacancy in the office of vice chairperson shall be filled by election at the next regularly scheduled meeting after the vacancy occurs.

186.4(2) Duties of officers.

a. The chairperson of the council shall preside at all meetings of the council, and the chairperson of the committee shall preside at all meetings of the committee.

b. Robert's Rules of Order shall govern all meetings.

c. 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 the restrictions upon the chairperson.

d. The vice chairperson shall also perform such other duties as may be assigned by the chairperson.
[**ARC 9246B**, IAB 12/1/10, effective 1/5/11]

641—186.5(135A) Members of advisory bodies.

186.5(1) The director, pursuant to 2009 Iowa Code Supplement sections 135A.4 and 135A.5, shall appoint members of the council and committee.

a. Members shall serve for a term of two years and may be reappointed for a maximum of three consecutive terms. Initial appointments shall be in staggered terms.

b. Vacancies shall be filled in the same manner in which the original appointments were made for the balance of the unexpired term.

186.5(2) A member's designee shall meet the same criteria for which the member was appointed. The member shall notify the department when the designee will be in attendance. The designee shall have voting rights.

186.5(3) Two consecutive unexcused absences of a member or designee shall be grounds for the director to consider dismissal of the council member or committee member and to appoint another. The department staff person assigned to the council or committee is charged with providing notification of absences to the director.
[**ARC 9246B**, IAB 12/1/10, effective 1/5/11]

641—186.6(135A) Meetings. The council and committee shall each hold a meeting at least quarterly. Notice of routine meetings and agenda should be made available to the members a minimum of five working days prior to the meeting.

186.6(1) Persons wishing to submit materials for consideration by the council or committee should submit the materials electronically to the department at least 14 days in advance of the scheduled meeting to ensure that members have adequate time to review the materials.

186.6(2) Persons wishing to make a presentation to the council or committee shall submit the request to the department not less than 14 days prior to the meeting. Presentations upon matters appearing on the agenda may be made either at the discretion of the chairperson or the department.

186.6(3) All meetings are open to the public in accordance with the open meetings law, Iowa Code chapter 21.

186.6(4) The council or committee may conduct a meeting by electronic means pursuant to Iowa Code section 21.8.

186.6(5) A simple majority of appointed members shall be considered a quorum.

186.6(6) Any member or member's designee who is unable to attend a meeting shall notify the department at least 24 hours prior to the start of a regularly scheduled meeting; a meeting may be canceled if a quorum will not be present.

186.6(7) When a quorum is present, a position is carried by affirmative vote of the majority of those present.

186.6(8) Minutes. Minutes of all meetings showing the date, time, place, members present, members absent, and the general topics discussed shall be kept. The minutes shall reflect the actions agreed upon by the members for topics requiring the members' input or consensus.
[**ARC 9246B**, IAB 12/1/10, effective 1/5/11]

641—186.7(135A) Conflict of interest. A conflict of interest exists when members of the council or committee participate in a way that directly affects the financial interests of the council or committee members.

186.7(1) To avoid conflict of interest issues, council or committee members who have a financial interest in an action must abstain from participating in the entire process including discussion and voting.

186.7(2) The council or committee members who have or think they may have a conflict of interest shall declare that there is or may be a conflict of interest and request a determination from the department.

186.7(3) If a conflict of interest is determined to exist, council or committee members shall abstain from voting and shall be recorded as abstaining when votes are taken.
[**ARC 9246B**, IAB 12/1/10, effective 1/5/11]

641—186.8(135A) Subcommittees. The council and committee may designate one or more subcommittees to perform such duties as may be deemed necessary.
[**ARC 9246B**, IAB 12/1/10, effective 1/5/11]

These rules are intended to implement 2009 Iowa Code Supplement sections 135A.4 and 135A.5.

[Filed ARC 9246B (Notice ARC 9093B, IAB 9/22/10), IAB 12/1/10, effective 1/5/11]

CHAPTERS 187 to 189
Reserved

CHAPTER 190
CONSENT FOR THE SALE OF GOODS AND SERVICES
Rescinded IAB 4/11/07, effective 5/16/07