CHAPTER 90
CASE MANAGEMENT SERVICES

Case management services are designed to ensure the health, safety, and welfare of members by assisting them in gaining access to appropriate and necessary medical services and interrelated social, educational, housing, transportation, vocational, and other services. The term "case management" encompasses all categories of case management: targeted case management, case management and administrative case management provided to members enrolled in a 1915(c) waiver, community-based case management provided through managed care, and integrated health home (IHH) care coordination provided to the habilitation and children's mental health waiver populations. If a part of these rules does not apply to all categories of case management, then the rule will clarify the affected category(ies).
[**ARC 4897C**, IAB 2/12/20, effective 3/18/20]

441—90.1(249A) Definitions.

"Adult" means a person 18 years of age or older on the first day of the month in which service begins.

"Applicant" means a person who has applied for an HCBS waiver or habilitation program.

"Care coordination" means the case management services provided by an integrated health home to members who are also receiving home- and community-based habilitation services pursuant to rule 441—78.27(249A) or HCBS children's mental health waiver services pursuant to rules 441—83.121(249A) through 441—83.129(249A).

"Case management" means the categories of case management: targeted case management, case management provided to members enrolled in a 1915(c) waiver, community-based case management provided through managed care, and integrated health home (IHH) care coordination provided to the habilitation and children's mental health waiver populations.

"Case manager" means the staff person providing all categories of case management services regardless of the entity providing the service or the program in which the member is enrolled, including IHH care coordination.

"Child" means a person other than an adult.

"Chronic mental illness" means a condition present in adults who have a persistent mental or emotional disorder that seriously impairs their functioning relative to such primary aspects of daily living as personal relations, living arrangements, or employment. The definition of chronic mental illness and qualifying criteria are found at rule 441—24.1(225C). For purposes of this chapter, people with mental disorders resulting from Alzheimer's disease or substance abuse shall not be considered chronically mentally ill.

"Community-based case manager" means the employee of a Medicaid-contracted managed care organization (MCO) who provides case management services to MCO-enrolled members.

"Core standardized assessment" or *"CSA"* means an assessment instrument for determining the suitability of non-institutionally based long-term services and supports for an individual. The instrument shall be used in a uniform manner throughout the state to determine an applicant's or member's needs for training, support services, medical care, transportation, and other services and to develop an individual service plan to address such needs. The core standardized assessment shall be performed by a contractor under the direction of the department for the fee-for-service population. MCOs shall perform core standardized assessments for MCO-enrolled members or shall delegate the responsibility for completion of assessments. 441—Chapter 83 designates the assessment and reassessment tools to be used for each HCBS waiver. 441—Chapter 78 designates the assessment and reassessment tools to be used for habilitation.

"Department" means the department of human services.

"Developmental disability" means a severe, chronic disability that is determined through professionally administered screening and evaluations and that:

1. Is attributable to a mental or physical impairment or combination of mental and physical impairments;
2. Is manifested before the age of 22;

3. Is likely to continue indefinitely;

4. Results in substantial functional limitations in three or more of the following areas of major life activity: (a) self-care, (b) receptive and expressive language, (c) learning, (d) mobility, (e) self-direction, (f) capacity for independent living, and (g) economic self-sufficiency; and

5. Reflects the person's need for a combination and sequence of special, interdisciplinary, or generic services, individualized supports, or other forms of assistance that are of lifelong or extended duration and are individually planned and coordinated.

"Fee-for-service member" or *"FFS member"* means a member who is not enrolled with a managed care organization because the member is exempt from managed care organization enrollment.

"Home- and community-based services" or *"HCBS"* means services provided pursuant to Sections 1915(c) and 1915(i) of the Social Security Act.

"Integrated health home" or *"IHH"* means a provider of health home services that is a Medicaid-enrolled provider and that is determined through the provider enrollment process to have the qualifications, systems and infrastructure in place to provide IHH services pursuant to rule 441—77.47(249A). IHH covered services and member eligibility for IHH enrollment are also governed by rule 441—78.53(249A) and the health home state plan amendment. The IHH provides care coordination services for enrolled habilitation and children's mental health waiver members.

"Intellectual disability" means a diagnosis of intellectual disability (intellectual developmental disorder), global developmental delay, or unspecified intellectual disability (intellectual developmental disorder). Diagnosis criteria are outlined in rule 441—83.61(249A).

"Major incident" means an occurrence that involves a member who is enrolled in an HCBS waiver, targeted case management, or habilitation services and that:

1. Results in a physical injury to or by the member that requires a physician's treatment or admission to a hospital;

2. Results in the death of any person;

3. Requires emergency mental health treatment for the member;

4. Requires the intervention of law enforcement;

5. Requires a report of child abuse pursuant to Iowa Code section 232.69, a report of dependent adult abuse pursuant to Iowa Code section 235B.3, or a report of elder abuse pursuant to Iowa Code chapter 235F; or

6. Involves a member's location being unknown by provider staff who are responsible for protective oversight.

"Managed care organization" or *"MCO"* means the same as defined in rule 441—73.1(249A).

"Medical institution" means an institution that is organized, staffed, and authorized to provide medical care as set forth in the most recent amendment to 42 Code of Federal Regulations Section 435.1009. A residential care facility is not a medical institution.

"Member" means a person who has been determined to be eligible for Medicaid under 441—Chapter 75.

"Minor incident" means an occurrence that involves a member who is enrolled in an HCBS waiver, targeted case management, or habilitation services and that is not a major incident but that:

1. Results in the application of basic first aid;

2. Results in bruising;

3. Results in seizure activity;

4. Results in injury to self, to others, or to property; or

5. Constitutes a prescription medication error.

"Person-centered service plan" or *"service plan"* means a service plan created through the person-centered planning process, directed by the member with long-term care needs or the member's guardian or representative, to identify the member's strengths, capabilities, preferences, needs, and desired outcomes.

"Rights restriction" means limitations not imposed on the general public in the areas of communication, mobility, finances, medical or mental health treatment, intimacy, privacy, type of work, religion, place of residence, and people with whom a member may share a residence.

"Targeted case management" means case management services furnished to assist members who are part of a targeted population.

"Targeted population" means people who meet one of the following criteria:

1. An adult who is identified with a primary diagnosis of intellectual disability, chronic mental illness, or developmental disability; or

2. A child who is eligible to receive HCBS intellectual disability waiver services or HCBS children's mental health waiver services according to 441—Chapter 83.

A member enrolled with a managed care organization or integrated health home is not part of the targeted population.

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441—90.2(249A) Targeted case management. Rule 441—90.2(249A) applies only to the case management category of targeted case management and the defined targeted population.

90.2(1) *Eligibility for targeted case management.* A person who meets all of the following criteria shall be eligible for targeted case management:

a. The person is eligible for Medicaid or is conditionally eligible under 441—subrule 75.1(35);

b. The person is a member of a targeted population;

c. The person resides in a community setting or qualifies for transitional case management as set forth in subrule 90.2(4);

d. The person has applied for targeted case management in accordance with the policies of the provider;

e. The person's need for targeted case management has been determined in accordance with rule 441—90.2(249A); and

f. The person is not eligible for, or enrolled in, Medicaid managed care.

90.2(2) *Determination of need for targeted case management.* Assessment at least every 365 days of the need for targeted case management is required as a condition of eligibility under the medical assistance program. The targeted case management provider shall determine the member's initial and ongoing need for service based on diagnostic reports, documentation of provision of services, and information supplied by the member and other appropriate sources. The evidence shall be documented in the member's file and shall demonstrate that all of the following criteria are met:

a. The member has a need for targeted case management to manage necessary medical, social, educational, housing, transportation, vocational, and other services for the benefit of the member;

b. The member has functional limitations and lacks the ability to independently access and sustain involvement in necessary services; and

c. The member is not receiving, under the medical assistance program or under a Medicaid managed health care plan, other paid benefits that serve the same purpose as targeted case management or integrated health home care coordination.

90.2(3) *Application for targeted case management.* The provider shall process an application for targeted case management no later than 30 days after receipt of the application. The provider shall refer the applicant to the department's service unit or mental health and disability services regions if other services outside the scope of case management are needed or requested.

a. Application process and documentation. The application shall include the member's name, the nature of the request for services, and a summary of any evaluation activities completed. For FFS members, the provider shall inform the applicant in writing of the applicant's right to choose the provider of case management services and, at the applicant's request, shall provide a list of other case management services agencies from which the applicant may choose. The provider shall maintain this documentation for at least five years.

b. Application decision for targeted case management. The case manager shall inform the applicant, or the applicant's guardian or representative, of any decision to approve, deny, or delay the service in accordance with the notification requirements at 441—subrule 7.7(1).

c. Denial of applications. The case manager shall deny an application for service when:

(1) The applicant is not currently eligible for Medicaid;

(2) The applicant does not meet the eligibility criteria in 441—subrule 90.2(1);

(3) The applicant, or the applicant's guardian or representative, withdraws the application;

(4) The applicant does not provide information required to process the application;

(5) The applicant is receiving duplicative targeted case management or integrated health home care coordination from another Medicaid provider; or

(6) The applicant does not have a need for targeted case management.

90.2(4) *Transition to a community setting.* Managed care organizations must provide transition services to all enrolled members. Fee-for-service targeted case management services may be provided to a member transitioning to a community setting during the 60 days before the member's discharge from a medical institution when the following requirements are met:

a. The member is an adult who qualifies for targeted case management and is a member of a targeted population. Transitional case management is not an allowable service for other HCBS programs or populations;

b. Case management services shall be coordinated with institutional discharge planning, but shall not duplicate institutional discharge planning;

c. The amount, duration, and scope of case management services shall be documented in the member's service plan, which must include case management services before and after discharge, to facilitate a successful transition to community living;

d. Payment shall be made only for services provided by Medicaid-enrolled targeted case management providers; and

e. Claims for reimbursement for case management services shall not be submitted until the member's discharge from the medical institution and enrollment in community services.

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441—90.3(249A) Termination of targeted case management services. Rule 441—90.3(249A) applies only to the case management category of targeted case management and the defined targeted population.

90.3(1) Targeted case management shall be terminated when:

a. The member does not meet eligibility criteria under rule 441—90.2(249A);

b. The member has achieved all goals and objectives of the service;

c. The member has no ongoing need for targeted case management;

d. The member is receiving targeted case management based on eligibility under an HCBS program but is no longer eligible for the program;

e. The member or the member's guardian or representative requests termination;

f. The member is unwilling or unable to accept further services; or

g. The member or the member's guardian or representative fails to provide access to information necessary for the development of the service plan or for implementation of targeted case management.

90.3(2) The provider shall notify the member or the member's guardian or representative in writing of the termination of targeted case management, in accordance with 441—subrule 7.7(1).

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441—90.4(249A) Case management services. Rule 441—90.4(249A) applies to all categories of case management and all populations covered by case management.

90.4(1) *Covered services.* The following shall be included in case management services provided to members, whether FFS members or MCO-enrolled members:

a. Assessment. Initial assessments and regular reassessments must be done for each applicant and member to determine the need for any medical, social, educational, housing, transportation, vocational, or other services. The assessments and reassessments shall address all of the applicant's and member's areas of need, strengths, preferences, and risk factors, considering the person's physical and social environment. Applicants and members will receive individualized prior notification of the assessment tool to be used and of who will conduct the assessment. The assessment and reassessment will be done using the core standardized assessment or another tool as designated in 441—Chapter 83 for each waiver population and 441—Chapter 78 for the habilitation population. Initial assessments must be face to face. Reassessments using the interRAI must be done face to face. Only the Supports

Intensity Scale® assessment can be done telephonically, and then only when the situation meets the criteria outlined by the American Association on Intellectual and Developmental Disabilities (AAIDD). The off-year assessment (OYA) for the intellectual disability waiver can be done telephonically. A reassessment must be conducted at a minimum every 365 days and more frequently if material changes occur in the member's condition or circumstances. Case managers may participate during the assessment or reassessment process at the request of the applicant or member; the case manager does not assume the role of the assessor.

b. Person-centered service plan. At least every 365 days, the case manager shall develop and revise a comprehensive, person-centered service plan in collaboration with the member, the member's service providers, and other people identified as necessary by the member, as practicable. The person-centered service plan will be developed based on the assessment and shall include a crisis intervention plan based on the risk factors identified in a risk assessment. The case manager shall document the member's history, including current and past information and social history, and shall update the history annually. The case manager shall gather information from other sources such as family members, medical providers, social workers, guardians, representatives, and others as necessary to form a thorough social history and comprehensive person-centered service plan with the member. The person-centered service plan may also be referred to as a person-centered treatment plan.

(1) The person-centered service plan shall address all service plan components outlined in this chapter and in 441—Chapter 83 for the waiver in which the member is enrolled or 441—Chapter 78 for members enrolled in habilitation.

(2) Person-centered planning shall be implemented in a manner that supports the member, makes the member central to the process, and recognizes the member as the expert on goals and needs. In order for this to occur, there are certain process elements that must be included in the process. These include:

1. The member, guardian or representative must have control over who is included in the planning process, as well as have the authority to request meetings and revise the person-centered service plan (and any related budget) whenever reasonably necessary.

2. The process is timely and occurs at times and locations of convenience to the member, the member's guardian or representative and family members, and others, as practicable.

3. Necessary information and support are provided to ensure that the member or the member's guardian or representative is central to the process and understands the information. This includes the provision of auxiliary aids and services when needed for effective communication.

4. A strengths-based approach to identifying the positive attributes of the member shall be used, including an assessment of the member's strengths and needs. The member should be able to choose the specific planning format or tool used for the planning process.

5. The member's personal preferences shall be considered to develop goals and to meet the member's HCBS needs.

6. The member's cultural preferences must be acknowledged in the planning process, and policies/practices should be consistent with the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (the National CLAS Standards) of the Office of Minority Health, U.S. Department of Health and Human Services.

7. The planning process must provide meaningful access to members and their guardians or representatives with limited English proficiency (LEP), including low literacy materials and interpreters.

8. Members who are under guardianship or other legal assignment of individual rights, or who are being considered as candidates for these arrangements, must have the opportunity in the planning process to address any concerns.

9. There shall be mechanisms for solving conflict or disagreement within the process, including clear conflict of interest guidelines.

10. Members shall be offered information on the full range of HCBS available to support achievement of personally identified goals.

11. The member or the member's guardian or representative shall be central in determining what available HCBS are appropriate and will be used.

12. The member shall be able to choose between providers or provider entities, including the option of self-directed services when available.

13. The person-centered service plan shall be reviewed at least every 365 days or sooner if the member's functional needs change, circumstances change, or quality of life goals change, or at the member's request. There shall be a clear process for members to request reviews. The case management entity must respond to such requests in a timely manner that does not jeopardize the member's health or safety.

14. The planning process should not be constrained by any case manager's or guardian's or representative's preconceived limits on the member's ability to make choices.

15. Employment and housing in integrated settings shall be explored, and planning should be consistent with the member's goals and preferences, including where the member resides and with whom the member lives.

(3) Elements of the person-centered service plan. The person-centered service plan shall identify the services and supports that are necessary to meet the member's identified needs, preferences, and quality of life goals. The person-centered service plan shall:

1. Reflect that the setting where the member resides is chosen by the member. The chosen setting must be integrated in, and support full access to, the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community to the same degree of access as individuals not receiving HCBS.

2. Be prepared in person-first singular language and be understandable by the member or the member's guardian or representative.

3. Note the strengths-based positive attributes of the member at the beginning of the plan.

4. Identify risks, while considering the member's right to assume some degree of personal risk, and include measures available to reduce risks or identify alternate ways to achieve personal goals.

5. Document goals in the words of the member or the member's guardian or representative, with clarity regarding the amount, duration, and scope of HCBS services that will be provided to assist the member. Goals shall consider the quality of life concepts important to the member.

6. Describe the services and supports that will be necessary and specify what HCBS services are to be provided through various resources, including natural supports, to meet the goals in the person-centered service plan.

7. Document the specific person or persons, provider agency and other entities providing services and supports.

8. Ensure the health and safety of the member by addressing the member's assessed needs and identified risks.

9. Document non-paid supports and items needed to achieve the goals.

10. Include the signatures of everyone with responsibility for the plan's implementation, including the member or the member's guardians or representatives, the case manager, the support broker/agent (when applicable), and providers, and include a timeline for review of the plan. The plan must be discussed with family, friends, and caregivers designated by the member so that they fully understand it and their roles.

11. Identify each person and entity responsible for monitoring the plan's implementation.

12. Identify needed services based upon the assessed needs of the member and prevent unnecessary or inappropriate services and supports not identified in the assessed needs of the member.

13. Document an emergency back-up plan that encompasses a range of circumstances (e.g., weather, housing, and staff).

14. Address elements of self-direction through the consumer choices option (e.g., financial management service, support broker/agent, alternative services) whenever the consumer choices option is chosen.

15. Be distributed directly to all parties involved in the planning process.

c. Referral and related activities. The case manager shall assist, as needed, the member in obtaining needed services, such as by scheduling appointments for the member and by connecting the

member with medical, social, educational, housing, transportation, vocational or other service providers or programs that are capable of providing needed services to address identified needs and risk factors and to achieve goals specified in the person-centered service plan.

d. Monitoring and follow-up. The case manager shall perform monitoring activities and make contacts that are necessary to ensure the health, safety, and welfare of the member and to ensure that the person-centered service plan is effectively implemented and adequately addresses the needs of the member. At a minimum, monitoring shall include assessing the member, the places of service (including the member's home, when applicable), and all services regardless of the service funding stream. Monitoring shall also include review of service provider documentation. Monitoring of the following aspects of the person-centered service plan shall lead to revisions of the plan if deficiencies are noted:

(1) Services are being furnished in accordance with the member's person-centered service plan, including the amount of service provided and the member's attendance and participation in the service;

(2) The member has declined services in the service plan;

(3) Communication among providers is occurring, as practicable, to ensure coordination of services;

(4) Services in the person-centered service plan are adequate, including the member's progress toward achieving the goals and actions determined in the person-centered service plan; and

(5) There are changes in the needs or circumstances of the member. Follow-up activities shall include making necessary adjustments in the person-centered service plan and service arrangements with providers.

e. Contacts. Case managers shall make contacts with the member, the member's guardians or representatives, or service providers as frequently as necessary and no less frequently than necessary to meet the following requirements:

(1) The case manager shall have at least one face-to-face contact with the member in the member's residence at least quarterly;

(2) The case manager shall have at least one contact per month with the member or the member's guardians or representatives. This contact may be face to face or by telephone;

(3) Community-based case management contacts will be made in accordance with the Medicaid contract MED-16-019, or subsequent Medicaid managed care contracts with the department, in those instances where the contract specifies contacts different from this rule.

90.4(2) *Exclusions.* Payment shall not be made for activities otherwise within the definition of case management services when any of the following conditions exist:

a. The activities are an integral component of another covered Medicaid service.

b. The activities constitute the direct delivery of underlying medical, social, educational, housing, transportation, vocational or other services to which a member has been referred. Such services include, but are not limited to:

(1) Services under parole and probation programs;

(2) Public guardianship programs;

(3) Special education programs;

(4) Child welfare and child protective services; or

(5) Foster care programs.

c. The activities are components of the administration of foster care programs, including but not limited to the following:

(1) Research gathering and completion of documentation required by the foster care program;

(2) Assessing adoption placements;

(3) Recruiting or interviewing potential foster care parents;

(4) Serving legal papers;

(5) Conducting home investigations;

(6) Providing transportation related to the administration of foster care;

(7) Administering foster care subsidies; or

(8) Making placement arrangements.

d. The activities for which a member may be eligible are a component of the administration of another nonmedical program, such as a guardianship, child welfare or child protective services, parole, probation, or special education program, except for case management that is included in an individualized education program or individualized family service plan consistent with Section 1903(c) of the Social Security Act.

e. The activities duplicate institutional discharge planning.

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441—90.5(249A) Rights restrictions. Rule 441—90.5(249A) applies to all categories of case management and all populations covered by case management. Any effort to restrict the rights of a member to realize the member's preferences or goals must be justified by a specific individualized assessed safety need and documented in the person-centered service plan. The following requirements must be documented in the plan when a safety need has been identified that warrants a rights restriction:

1. The specific and individualized assessed safety need;
2. The positive interventions and supports used prior to any modifications or additions to the person-centered service plan regarding safety needs;
3. The less intrusive methods of meeting the safety needs that have been tried but were not successful;
4. A clear description of the rights restriction that is directly proportionate to the specific assessed safety need;
5. The regular collection and review of data to measure the ongoing effectiveness of the rights restriction;
6. The established time limits for periodic reviews to determine whether the rights restriction is still necessary or can be terminated;
7. The informed consent of the member to the proposed rights restriction; and
8. An assurance that the rights restriction itself will not cause undue harm to the member.

[**ARC 4897C**, IAB 2/12/20, effective 3/18/20]

441—90.6(249A) Documentation and billing.

90.6(1) *Documentation of contacts.* Subrule 90.6(1) applies to all categories of case management and all populations covered by case management.

a. Documentation of case management services contacts shall include:

(1) The name of the individual case manager;

(2) The need for, and occurrences of, coordination with other case managers within the same agency or referral or transition to another case management agency; and

(3) Other requirements as outlined in rule 441—79.3(249A) to support payment of services.

b. Targeted case management providers serving FFS members must also adhere to 441—subrule 24.4(4).

90.6(2) *Rounding units of service for case management services.* Subrule 90.6(2) applies only to targeted case management provided to FFS members or case management provided to brain injury or elderly waiver FFS members. For all fee-for-service case management units of service, the following rounding process shall be used:

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

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

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

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

90.6(3) *Collateral contacts.* Subrule 90.6(3) applies only to targeted case management provided to FFS members or case management provided to brain injury or elderly waiver FFS members. For all fee-for-service case management units of service, the case manager may bill for documented contacts with other entities and individuals if the contacts are directly related to the member's needs and care,

such as helping the member access services, identifying needs and supports to assist the member in obtaining services, providing other case managers with useful feedback, and alerting other case managers to changes in the member's needs.

90.6(4) *Billable activities for case management services.* Subrule 90.6(4) applies only to targeted case management provided to FFS members or case management provided to brain injury or elderly waiver FFS members. Billable activities for case management services are limited to the following activities, and any activity included in this list must be billed if the activity has occurred.

a. Face-to-face meeting with the member:

(1) Contact time; and

(2) Documentation completed during meeting.

b. Telephone conversation with the member:

(1) Contact time; and

(2) Documentation completed during meeting.

c. Collateral contacts on behalf of the member, including face-to-face, telephone, and email contacts:

(1) Contact time; and

(2) Documentation completed during meeting.

d. Individual care plans and person-centered service plans:

(1) Creation; and

(2) Revision.

e. Social histories:

(1) Creation; and

(2) Revision.

f. Assessments and reassessments:

(1) Participation during the assessment if requested by the member; and

(2) Utilization of the assessment for creation of the person-centered service plan.

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441—90.7(249A) Case management services provider requirements. Rule 441—90.7(249A) applies to all categories of case management and all populations covered by case management.

90.7(1) *Reporting procedures for major incidents.*

a. When a major incident occurs or a staff member becomes aware of a major incident:

(1) The staff member shall notify the following persons of the incident by midnight of the next calendar day after the incident:

1. The staff member's supervisor;

2. The member or member's legal guardians; and

3. The member's case manager. The case manager shall create an incident report if a provider has not submitted a report.

(2) By midnight of the next business day after the incident, the staff member who observed or first became aware of the incident shall also report as much information as is known by the staff member about the incident to the member's managed care organization in the format required by the managed care organization. If the member is not enrolled with a managed care organization, or is receiving money follows the person funding, the staff member shall report the information by direct data entry into the Iowa Medicaid portal access (IMPA) system. The case manager is responsible for reporting the incident if the provider of service has not already reported the incident.

(3) The following information shall be reported:

1. The name of the member involved;

2. The date, time, and location where the incident occurred;

3. A description of the incident;

4. The names of all provider staff and others who were present at the time of the incident or who responded after becoming aware of the incident. The confidentiality of other Medicaid-eligible members

or non-Medicaid-eligible persons who were present must be maintained by the use of initials or other means;

5. The action taken to manage or respond to the incident;

6. The resolution of or follow-up to the incident; and

7. The date the report is made and the handwritten or electronic signature of the person making the report.

(4) When complete information about the incident is not available at the time of the initial report, the case management services provider must submit follow-up reports until the case manager is satisfied with the incident resolution and follow-up.

(5) The case management services provider shall maintain the completed report in a centralized file with a notation in the member's file.

(6) The case management services provider shall track incident data and analyze trends to assess the health and safety of members served and to determine whether changes need to be made for service implementation or whether staff training is needed to reduce the number or severity of incidents.

b. When an incident report for a major incident is received from any provider, the case manager shall monitor the situation to ensure that the member's needs continue to be met.

c. When any major incident occurs, the case manager shall reevaluate the risk factors identified in the risk assessment portion of the service plan in order to ensure the continued health, safety, and welfare of the member. Documentation must be made in the person-centered service plan of this review and follow-up activities.

90.7(2) *Reporting procedures for minor incidents.* Minor incidents may be reported in any format designated by the case management services provider. When a minor incident occurs, or a staff member becomes aware of a minor incident, the staff member involved shall submit the completed incident report to the staff member's supervisor within 72 hours of the incident. The completed report shall be maintained in a centralized file with a notation in the member's file.

90.7(3) *Quality assurance.* Case management services providers shall cooperate with quality assurance activities conducted by the Iowa Medicaid enterprise or a Medicaid managed care organization, as well as any other state or federal entity with oversight authority to ensure the health, safety, and welfare of Medicaid members. These activities may include, but are not limited to:

a. Postpayment review of case management services;

b. Review of incident reports;

c. Review of reports of abuse or neglect; and

d. Technical assistance in determining the need for service.

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[Filed Emergency After Notice ARC 2164C (Notice ARC 2062C, IAB 7/22/15), IAB 9/30/15, effective 10/1/15]
[Filed Emergency After Notice ARC 2361C (Notice ARC 2242C, IAB 11/11/15), IAB 1/6/16, effective 1/1/16]
[Filed ARC 4897C (Notice ARC 4739C, IAB 11/6/19), IAB 2/12/20, effective 3/18/20]

[1] January 1, 2003, effective date of 90.2(5) and 90.3 delayed 70 days by the Administrative Rules Review Committee at a special meeting held December 19, 2002.