

191—72.10(514H) Maintaining auditing information.

72.10(1) Each issuer shall maintain information as stipulated in 72.10(6) on all policyholders or certificate holders who have ever received any benefit under the policy or certificate. Such information shall be updated at least quarterly. This requirement for updating shall not require the conduct of any assessment, reassessment, or other evaluation of the policyholder's or certificate holder's condition which is not otherwise required by federal or state statute or regulation.

72.10(2) When a policyholder or certificate holder who has received any benefit dies or lapses the policy or certificate for any reason, the issuer must retain the stipulated information for a period of at least five years after the time when the policy was in force. Unless notified by the division of insurance to the contrary during this period, after the five years, the service summary provided by the issuer will be deemed to comply with all asset protection reporting, record keeping, and auditing requirements of this rule. The issuer may use microfiche, microfilm, optical storage media, or any other cost-effective method of record storage as alternatives to storage of paper copies of stipulated information.

72.10(3) At the time the policy or certificate ceases to be in force, the issuer shall notify the policyholder or certificate holder of the right to request service records as stipulated in 72.10(6).

72.10(4) The issuer shall also, upon request in writing, provide such policyholder or certificate holder or the policyholder's or certificate holder's authorized designee, if any, with a copy of the issuer's service records as required in 72.10(6) which are necessary to establish the asset disregard. These records shall be provided to the policyholder or certificate holder or the policyholder's or certificate holder's authorized designee, if requested, within 60 days of the request. The issuer may charge a reasonable fee to cover the costs of providing each set of requested service record copies.

72.10(5) The issuer shall enclose with the records a statement advising the former policyholder or certificate holder that it is in the best interest of the former policyholder or certificate holder to retain the records to establish eligibility for Medicaid.

72.10(6) The information to be maintained includes the following:

a. Evidence that the insured event has taken place. The occurrence of the insured event may be documented in any of the following ways:

(1) By case management agency staff, as part of the initial assessment of the client or as part of a subsequent reassessment.

(2) By an assessment conducted as part of the preadmission screening program of the Iowa Foundation of Medical Care.

(3) By an assessment of a resident of a nursing facility as required by Section 1919(b)(3) of the Social Security Act.

(4) For persons for whom subparagraphs (1) through (3) are not available or do not provide the required information, by an assessment, carried out by or under the supervision of a physician or a registered nurse, which is substantially comparable to any of the methods in subparagraphs (1) through (3). These assessments must be based on direct observations and interviews in conjunction with a medical record review. The physician or registered nurse carrying out or supervising the assessment must sign and certify the completion of the assessment. Each individual who completes a portion of such assessment shall sign and certify as to the accuracy of that portion of the assessment.

b. Description of services provided under the policy or certificate, including the following:

(1) Name, address, telephone number, and license number, if applicable, of provider.

(2) Amount, date, and type of services provided, and whether the services qualify for asset protection.

(3) Dollar amounts paid by the issuer, whether on an indemnity, expense incurred, or other basis.

(4) The charges of the service providers, including copies of invoices for all services counting toward asset protection.

(5) Identification of the case management agency, if applicable, and copies of all assessments and reassessments.

(6) Determination of whether the policyholder or certificate holder was a qualified insured at the time of benefit payment. The issuer may rely on written representation by the policyholder or certificate holder as to whether the required coverages were held.

c. In order for home- and community-based services to qualify for asset protection, these services must be in accord with a plan of care developed by a case management agency. If the policyholder or certificate holder has received any benefits delivered as part of a plan of care, the issuer must retain the following:

(1) A copy of the original plan of care.

(2) A copy of any changes made in the plan of care. The plan of care must document that the changes are required by changes in the client's medical situation, cognitive abilities, behavioral abilities, or the availability of social supports. Such services shall count toward asset protection after the case management agency adds the documented need for and description of the new services to the plan of care. In cases when the service must begin before the revisions to the plan of care are made, the new services will only count toward asset protection if the revisions to the plan of care are made within ten business days of the commencement of the new services. Issuers must maintain initial assessments and subsequent reassessments as part of insured event documentation.

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