**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 2000 Iowa Acts, Senate File 2435, section 9.

**441—78.48(249A) Rehabilitation services for adults with chronic mental illness.** Subject to the requirements of this rule, payment shall be approved for the services listed in subrule 78.48(6) when provided to adults with a chronic mental illness. These services must be rehabilitative in nature and may not be primarily habilitative. Services must be designed to promote integration and stability in the community, quality of life, and the person's ability to obtain or retain employment or to function in other nonwork, role-appropriate settings.

**78.48(1)** *Definitions.*

*"Adult"* means a person 18 years of age or older.

*"Adults with chronic mental illness"* means adults with a persistent mental or emotional disorder that seriously impairs their functioning relative to primary aspects of daily living such as personal relations, living arrangements, or employment. Adults with chronic mental illness typically meet at least one of the following criteria:

1. Have undergone psychiatric treatment more intensive than outpatient care, more than once in a lifetime (e.g., emergency services, alternative home care, partial hospitalization or inpatient hospitalization).

2. Have experienced at least one episode of continuous, structured supportive residential care other than hospitalization.

3. In addition, these persons typically meet at least two of the following criteria on a continuing or intermittent basis for at least two years:

- Are unemployed, or employed in a sheltered setting, or have markedly limited skills and a poor work history.
- Require financial assistance for out-of-hospital maintenance and may be unable to procure this assistance without help.
- Show severe inability to establish or maintain a personal social support system.
- Require help in basic living skills.
- Exhibit inappropriate social behavior that results in demand for intervention by the mental health or judicial system.

In atypical instances, a person who varies from the above criteria could still be considered to be a person with chronic mental illness.

Notwithstanding the foregoing, for the purposes of this rule persons with mental disorders resulting from Alzheimer's disease or substance abuse shall not be considered chronically mentally ill.

*"Case planner"* means an individual, designated by the recipient, performing the functions described under subrule 78.48(3) who is a targeted case manager enrolled in the Iowa Medicaid program or who has the qualifications to enroll as such, but who does not have a financial interest in any services being rendered as specified in the comprehensive plan, and who meets one of the following qualifications:

1. Has a bachelor's degree with 30 semester hours or equivalent quarter hours in a human services field and at least one year of experience in the delivery of services to the population groups served.
2. Has an Iowa license to practice as a registered nurse and at least three years of experience in the delivery of services to the population groups served.

*"Central point of coordination (CPC)"* is defined as in rule 441—25.11(331).

*"Comprehensive plan"* means a written plan of care completed by the recipient's case planner as to that recipient's need for services including identification of the rehabilitative service needs related to the recipient's chronic mental illness.

*"Department"* means the Iowa department of human services or its designee.

*"Direct contact"* means a provider's face-to-face interaction with a person for the delivery of a rehabilitative service.

*"Habilitative services"* means services 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.

*"Legal representative"* means a person authorized by law to act on behalf of a person with regard to a matter described in this rule.

*"Licensed practitioner of the healing arts"* or *"LPHA"* means a person enrolled as a Medicaid provider who is:

1. A physician (M.D. or D.O.); or
2. A psychologist who meets the standards of the National Register of Health Service Providers in Psychology, 1981 edition, published by the council for the National Register of Health Service Providers in Psychology.

*"Licensed professional"* means one of the following professionals licensed under Iowa law and who is employed by an enrolled Medicaid provider, under contract with a Medicaid provider, or employed by a professional association or institution of higher learning under contract with a Medicaid provider:

1. Mental health counselor.
2. A bachelor, master, or independent social worker.
3. Registered nurse.
4. Advanced registered nurse practitioner.
5. Physician assistant.
6. A psychologist who does not qualify as a licensed practitioner of the healing arts.

*"Medicaid provider"* means an individual or entity with which the Iowa Medicaid program has a provider agreement to provide rehabilitation services consistent with this rule.

*"Paraprofessional"* means a person who:

1. Is not a licensed practitioner of the healing arts (LPHA) or a licensed professional.
2. Provides services consistent with the rehabilitation component of a comprehensive plan for the recipient and under the supervisory oversight of an LPHA, licensed professional, or enrolled provider of rehabilitation services for adults with chronic mental illness.
3. Has demonstrated competency in delivering the rehabilitative services in accordance with the standards of a nationally recognized organization offering training in the area in which the paraprofessional delivers services, as certified by the supervising LPHA, licensed professional, or enrolled provider of rehabilitation services for adults with chronic mental illness.

4. Delivers the services through employment by or a contract with a provider enrolled in the Medicaid program.

*"Peer support counselor"* means a person who has been diagnosed with a chronic mental illness, who provides counseling and support services to other adults with the same or a similar diagnosed mental illness and who meets the following requirements:

1. Has completed peer counseling and support training, as certified by the supervising LPHA, licensed professional, or enrolled provider of rehabilitation services for adults with chronic mental illness.

2. Abides by the ethical guidelines and requirements applicable to a licensed mental health counselor as reflected in the National Board for Certified Counselors code of ethics including, but not limited to, guidelines regarding patient confidentiality, nonfraternization with patients, and mandatory abuse reporting requirements.

3. Provides services consistent with the rehabilitation component of a comprehensive plan for the recipient and under the supervisory oversight of an LPHA, licensed professional, or enrolled provider of rehabilitation services for adults with chronic mental illness.

4. Has demonstrated competency in delivering the rehabilitative services in accordance with the standards of a nationally recognized organization offering training in the area in which the person delivers services, as certified by the supervising LPHA, licensed professional, or enrolled provider of rehabilitation services for adults with chronic mental illness.

5. Delivers the service through employment by or a contract with a provider enrolled in the Medicaid program.

*"Rehabilitation services for adults with chronic mental illness"* means the services listed under subrule 78.48(6).

*"Rehabilitative necessity"* and *"rehabilitatively necessary"* means services that are:

1. Reasonable and necessary;

2. Rehabilitative in nature and not habilitative;

3. Designed to promote a recipient's integration and stability in the community and quality of life; and

4. Designed to promote a recipient's ability to obtain or retain employment or to function in nonwork settings and address the symptoms of mental and functional disabilities and behaviors resulting from chronic mental illness that interfere with these activities.

*"Rehabilitative services"* means services designed to assist individuals in reacquisition and restoration of skills that have been lost or have deteriorated due to disease or injury, as well as associated retraining to reacquire self-help, socialization, and adaptive skills necessary to reside successfully in a home or community setting.

**78.48(2)** *Requirements for covered services.* Rehabilitation services for adults with chronic mental illness provided under Iowa Medicaid shall be limited to those services that are rehabilitatively necessary and that meet all of the requirements below. The rehabilitation service must be:

*a.* Included in a comprehensive plan developed as specified in subrule 78.48(3).

*b.* Consistent with professionally accepted guidelines and standards of practice for the rehabilitation service being provided.

*c.* Furnished in the most appropriate and least restrictive available setting in which the service can be safely provided and at the most appropriate level for the individual.

*d.* Provided by or through a provider enrolled in the Iowa Medicaid program. Medicaid providers may employ or contract with paraprofessionals or licensed professionals to deliver rehabilitation services to recipients, subject to the following conditions:

(1) Licensed professionals may provide the services only as allowed under their scope and licensure.

(2) Paraprofessionals may render services only under the supervision of an LPHA, a licensed professional, or an enrolled provider of rehabilitation services to adults with chronic mental illness.

(3) Services provided by a paraprofessional or licensed professional through a contract with or employment by an enrolled provider shall comply with the requirements that are applicable to the enrolled provider.

(4) Services delivered by a residential care facility, supported employment provider, supported community living provider, or adult day care provider through a contract with an enrolled provider of rehabilitation services to adults with chronic mental illness, where these providers are not enrolled themselves, shall comply with the requirements that are applicable to the enrolled provider.

(5) Peer support counseling may be provided only by a "peer support counselor."

**78.48(3)** *Comprehensive treatment plan.* A comprehensive treatment plan that includes a rehabilitation service component must be developed by a case planner as designated by the recipient in coordination with an interdisciplinary team before a recipient receives rehabilitation services. The following limitations and requirements shall apply:

*a.* A written assessment of need shall be made by the recipient's case planner as to the recipient's need for services, including identification of the rehabilitation service needs related to the recipient's chronic mental illness.

*b.* The comprehensive plan shall be developed by a case planner designated by the recipient or the recipient's legal representative and shall be based upon an assessment of the following:

(1) The social, cultural, and other factors which may affect the recipient's ability to maintain the current level of functioning or achieve a higher level of functioning.

(2) The recipient's current level of functioning and any barriers to maintaining the current or achieving a higher level of functioning.

(3) The appropriate services and service settings necessary to assist the recipient to maintain the current or achieve a higher level of functioning.

*c.* The interdisciplinary team shall include all persons or providers whose participation is necessary and appropriate relative to the recipient's needs and situation, as determined by the case planner.

*d.* The comprehensive plan shall include or identify the following:

(1) Individualized goals for the recipient.

(2) Objectives for the recipient specific to the recipient's individual needs and in the form of measurable and time-limited statements of what is to be accomplished.

(3) The specific services to be provided to the recipient that will achieve the stated goals and objectives.

(4) The providers, agencies or other persons who will be responsible for providing the indicated services.

(5) The date of service initiation and the anticipated duration of services.

(6) The persons legally authorized to act on behalf of the recipient, when applicable.

*e.* The case planner shall assist the recipient to obtain all the services identified in the comprehensive plan. This shall include securing initial and continuing approval by an LPHA as required for Medicaid funding under subrule 78.48(4) for rehabilitation services. The case planner shall also provide the CPC for the county with financial responsibility for the recipient with information regarding the rehabilitative services in the comprehensive plan for service-tracking purposes.

*f.* The case planner shall monitor the services and service settings identified in the comprehensive plan to ensure that they continue to be necessary and appropriate and shall communicate with the interdisciplinary team regarding these issues. The case planner shall:

(1) Do a quarterly face-to-face review of the recipient's progress toward achieving the goals and objectives in the comprehensive plan.

(2) Review the recipient's level of functioning and continued need for the services at least annually, or more frequently if the recipient's conditions warrant. This review shall be based on the quarterly determinations required by subparagraph (1) above. The comprehensive plan shall be revised based on the results of this review and using the process set forth in paragraph 78.48(3)*"b."*

(3) Inform the CPC for the county with financial responsibility for the recipient of any changes made in the rehabilitation services included in the recipient's comprehensive plan.

**78.48(4)** *Approval of rehabilitation services by an LPHA.*

*a.* As a condition of Medicaid reimbursement for rehabilitation services, an LPHA must certify the recipient's diagnosis of chronic mental illness and the recipient's need for rehabilitation services.

*b.* As a condition of ongoing Medicaid funding for rehabilitation services, the LPHA shall review and approve the recipient's continued need at least annually, or more frequently if conditions warrant.

**78.48(5)** *Individual eligibility for rehabilitation services.* In order for individuals to be eligible for rehabilitation services, the individuals must meet the definition of "adults with a chronic mental illness" and have a need for rehabilitation services.

**78.48(6)** *Services.* Rehabilitation services for adults with chronic mental illness are limited to the following:

*a. Rehabilitation support services.* Rehabilitation support services are services that address mental and functional disabilities that negatively affect integration and stability in the community or quality of life and that reduce or manage those symptoms of or behaviors resulting from mental illness that interfere with a person's ability to obtain or retain employment or to function in other nonwork, role-appropriate settings. Rehabilitation support services are limited to the following:

(1) Community living skills training services. These services are age-appropriate skills training or supportive interventions that focus on the improvement of communication skills, appropriate interpersonal behaviors, and other skills necessary for independent living or, when age-appropriate, for functioning effectively with family, peers, and teachers. Training for independent living may include, but is not limited to, skills related to personal hygiene, household tasks, transportation use, money management, the development of natural supports, access to needed services in the community (e.g., medical care, dental care, legal services), living accommodations, and social skills (e.g., communicating one's needs and making appropriate choices for the use of leisure time).

(2) Employment-related services. These services are age-appropriate training and supports that are not job- or task-specific and have as their focus the development of skills to reduce and manage the symptoms of mental illness that interfere with the person's ability to make vocational choices and to attain or retain employment. Included are activities such as skills training related to task focus, maintaining concentration, task completion, planning and managing activities to achieve outcomes, personal hygiene, grooming, communication, and skills training related to securing appropriate clothing, developing natural supports, and arranging transportation. Also included are supportive contacts in an educational setting on or off the work site to reduce or manage behaviors or symptoms related to the individual's mental illness that interfere with job performance or progress toward the development of skills that would enable the individual to obtain or retain employment.

*b. Day program services.* Day program services are limited to the following:

(1) Day program for skills training. These services are age-appropriate and site-appropriate services provided to persons who require skills training to increase integration and stability in the community, establish support networks, increase the persons' awareness of the community, develop coping strategies, and function effectively in their social environment. Services shall concentrate on skills training activities focusing on symptom management, independent living, self-reliance, general employment interventions, impulse control, and effective interactions with peers, family, and teachers.

(2) Day program for skills development. These services are age-appropriate, site-based services provided to persons who are in need of day program services to ensure personal well-being, to limit skill deterioration, to promote skill development, and to reduce the risk of or duration of institutionalization. Services focus on the development of functional skills, symptom management and reduction, nursing services, and training in activities of daily living, such as skills related to the development of age-appropriate interests and personal care skills.

**78.48(7)** *Service location.* Rehabilitation services for adults with a chronic mental illness must be provided in a service location that is consistent with the rehabilitation component of the recipient's comprehensive plan.

**78.48(8)** *Excluded services.* Rehabilitation services for adults with a chronic mental illness do not include any of the following:

*a.* Services to persons under 65 years of age residing in institutions for mental diseases as defined in 42 CFR 435.1009(2) as amended November 10, 1994.

*b.* Job- and task-specific vocational services.

*c.* Services which are solely educational in nature.

*d.* Room and board.

*e.* Services that are otherwise covered by the Iowa Medicaid program or that are an integral and inseparable part of another Medicaid-reimbursable service including, but not limited to, targeted case management services, institutional services, HCBS waiver services, or services under a behavioral health managed care program.

The services of a case planner under subrule 78.48(3) are not separately payable as a rehabilitation service for adults with chronic mental illness. Case planners under subrule 78.48(3) may be separately reimbursed under the existing Medicaid "case manager" provider type. Any person performing the functions of a case planner under subrule 78.48(3) who meets the definition of a case planner and who is not otherwise currently enrolled in Iowa Medicaid as a case manager may enroll for this purpose. The reimbursement methodology for case planners under subrule 78.48(3) will be the same as the reimbursement methodology for targeted case managers under rule 441—78.33(249A) and 441—subrule 79.1(2).

*f.* Inpatient hospital services.

*g.* Respite services.

*h.* Family support services.

*i.* Services that are not in the person's comprehensive plan.

*j.* Any services not provided directly to the eligible recipient.

This rule is intended to implement Iowa Code section 249A.4 and 2000 Iowa Acts, chapter 1228, section 8, subsection 11.

**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, and medical transportation.

**78.49(2)** *Coordination services.* Payment shall also be approved for infant and toddler coordination services, subject to the following requirements:

*a.* Payable coordination services must consist of activities to assist and enable a child and family to receive infant and toddler program services and must serve as the point of contact in assisting parents to obtain the services and assistance needed. This must include, but is not limited to:

(1) Explaining the infants and toddlers with disabilities program, including parental rights and procedural safeguards.

(2) Identifying the family's concerns related to the child's needs.

(3) Coordinating the evaluations and assessments needed by the child.

(4) Facilitating and participating in the development, review and evaluation of individualized family service plans (IFSP) pursuant to rule 281—41.5(256B,34CFR300). This must include identifying the people to participate in the development of the service plan and face-to-face or telephone contacts with others for the purpose of developing, reviewing, and revising the IFSP.

(5) Assisting parents in gaining access to the infant and toddler program services and other services identified in the IFSP. This must include face-to-face or telephone contacts with the child and family for the purpose of assessing or reassessing needs.

(6) Assisting families in identifying available service providers and funding resources. This must include documentation of unmet needs and gaps in services.

(7) Coordinating and monitoring the delivery of services, informing families of the availability of advocacy services, coordinating with medical and health providers, and periodic observation of services to ensure that quality services are being provided and are effectively meeting the needs of the child.

(8) Facilitating the timely delivery of services.

(9) Continuously seeking the appropriate services for the duration of the child's eligibility.

(10) Arranging or authorizing payment for medical transportation.

(11) Keeping records, including preparing reports, updating service plans, making notes about IFSP activities in the recipient's record, and preparing and responding to correspondence with the child, family, and others.

*b.* A minimum of one face-to-face contact per month between the service coordinator and the child and family is required for payment of infant and toddler coordination services.

**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.* The responsible infant and toddler program provider has entered into an agreement with the department certifying that the nonfederal share of the cost is available within funds allocated for the infants and toddlers with disabilities program.

*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 has certified on Form 470-3816, Medicaid Billing Remittance, that the funds remitted for the nonfederal share of the costs of the services are not federal funds and are unrestricted public funds available for match pursuant to 42 CFR 433.51 as amended January 26, 1993.

**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-eligible individuals 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.

Vaccines available through the Vaccines for Children program under Section 1928 of the Social Security Act are not covered as local education agency services. However, the administration of vaccines is a covered service.

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.

**78.50(2)** *Coordination services.* Payment shall also be approved for local education agency services coordination, subject to the following requirements:

*a.* Service coordination must consist of activities to assist and enable a child to receive local education agency services and must serve as the point of contact in assisting parents to obtain the services and assistance needed. This must include, but is not limited to:

(1) Coordinating the evaluations and assessments needed by the child.

(2) Facilitating and participating in the development and review of the initial and annual individual education plan (IEP) or individual health plan (IHP) pursuant to 281—Chapter 41, Division VIII, or 281—subrule 41.96(1).

(3) Conducting triennial reviews.

(4) Providing ongoing service coordination.

(5) Facilitating the timely delivery of needed services.

(6) Keeping records, including preparing reports, updating service plans, making notes about IEP/IHP activities in the child's record, and maintaining face-to-face contact as required in 78.50(2)*"b."*

*b.* A minimum of one face-to-face contact per quarter between the service coordinator and the child and family is required for payment of local education agency coordination services.

**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.* The responsible local education agency services provider has entered into an agreement with the department certifying that the nonfederal share of the cost is available within funds allocated for the local education agency services provider's program.

*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 has certified on Form 470-3816, Medicaid Billing Remittance, that the funds remitted for the nonfederal share of the costs of the services are not federal funds.

**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.

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